Tab 1	b 1 SB 322 by Burton ; (Similar to H 07041) Public Records and Meeting	ngs
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Tab 2	SB 701	6 by H	IP; (Compa	re to H 00877) Health Care		
209374	Α	S	RCS	FP, Burton	Delete L.688 - 1050:	01/11 11:53 AM
325568	Α	S	RCS	FP, Burton	Delete L.1222:	01/11 11:53 AM
655244	Α	S	RCS	FP, Burton	Delete L.1435 - 1446:	01/11 11:53 AM
520732	Α	S	RCS	FP, Burton	Delete L.1846 - 1905:	01/11 11:53 AM
780532	—AA	S	WD	FP, Thompson	After L.75:	01/11 11:53 AM
640470	Α	S	RCS	FP, Burton	Delete L.2139 - 2198:	01/11 11:53 AM
871294	AA	S	RCS	FP, Burton	Delete L.51:	01/11 11:53 AM
533656	Α	S	RCS	FP, Burton	Delete L.2311 - 2447:	01/11 11:53 AM
263310	Α	S	RCS	FP, Burton	Delete L.2761:	01/11 11:53 AM
595448	Α	S	RCS	FP, Burton	Delete L.3303:	01/11 11:53 AM
181804	Α	S	RCS	FP, Burton	Delete L.6657 - 6784:	01/11 11:53 AM
Tab 3	SB 701	8 by H	P (CO-IN	RODUCERS) Harrell; (Simila	r to H 01501) Health Care Innovati	on

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

FISCAL POLICY Senator Hutson, Chair Senator Stewart, Vice Chair

TIME:	Thursday, January 11, 2024 10:00 a.m.—12:00 noon <i>Pat Thomas Committee Room,</i> 412 Knott Building
MEMBERS:	Senator Hutson, Chair; Senator Stewart, Vice Chair; Senators

MBERS: Senator Hutson, Chair; Senator Stewart, Vice Chair; Senators Albritton, Berman, Boyd, Burton, Calatayud, Collins, DiCeglie, Garcia, Jones, Mayfield, Osgood, Rodriguez, Simon, Thompson, Torres, Trumbull, Wright, and Yarborough

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	SB 322 Burton (Compare S 1500, Linked S 7016)	 Public Records and Meetings; Providing an exemption from public records requirements for certain information held by the Department of Health, the Board of Medicine, the Board of Osteopathic Medicine, the Board of Speech-Language Pathology and Audiology, and the Board of Physical Therapy Practice pursuant to the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact, as applicable; authorizing disclosure of the information under certain circumstances; providing an exemption from public meetings requirements for certain meetings, or portions of meetings, of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-Language Pathology Interstate Compact Commission; providing for future legislative review and repeal of the exemptions; providing statements of public necessity, etc. FP 01/11/2024 Favorable 	Favorable Yeas 18 Nays 0
2	SB 7016 Health Policy (Compare H 877, H 975, H 1441, H 1549, S 68, S 668, S 1008, S 1498, S 1582, Linked S 322)	Health Care; Revising the purpose of the Dental Student Loan Repayment Program; requiring the Department of Health to provide annual reports to the Governor and the Legislature on specified student loan repayment programs; providing requirements for birth centers designated as advanced birth centers with respect to operating procedures, staffing, and equipment; authorizing certain psychiatric nurses to order emergency treatment of certain patients; creating the Training, Education, and Clinicals in Health (TEACH) Funding Program for a specified purpose; enacting the Interstate Medical Licensure Compact in this state, etc. FP 01/11/2024 Fav/CS	Fav/CS Yeas 18 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Fiscal Policy

Thursday, January 11, 2024, 10:00 a.m.-12:00 noon

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	SB 7018 Health Policy (Similar H 1501)	Health Care Innovation; Creating the Health Care Innovation Council within the Department of Health for a specified purpose; requiring the council to submit annual reports to the Governor and the Legislature; requiring the department to administer a revolving loan program for applicants seeking to implement certain health care innovations in this state; authorizing the department to contract with a third party to administer the program, including loan servicing, and manage the revolving loan fund, etc. FP 01/11/2024 Favorable	Favorable Yeas 19 Nays 0

Other Related Meeting Documents

The Florida Senate BILL ANALYSIS AND FISCAL IMPACT STATEMENT

	Prepare	d By: The	Professional S	taff of the Committe	e on Fiscal Polic	ÿ
BILL:	SB 322					
INTRODUCER: Senator Bu		on				
SUBJECT: Public Recor		ds and M	eetings			
DATE:	January 9, 20	24	REVISED:			
ANAL	YST		DIRECTOR	REFERENCE		ACTION
1. Siples		Yeatmar	1	FP	Favorable	

I. Summary:

SB 322 creates public records and public meeting exemptions for the Interstate Medical Licensure Compact (IMLC), the Audiology and Speech-Language Pathology Interstate Compact, and the Physical Therapy Licensure Compact.

The bill protects from public disclosure the personal identifying information of a physician, audiologist, speech-language pathologist, physical therapist, and physical therapist assistant, other than the individual's name, licensure status, or license number, obtained from the coordinated licensure system or database (coordinated system) under the applicable compact and held by the Department of Health (DOH) or applicable board, unless the state that originally reported the information to the coordinated system authorizes the disclosure by law.

The bill exempts a meeting or a portion of a meeting of the compact commissions if the commission discusses specified topics or items that are exempt from disclosure under federal or state law. Recordings, minutes, and records generated during an exempt commission meeting are exempted under the bill from the public records provisions in s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

The exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless reviewed and reenacted by the Legislature.

The bill provides a statement of public necessity as required by the State Constitution.

Because the bill creates a new public records exemption, it requires a two-thirds vote of the members present and voting in each house of the Legislature for final passage.

The bill provides the effective date is the same date that SB 7016, or similar legislation, if adopted, takes effect.

II. Present Situation:

Access to Public Records – Generally

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.¹ The right to inspect or copy applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.²

Additional requirements and exemptions related to public records are found in various statutes and rules, depending on the branch of government involved. For instance, s.11.0431, F.S., provides public access requirements for legislative records. Relevant exemptions are codified in s. 11.0431(2)-(3), F.S., and adopted in the rules of each house of the Legislature.³ Florida Rule of Judicial Administration 2.420 governs public access to judicial branch records.⁴ Lastly, ch. 119, F.S., known as the Public Records Act, provides requirements for public records held by executive agencies.

Executive Agency Records – The Public Records Act

The Public Records Act provides that all state, county and municipal records are open for personal inspection and copying by any person, and that providing access to public records is a duty of each agency.⁵

Section 119.011(12), F.S., defines "public records" to include:

All documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connections with the transaction of official business by any agency.

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business that are used to "perpetuate, communicate, or formalize knowledge of some type."⁶

¹ FLA. CONST. art. I, s. 24(a).

 $^{^{2}}$ Id.

³ See Rule 1.48, Rules and Manual of the Florida Senate, (2022-2024) and Rule 14.1, Rules of the Florida House of Representatives, Edition 2, (2022-2024)

⁴ State v. Wooten, 260 So. 3d 1060 (Fla. 4th DCA 2018).

⁵ Section 119.01(1), F.S. Section 119.011(2), F.S., defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."

⁶ Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc., 379 So. 2d 633, 640 (Fla. 1980).

The Florida Statutes specify conditions under which public access to public records must be provided. The Public Records Act guarantees every person's right to inspect and copy any public record at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.⁷ A violation of the Public Records Act may result in civil or criminal liability.⁸

The Legislature may exempt public records from public access requirements by passing a general law by a two-thirds vote of both the House and the Senate.⁹ The exemption must state with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish the stated purpose of the exemption.¹⁰

General exemptions from the public records requirements are contained in the Public Records Act.¹¹ Specific exemptions often are placed in the substantive statutes relating to a particular agency or program.¹²

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute.¹³ Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances.¹⁴

Open Meetings Laws

The State Constitution provides that the public has a right to access governmental meetings.¹⁵ Each collegial body must provide notice of its meetings to the public and permit the public to attend any meeting at which official acts are taken or at which public business is transacted or discussed.¹⁶ This applies to the meetings of any collegial body of the executive branch of state government, counties, municipalities, school districts or special districts.¹⁷

⁷ Section 119.07(1)(a), F.S.

⁸ Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.

⁹ FLA. CONST. art. I, s. 24(c).

¹⁰ *Id. See, e.g., Halifax Hosp. Medical Center v. News-Journal Corp.*, 724 So. 2d 567 (Fla. 1999) (holding that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption); *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004) (holding that a statutory provision written to bring another party within an existing public records exemption is unconstitutional without a public necessity statement).

¹¹ See, e.g., s. 119.071(1)(a), F.S. (exempting from public disclosure examination questions and answer sheets of examinations administered by a governmental agency for the purpose of licensure).

¹² See, e.g., s. 213.053(2)(a), F.S. (exempting from public disclosure information contained in tax returns received by the Department of Revenue).

¹³ WFTV, Inc. v. The Sch. Bd. of Seminole County, 874 So. 2d 48, 53 (Fla. 5th DCA 2004).

¹⁴ Williams v. City of Minneola, 575 So. 2d 683 (Fla. 5th DCA 1991).

¹⁵ FLA. CONST., art. I, s. 24(b).

¹⁶ Id.

¹⁷ FLA. CONST., art. I, s. 24(b). Meetings of the Legislature are governed by Article III, section 4(e) of the Florida Constitution, which states: "The rules of procedure of each house shall further provide that all prearranged gatherings, between more than two members of the legislature, or between the governor, the president of the senate, or the speaker of the house of representatives, the purpose of which is to agree upon formal legislative action that will be taken at a subsequent

Public policy regarding access to government meetings is also addressed in the Florida Statutes. Section 286.011, F.S., known as the "Government in the Sunshine Law,"¹⁸ or the "Sunshine Law,"¹⁹ requires all meetings of any board or commission of any state or local agency or authority at which official acts are to be taken be open to the public.²⁰ The board or commission must provide the public reasonable notice of such meetings.²¹ Public meetings may not be held at any location that discriminates on the basis of sex, age, race, creed, color, origin or economic status or which operates in a manner that unreasonably restricts the public's access to the facility.²² Minutes of a public meeting must be promptly recorded and open to public inspection.²³ Failure to abide by open meetings requirements will invalidate any resolution, rule or formal action adopted at a meeting.²⁴ A public officer or member of a governmental entity who violates the Sunshine Law is subject to civil and criminal penalties.²⁵

The Legislature may create an exemption to open meetings requirements by passing a general law by at least a two-thirds vote of each house of the Legislature.²⁶ The exemption must explicitly lay out the public necessity justifying the exemption, and must be no broader than necessary to accomplish the stated purpose of the exemption.²⁷ A statutory exemption which does not meet these two criteria may be unconstitutional and may not be judicially saved.²⁸

Open Government Sunset Review Act

The provisions of s. 119.15, F.S., known as the Open Government Sunset Review Act²⁹ (the Act), prescribe a legislative review process for newly created or substantially amended³⁰ public records or open meetings exemptions, with specified exceptions.³¹ The Act requires the repeal of such exemption on October 2nd of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.³²

 21 *Id*.

- ²⁵ Section 286.011(3), F.S.
- ²⁶ FLA. CONST., art. I, s. 24(c).
- ²⁷ Id.

²⁹ Section 119.15, F.S.

³² Section 119.15(3), F.S.

time, or at which formal legislative action is taken, regarding pending legislation or amendments, shall be reasonably open to the public."

¹⁸ Times Pub. Co. v. Williams, 222 So. 2d 470, 472 (Fla. 2d DCA 1969).

¹⁹ Board of Public Instruction of Broward County v. Doran, 224 So. 2d 693, 695 (Fla. 1969).

²⁰ Section 286.011(1)-(2), F.S.

²² Section 286.011(6), F.S.

²³ Section 286.011(2), F.S.

²⁴ Section 286.011(1), F.S.

²⁸ Halifax Hosp. Medical Center v. New-Journal Corp., 724 So. 2d 567 (Fla. 1999). In Halifax Hospital, the Florida Supreme Court found that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption. *Id.* at 570. The Florida Supreme Court also declined to narrow the exemption in order to save it. *Id.* In *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004), the court found that the intent of a public records statute was to create a public records exemption. The *Baker County Press* court found that since the law did not contain a public necessity statement, it was unconstitutional. *Id.* at 196.

³⁰ An exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings as well as records. Section 119.15(4)(b), F.S.

³¹ Section 119.15(2)(a) and (b), F.S., provides that exemptions required by federal law or applicable solely to the Legislature or the State Court System are not subject to the Open Government Sunset Review Act.

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.³³ An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- It allows the state or its political subdivisions to effectively and efficiently administer a governmental program, and administration would be significantly impaired without the exemption;³⁴
- It protects sensitive, personal information, the release of which would be defamatory, cause unwarranted damage to the good name or reputation of the individual, or would jeopardize the individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;³⁵ or
- It protects information of a confidential nature concerning entities, such as trade or business secrets.³⁶

The Act also requires specified questions to be considered during the review process. In examining an exemption, the Act directs the Legislature to question the purpose and necessity of reenacting the exemption.

Public Necessity Statement and Two-thirds Vote Requirement

If the exemption is continued and expanded, then a public necessity statement and a two-thirds vote for passage are required.³⁷ If the exemption is continued without substantive changes or if the exemption is continued and narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to expire, the previously exempt records will remain exempt unless otherwise provided by law.³⁸

Interstate Medical Licensure Compact

SB 7016 establishes Florida as a member state in the Interstate Medical Licensure Compact (IMLC). The IMLC provides an expedited pathway for allopathic and osteopathic physicians to qualify to practice medicine within compact member states. The IMLC currently includes 37 states, the District of Columbia and the Territory of Guam.³⁹

States participating in the IMLC are able to streamline the acquisition of a license by using an expedited process to share information with each other that the physician has previously submitted in his or her state of principal licensure.⁴⁰ Prior to participating in the IMLC, a

³³ Section 119.15(6)(b), F.S.

³⁴ Section 119.15(6)(b)1., F.S.

³⁵ Section 119.15(6)(b)2., F.S.

³⁶ Section 119.15(6)(b)3., F.S.

³⁷ See generally s. 119.15, F.S.

³⁸ Section 119.15(7), F.S.

³⁹ Interstate Medical Licensure Compact, A Faster Pathway to Licensure, available at <u>https://www.imlcc.org/a-faster-pathway-to-physician-licensure/</u> (last visited Dec. 18, 2023).

 $^{^{40}}$ Id.

physician must also complete a background screening. Approximately 80 percent of U.S. physicians meet the criteria for expedited licensure under the IMLC.⁴¹

The IMLC requires the establishment of a coordinated information system containing licensure and disciplinary information for all physicians licensed or who have applied for license under the IMLC. Member states must report disciplinary or investigatory records. Member states may also report non-public complaint, disciplinary, or investigatory information that is not otherwise required to be reported. All information provided to the IMLC Commission or distributed by member boards is confidential and may only be used for investigatory or disciplinary matters.⁴²

IMLC Commission

The IMLC Commission, as created in the model legislation of the IMLC, serves as its administrator. Each member state has two voting representatives on the IMLC Commission and, if the state has separate regulatory boards for allopathic and osteopathic medicine, then the representation is split between the two boards.⁴³

The IMLC Commission meets at least once per calendar year in a publicly noticed meeting. The IMLC also creates an executive committee that may act on behalf of the IMLC Commission, with the exception of rulemaking. Information, rules, and minutes of the IMLC Commission and the executive committee, with the exception of the discussion of certain topics that may be closed to the public, are available for public inspection.⁴⁴

All or a portion of an IMLC Commission meeting may be closed to the public if a topic is likely to involve certain matters, based on a two-thirds vote of the members present at the meeting. Meetings may be closed to discuss:

- Personnel matters;
- Matters specifically exempted from disclosure by federal law;
- Trade secrets or commercial or financial information that is privileged or confidential;
- Information that involves accusing a person of a crime or formally censuring a person;
- Discussion of information of a personal nature, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy;
- Investigative records compiled for law enforcement purposes; or
- Information that specifically relates to the participation in a civil action or other legal proceeding.⁴⁵

The commission must keep detailed minutes about all matters discussed and all actions taken.

⁴¹ *Id*.

⁴² IMLC, *Compact Law and Model Legislation*, pp. 8-9., *available at <u>https://www.imlcc.org/wp-</u> content/uploads/2021/02/IMLC-Compact-Law.pdf* (last visited Dec. 18, 2023).

⁴³ *Id.*, at 11-13.

⁴⁴ *Id.*, at 13.

⁴⁵ *Id.* at 12-13.

Audiology and Speech-Language Pathology Interstate Compact

SB 7016 establishes Florida as a member state in the Audiology and Speech Language Pathology Interstate Compact (ASLP Compact). The ASLP Compact provides a pathway for an audiologist or speech-language pathologist who is licensed in his or her primary state of residence to apply for and be granted a privilege to practice audiology or speech-language pathology, respectively, in another member state, without obtaining a license in that state.

Although the ASLP Compact has been enacted into law in 29 states, it is not yet fully operational.⁴⁶ It is anticipated that it will begin processing applications for compact privileges in early 2024.

The ASLP Compact requires the development and maintenance of a coordinated database and reporting system containing licensure and disciplinary information for all licensed individuals practicing under the compact.

The compact overrides a compact state's laws to the contrary and requires the submission of a uniform data set on all licensees containing:

- Identifying information;
- Licensure data;
- Adverse actions against a license or compact privilege;
- Non-confidential information related to alternative program participation;
- Any denial of application for licensure and the reason for the denial;
- Current significant investigative information pertaining to a licensee; and
- Other information determined by commission rules.

The ASLP Compact Commission must promptly notify all member states of adverse action taken against any licensee or individual applying for a license. Such information must be available to any other member state.

A member state may designate information that may not be shared with the public without the express permission of that member state. Any information submitted to the coordinated database which is subsequently required to be expunged by law must be removed from the coordinated database.

ASLP Compact Commission

The ASLP Compact Commission, as created in the model legislation of the ASLP Compact, serves as its administrator.⁴⁷ Each member state has two delegates on the ASLP Compact Commission.

⁴⁶ ASLP Compact, *ASLP-IC: Audiology & Speech-Language Pathology Interstate Compact, available at* <u>https://aslpcompact.com/</u> (last visited at Dec. 18, 2023).

⁴⁷ ASLP Compact, *Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC)*, pp. 10-16., *available at* <u>https://aslpcompact.com/wp-content/uploads/2021/01/Final_ASLP-IC_Legislation_Correct_1.6.21.pdf</u> (last visited Dec. 18, 2023).

The ASLP Compact Commission meets at least once per calendar year in a publicly noticed meeting. The ASLP Compact also creates an executive committee that may act on behalf of the ASLP Compact Commission. Information, rules, and minutes of the ASLP Compact Commission and the executive committee, except those involving the discussion of certain topics that may be closed to the public, are available for public inspection.⁴⁸

Although most of the ASLP Compact Commission's meeting are required to be open to the public, the commission may convene in a closed, non-public meeting to discuss:

- A member state's noncompliance;
- Matters related to the commission's internal personnel practices and procedures;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations;
- Accusation of any person of a crime or a formal censure of a person;
- Information disclosing trade secrets or commercial or financial information that is privileged or confidential;
- Personal information, which if disclosed would constitute a clearly unwarranted invasion of personal privacy;
- Investigatory records compiled for law enforcement purposes;
- Information related to investigatory reports for use by the commission regarding compliance issues pursuant to the compact; or
- Matters specifically exempted from disclosure by federal or state statute.⁴⁹

If a meeting or portion of a meeting is closed, the ASLP Compact Commission's legal counsel must certify that the meeting may be closed and reference each relevant exempting provision.⁵⁰ The commission must keep detailed minutes about all matters discussed, actions taken, participants, views expressed, and documents considered. Under the compact, these minutes and documents must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.⁵¹

Physical Therapy Licensure Compact

SB 7016 establishes Florida as a member state in the Physical Therapy Licensure Compact (PT Compact). The PT Compact provides a pathway for a physical therapist or physical therapist assistant who is licensed in his or her primary state of residence to apply for and be granted a privilege to practice in another member state, without obtaining a license in that state. Currently, 37 states participate in the PT Compact.⁵²

The PT Compact requires the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information for all licensed individuals in member states.

⁴⁸ *Id.*, at 14.

⁴⁹ Id.

⁵⁰ Id.

⁵¹ *Id.*, at 15.

⁵² PT Compact, Compact Map, available at <u>https://ptcompact.org/ptc-states</u> (last visited Dec. 18, 2023).

The compact overrides a compact state's laws to the contrary and requires the submission of a uniform data set on all licensees containing:

- Identifying information;
- Licensure data;
- Adverse actions against a license or compact privilege;
- Non-confidential information related to alternative program participation;
- Any denial of application for licensure and the reason for the denial; and
- Other information determined by commission rules.⁵³

Investigative information pertaining to a licensee is only available to other party states. The PT Compact Commission must promptly notify all member states of adverse action taken against any licensee or individual applying for a license. Such information must be available to any other member state.

A member state may designate information that may not be shared with the public without the express permission of that member state. Any information submitted to the coordinated database which is subsequently required to be expunged by law must be removed from the coordinated database.

PT Compact Commission

The PT Compact Commission, as created in the model legislation of the PT Compact, serves as its administrator.⁵⁴ Each member state has one delegate on the PT Compact Commission.

The PT Compact Commission meets at least once per calendar year in a publicly noticed meeting. The PT Compact also creates an executive board that may act on behalf of the PT Compact Commission. Information, rules, and minutes of the PT Compact Commission and the executive board, except those involving the discussion of certain topics that may be closed to the public, are available for public inspection.⁵⁵

Although most of the PT Compact Commission's meeting are required to be open to the public, the commission may convene in a closed, non-public meeting to discuss:

- A member state's noncompliance;
- Matters related to the commission's internal personnel practices and procedures;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations;
- Accusation of any person of a crime or a formal censure of a person;
- Information disclosing trade secrets or commercial or financial information that is privileged or confidential;
- Personal information, which if disclosed would constitute a clearly unwarranted invasion of personal privacy;

⁵³ PT Compact, *Physical Therapy Compact Model Language*, pp. 18-19, *available at* <u>https://ptcompact.org/Portals/0/Images/PT_Compact_Language_Final%20with%20Cover%20Page1_11_2021.pdf</u> (last visited Dec. 18, 2023).

⁵⁴ *Id.*, at 9-18.

⁵⁵ *Id.*, at 14.

- Investigatory records compiled for law enforcement purposes;
- Information related to investigatory reports for use by the commission regarding compliance issues pursuant to the compact; or
- Matters specifically exempted from disclosure by federal or state statute.⁵⁶

If a meeting or portion of a meeting is closed, the PT Compact Commission's legal counsel must certify that the meeting may be closed and reference each relevant exempting provision.⁵⁷ The commission must keep detailed minutes about all matters discussed, actions taken, participants, views expressed, and documents considered. Under the compact, these minutes and documents must remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.⁵⁸

III. Effect of Proposed Changes:

Section 1 creates s.456.4503, F.S., to establish a public records and meetings exemption for activities related to the Interstate Medical Licensure Compact (IMLC). The bill exempts a physician's personal identifying information, other than the physician's name, licensure status, or license number, obtained from the coordinated information system and held by the Department of Health (DOH), Board of Medicine or Board of Osteopathic Medicine from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution, unless the state that originally reported the information to the coordinated information system authorizes the disclosure by law.

The bill exempts a meeting or a portion of a meeting of the IMLC Commission from s. 286.011, F.S., and s. 24(b), Art. I of the Statue Constitution if the IMLC Commission determines by a two-thirds vote of the commissioners present that the meeting would likely include a discussion of:

- Matters related to the IMLC Commission's internal personnel practices and procedures;
- Matters specifically exempted from disclosure by federal statutes;
- Trade secrets or commercial or financial information that is privileged or confidential;
- Accusation of any person of a crime or a formal censure of a person;
- Personal information, which if disclosed would constitute a clearly unwarranted invasion of personal privacy;
- Investigatory records compiled for law enforcement purposes; or
- Information related to participation in a civil action or other legal proceeding.

Recordings, minutes, and records generated during an exempt meeting are exempted from the public records provisions in s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

The exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless reviewed and reenacted by the Legislature.

Section 2 creates s. 468.1336, F.S., to establish a public records and meetings exemption for activities related to the Audiology and Speech-Language Pathology Interstate Compact (ASLP

⁵⁶ Id., at 14-15

⁵⁷ *Id.*, at 15.

⁵⁸ Id.

Compact). The bill exempts a audiologist's or speech-language pathologist's personal identifying information, other than the individual's name, licensure status, or license number, obtained from the coordinated database and reporting system and held by the DOH or Board of Speech-Language Pathology and Audiology from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution, unless the state that originally reported the information to the coordinated information system authorizes the disclosure by law.

The bill exempts a meeting or a portion of a meeting of the ASLP Compact Commission from s. 286.011, F.S., and s. 24(b), Art. I of the Statue Constitution if matters specifically exempted from disclosure by federal or state law are discussed. Recordings, minutes, and records generated during an exempt meeting are exempted from the public records provisions in s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

The exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless reviewed and reenacted by the Legislature.

Section 3 creates s. 486.113, F.S., to establish a public records and meetings exemption for activities related to the Physical Therapy Licensure Compact (PT Compact). The bill exempts a physical therapist's or physical therapist assistant's personal identifying information, other than the individual's name, licensure status, or license number, obtained from the coordinated database and reporting system and held by the DOH or Board of Physical Therapy from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution, unless the state that originally reported the information to the coordinated information system authorizes the disclosure by law.

The bill exempts a meeting or a portion of a meeting of the PT Compact Commission or the executive board from s. 286.011, F.S., and s. 24(b), Art. I of the Statue Constitution if the following matters will be discussed:

- A member state's noncompliance;
- Matters related to the commission's internal personnel practices and procedures;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations;
- Accusation of any person of a crime or a formal censure of a person;
- Information disclosing trade secrets or commercial or financial information that is privileged or confidential;
- Personal information, which if disclosed would constitute a clearly unwarranted invasion of personal privacy;
- Investigatory records compiled for law enforcement purposes;
- Information related to investigatory reports for use by the commission regarding compliance issues pursuant to the compact; or
- Matters specifically exempted from disclosure by federal or state statute

Recordings, minutes, and records generated during an exempt meeting are exempted from the public records provisions in s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

The exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless reviewed and reenacted by the Legislature.

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Section 4 contains the Legislative findings justifying the necessity for these exemptions. The protection from public disclosure of a physician's, audiologist's, speech-language pathologist's, physical therapist's, or physical therapist assistant's personal identifying information, other than the name, licensure status, or license number, obtained from the coordinated database and reporting systems is required under the IMLC, ASLP Compact, and PT Compact, respectively. Without this exemption, Florida would be unable to participate in these compacts.

The IMLC, ASLP Compact, and PT Compact require that meetings in which specified sensitive and confidential information is discussed must be closed to the public. Without this exemption from the public meetings law, Florida would be unable to participate in these compacts.

In addition, the IMLC, ASLP Compact, and PT Compact require that the mandatory recordings, minutes, and records generated during a closed meeting must not be disclosed publicly. The release of this information would negate the public meeting exemption and as such, the bill provides that the Legislature finds that the public records exemption is a public necessity.

Section 3 provides that the bill's effective date is the same date that SB 7016 or similar legislation takes effect, if adopted and becomes a law. SB 7016 takes effect upon becoming a law unless otherwise expressly provided.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Vote Requirement

Article I, section 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records or open meetings requirements. This bill creates public records exemptions and a public meeting exemption; therefore, it requires a two-thirds vote.

Public Necessity Statement

Article I, section 24(a) of the State Constitution and Article I, section 24(b) of the State Constitution require a bill creating or expanding an exemption to the public records or open meetings requirements to state with specificity the public necessity justifying the exemption. Section 4 of the bill contains a statement of public necessity statement for the exemptions.

Breadth of Exemption

Article I, section 24(c), of the State Constitution requires exemptions to the public records and open meetings requirements to be no broader than necessary to accomplish

the stated purpose of the law. The purpose of the bill is to protect personal identifying information of physicians licensed under the IMLC, audiologists and speech-language pathologists practicing under the ASLP Compact, and physical therapists and physical therapist assistants practicing under the PT Compact, other than the individual's name, licensure status, or licensure number; commission meetings in which specifically identified confidential and sensitive information is discussed; and the recordings, minutes, and records generated during an exempt commission meeting. These protections are required of a member state through these compacts and they do not appear to be broader than necessary to accomplish its purpose.

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 creates the following sections of the Florida Statutes: 456.4503, 468.1336, and 486.113.

IX. **Additional Information:**

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

None.

Β. Amendments:

None.

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

SB 322

By Senator Burton

12-01632A-24 2024322 1 A bill to be entitled 2 An act relating to public records and meetings; creating ss. 456.4503, 468.1336, and 486.113, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health, the Board of Medicine, the Board of Osteopathic Medicine, the Board of Speech-Language Pathology and Audiology, and the Board of Physical ç Therapy Practice pursuant to the Interstate Medical 10 Licensure Compact, the Audiology and Speech-Language 11 Pathology Interstate Compact, and the Physical Therapy 12 Licensure Compact, as applicable; authorizing 13 disclosure of the information under certain 14 circumstances; providing an exemption from public 15 meetings requirements for certain meetings, or 16 portions of meetings, of the Interstate Medical 17 Licensure Compact Commission, the Audiology and 18 Speech-Language Pathology Interstate Compact 19 Commission, and the Physical Therapy Compact 20 Commission; providing an exemption from public records 21 requirements for recordings, minutes, and records 22 generated during the exempt meetings or exempt 23 portions of meetings; providing for future legislative 24 review and repeal of the exemptions; providing 2.5 statements of public necessity; providing a contingent 26 effective date. 27 28 Be It Enacted by the Legislature of the State of Florida: 29

Page 1 of 8 CODING: Words stricken are deletions; words <u>underlined</u> are additions.

12-01632A-24 2024322 30 Section 1. Section 456.4503, Florida Statutes, is created 31 to read: 32 456.4503 Interstate Medical Licensure Compact Commission; 33 public records and meetings exemptions .-34 (1) A physician's personal identifying information, other 35 than the physician's name, licensure status, or licensure 36 number, obtained from the coordinated information system 37 described in Section 7 of s. 456.4501 and held by the department, the Board of Medicine, or the Board of Osteopathic 38 39 Medicine, is exempt from s. 119.07(1) and s. 24(a), Art. I of 40 the State Constitution unless the state that originally reported 41 the information to the coordinated information system authorizes the disclosure of such information by law. If disclosure is so 42 43 authorized, information may be disclosed only to the extent 44 authorized by law by the reporting state. (2) (a) A meeting or a portion of a meeting of the 45 Interstate Medical Licensure Compact Commission established in 46 47 Section 10 of s. 456.4501 is exempt from s. 286.011 and s. 48 24(b), Art. I of the State Constitution if the Interstate 49 Commission determines by a two-thirds vote of the commissioners present that the meeting would be likely to: 50 51 1. Relate solely to the internal personnel practices and 52 procedures of the Interstate Commission; 53 2. Discuss matters specifically exempted from disclosure by federal statute; 54 55 3. Discuss trade secrets or commercial or financial 56 information that is privileged or confidential; 57 4. Involve accusing a person of a crime, or formally 58 censuring a person; Page 2 of 8

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SB 322

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9	5. Discuss information of a personal nature, the disclosure
0	of which would constitute a clearly unwarranted invasion of
1	personal privacy;
2	6. Discuss investigative records compiled for law
3	enforcement purposes; or
4	7. Specifically relate to the participation in a civil
5	action or other legal proceeding.
6	(b) Recordings, minutes, and records generated during an
7	exempt meeting or exempt portion of a meeting are exempt from s
8	119.07(1) and s. 24(a), Art. I of the State Constitution.
9	(3) This section is subject to the Open Government Sunset
0	Review Act in accordance with s. 119.15 and shall stand repealed
1	on October 2, 2029, unless reviewed and saved from repeal
2	through reenactment by the Legislature.
3	Section 2. Section 468.1336, Florida Statutes, is created
4	to read:
5	468.1336 Audiology and Speech-Language Pathology Interstate
6	Compact Commission; public meetings and public records
7	exemptions
8	(1) An audiologist's or a speech-language pathologist's
9	personal identifying information, other than the audiologist's
0	or the speech-language pathologist's name, licensure status, or
1	licensure number, obtained from the coordinated database and
2	reporting system described in Article IX of s. 468.1335 and held
3	by the department or the board is exempt from s. $119.07(1)$ and
4	s. 24(a), Art. I of the State Constitution unless the state that
5	originally reported the information to the coordinated database
6	and reporting system authorizes the disclosure of such
	information by law. If disclosure is so authorized, information

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	12-01632A-24 2024322
38	may be disclosed only to the extent authorized by law by the
39	reporting state.
90	(2)(a) A meeting or a portion of a meeting of the Audiolog
91	and Speech-Language Pathology Interstate Compact Commission
92	established in Article VIII of s. 468.1335 at which matters
93	specifically exempted from disclosure by federal or state law
94	are discussed is exempt from s. 286.011 and s. 24(b), Art. I of
95	the State Constitution.
6	(b) Recordings, minutes, and records generated during an
97	exempt meeting or an exempt portion of a meeting are exempt fro
8	s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
9	(3) This section is subject to the Open Government Sunset
0	Review Act in accordance with s. 119.15 and shall stand repeale
)1	on October 2, 2029, unless reviewed and saved from repeal
2	through reenactment by the Legislature.
)3	Section 3. Section 486.113, Florida Statutes, is created t
) 4	read:
)5	486.113 Physical Therapy Compact Commission; public record
6	and meetings exemptions
)7	(1) A physical therapist's or physical therapist
8(assistant's personal identifying information, other than the
9	person's name, licensure status, or licensure number, obtained
0	from the coordinated database and reporting system described in
1	Article VIII of s. 486.112 and held by the department or the
2	board is exempt from s. 119.07(1) and s. 24(a), Art. I of the
3	State Constitution unless the state that originally reported th
4	information to the coordinated database and reporting system
5	authorizes the disclosure of such information by law. If
6	disclosure is so authorized, information may be disclosed only

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117	to the extent authorized by law by the reporting state.
118	(2)(a) A meeting or a portion of a meeting of the Physical
119	Therapy Compact Commission or the executive board or any other
120	committee of the commission established in Article VII of s.
121	486.112 at which matters concerning any of the following are
122	discussed is exempt from s. 286.011 and s. 24(b), Art. I of the
123	State Constitution:
124	1. Noncompliance of a member state with its obligations
125	under the compact.
126	2. The employment, compensation, or discipline of, or other
127	matters, practices, or procedures related to, specific employees
128	or other matters related to the commission's internal personnel
129	practices and procedures.
130	3. Current, threatened, or reasonably anticipated
131	litigation against the commission, executive board, or other
132	committees of the commission.
133	4. Negotiation of contracts for the purchase, lease, or
134	sale of goods, services, or real estate.
135	5. An accusation of any person of a crime or a formal
136	censure of any person.
137	6. Information disclosing trade secrets or commercial or
138	financial information that is privileged or confidential.
139	7. Information of a personal nature where disclosure would
140	constitute a clearly unwarranted invasion of personal privacy.
141	8. Investigatory records compiled for law enforcement
142	purposes.
143	9. Information related to any investigative reports
144	prepared by or on behalf of or for use of the commission or
145	other committee charged with responsibility for investigation or

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	12-01632A-24 2024322
146	determination of compliance issues pursuant to the compact.
147	10. Matters specifically exempted from disclosure by
148	federal or member state statute.
149	(b) Recordings, minutes, and records generated during an
150	exempt meeting or an exempt portion of a meeting are exempt from
151	s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
152	(3) This section is subject to the Open Government Sunset
153	Review Act in accordance with s. 119.15 and shall stand repealed
154	on October 2, 2029, unless reviewed and saved from repeal
155	through reenactment by the Legislature.
156	Section 4. (1) The Legislature finds that it is a public
157	necessity that any physician's, audiologist's, speech-language
158	pathologist's, physical therapist's, or physical therapist
159	assistant's personal identifying information, other than the
160	person's name, licensure status, or licensure number, obtained
161	from the coordinated database and reporting systems described in
162	Section 7 of s. 456.4501, Florida Statutes, Article IX of s.
163	468.1335, Florida Statutes, or Article VIII of s. 486.112,
164	Florida Statutes, and held by the Department of Health, the
165	Board of Medicine, the Board of Osteopathic Medicine, the Board
166	of Speech-Language Pathology and Audiology, or the Board of
167	Physical Therapy Practice, as applicable, be made exempt from s.
168	119.07(1), Florida Statutes, and s. 24(a), Article I of the
169	State Constitution. Protection of such information is required
170	under the Interstate Medical Licensure Compact, the Audiology
171	and Speech-Language Pathology Interstate Compact, and the
172	Physical Therapy Licensure Compact, each of which must be
173	adopted by the Legislature in order for this state to become a
174	member state of the respective compacts. Without the public
I	Page 6 of 8
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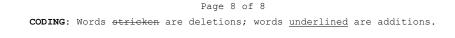
12-01632A-24 2024322 records exemption, this state would be unable to effectively and efficiently implement and administer the respective compacts. (2) (a) The Legislature finds that it is a public necessity that any meeting or portion of a meeting of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-Language Pathology Interstate Compact Commission, or the Physical Therapy Compact Commission held as provided in s. 456.4501, Florida Statutes, s. 468.1335, Florida Statutes, or s. 486.112, Florida Statutes, respectively, in which matters specifically exempted from disclosure by federal or state law are discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution. (b) The Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact, and the Physical Therapy Licensure Compact require that any meeting or portion of a meeting of the Interstate Medical Licensure Compact Commission, the Audiology and Speech-Language Pathology Interstate Compact Commission, and the Physical Therapy Compact Commission, respectively, in which the substance of paragraph (a) is discussed be closed to the public. In the absence of a public meetings exemption, the state would be prohibited from becoming a member state of the respective compacts and, thus, prohibited from effectively and efficiently administering the

- 198 respective compacts.
- 199 (3) The Legislature also finds that it is a public
- 200 necessity that the recordings, minutes, and records generated
- 201 during a meeting or a portion of a meeting exempt pursuant to s.
- 202 456.4503(2), Florida Statutes, s. 468.1336(2), Florida Statutes,
- 203 or s. 486.113(2), Florida Statutes, be made exempt from s.

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	12-01632A-24 2024322
04	
05	State Constitution. Release of such information would negate the
06	public meetings exemption. As such, the Legislature finds that
07	the public records exemption is a public necessity.
08	Section 5. This act shall take effect on the same date that
09	SB 7016 or similar legislation takes effect, if such legislation
10	is adopted in the same legislative session or an extension
11	thereof and becomes a law.



The Florida Senate BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Fiscal Policy					
CS/SB 7016					
Health Policy Committee					
Health Care					
January 16,	2024	REVISED:			
YST	_		REFERENCE	ACTION HP Submitted as Comm. Bill/Fav	
Brown, et al. Brown, et al.			FP	Fav/CS	
	CS/SB 7016 Health Polic Health Care January 16, YST	CS/SB 7016 Health Policy Comm Health Care January 16, 2024 YST STAF II. Browr	CS/SB 7016 Health Policy Committee Health Care January 16, 2024 REVISED: YST STAFF DIRECTOR I. Brown	CS/SB 7016 Health Policy Committee Health Care January 16, 2024 REVISED:	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 7016 revises or creates numerous provisions of Florida law relating to the state's health care workforce, health care services, health care practitioner licensure and regulation, health care facility licensure and regulation, the Medicaid program, and health-care-related education programs. Specifically, the bill revises:

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

The bill amends statutes relating to:

- The definition of and standards for clinical psychologists;
- The definition of and standards for psychiatric nurses;
- Mobile response team standards;
- Licensure for foreign-trained physicians;
- Certification of foreign medical schools;
- Medical faculty certificates;
- Autonomous-practice nurse midwives;
- The Florida Center for Nursing's annual report;
- Developmental research laboratory schools; and
- The Linking Industry to Nursing Education (LINE) Fund.

The bill creates:

- The Health Care Screening and Services Grant Program;
- An advanced birth center designation;
- The Training, Education, and Clinicals in Health (TEACH) Funding Program;
- Emergency department diversion requirements for hospitals and Medicaid managed care plans;
- A requirement for the Agency for Health Care Administration (AHCA) to produce an annual report entitled "Analysis of Potentially Preventable Health Care Events of Florida Medicaid Enrollees;"
- A requirement for the AHCA to seek federal approval to implement an acute hospital care at home program in Florida Medicaid;
- Limited licenses for graduate assistant physicians; and
- Temporary certificates for physician assistants (PA) and advanced practice registered nurses (APRN) to practice in areas of critical need.

The bill provides that Florida will enter into the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact, and the Physical Therapy Licensure Compact.

The bill contains numerous appropriations related to the programs and revisions listed above, as well as for provider reimbursement in the Medicaid program. See Section V. of this analysis.

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

II. Present Situation:

The Health Care Workforce Shortage

The term "health care workforce" means a health care professional working in health service settings. Physicians and nurses make up the largest segments of the health care workforce.¹ The United States has a health care professional shortage. A Health Professional Shortage Area (HPSA) is a geographic area, population group, or health care facility that has been designated by the federal Health Resources and Services Administration (HRSA) as having a shortage of health professionals. As of December 3, 2023, there are 8,544 Primary Care HPSAs, 7,651 Dental HPSAs, and 6,822 Mental Health HPSAs nationwide. To eliminate the shortages, an additional 17,637 primary care practitioners, 13,354 dentists, and 8,504 psychiatrists are needed, respectively.²

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

² U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas* (last visited Jan. 14, 2024).

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and the growth of the U.S. population³ and the expanded access to health care under the federal Affordable Care Act.⁴ Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.⁵ Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

Health Care Shortage Designations

The HRSA designates health care shortage areas in the U.S. The two main types of health care shortage areas designated by the HRSA are HPSAs and Medically Underserved Areas (MUA).

Health Care Professional Shortage Areas

There are three categories of HPSA: primary care, dental health, and mental health.⁶

HPSAs can be designated as geographic areas; areas with a specific group of people such as lowincome populations, homeless populations, and migrant farmworker populations; or as a specific facility that serves a population or geographic area with a shortage of providers.⁷ As of September 30, 2023, there are 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.⁸

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

⁵ The nation's 65-and-older population is projected to nearly double in size in coming decades, from 49 million in 2016 to 95 million people in 2060. *See:* U.S. Census Bureau, *U.S. and World Population Clock, available at*

<u>https://www.census.gov/popclock/</u>, and U.S. Census Bureau, *U.S. Population Projected to Begin Declining in Second Half of Century* (Nov. 9, 2023), *available at <u>https://www.census.gov/newsroom/press-releases/2023/population-projections.html</u> (both sites last visited Jan. 14, 2024).*

³ The U.S. population is expected to increase by 79 million people by 2060, and average of 1.8 million people each year between 2017 and 2060. *See* U.S. *Census Bureau, Demographic Turning Points for the U.S.; Population Projections for 2020 to 2060* (February 2020), *available at*

https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited Jan. 14, 2024).

⁴ Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034*, (June 2021), *available at <u>https://www.aamc.org/media/54681/download</u> (last visited Jan 14, 2024).*

⁶ Health Professional Shortage Areas (HPSAs) and Your Site, National Health Service Corps, available at <u>https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf</u>, (last visited Jan 14, 2024).

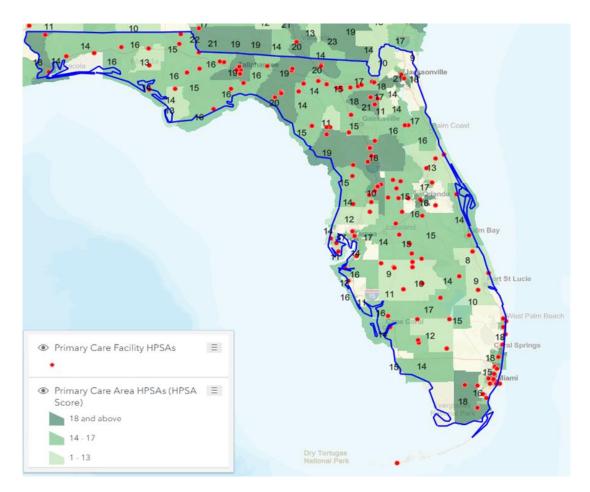
⁷ What is a Shortage Designation?, HRSA, available at <u>https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas</u>, (last visited Jan 14, 2024).

⁸ Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), *available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-*

<u>hlth-srvcs</u> (last visited Jan 14, 2024). To generate the report, select "Designated HPSA Quarterly Summary." ⁹ HRSA, *Scoring Shortage Designations, available at* <u>https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring</u>, (last visited Jan 14, 2024).

Primary Care HPSAs

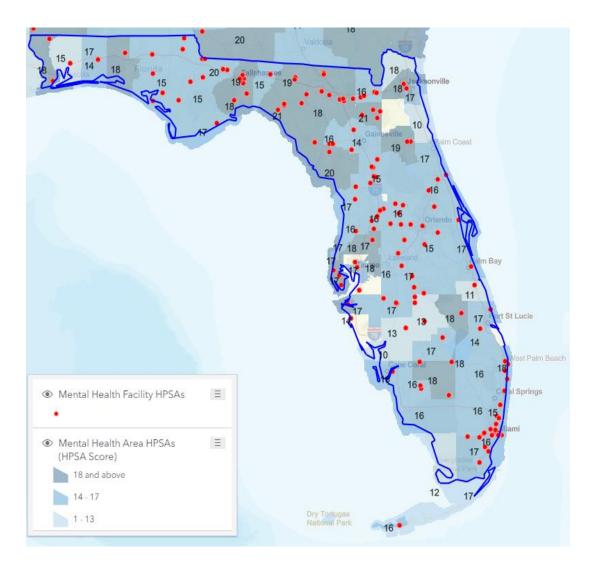
Below is a map of primary care HPSAs in Florida with their associated HPSA scores.¹⁰



¹⁰ The three maps were generated with HRSAs map tool, *available at* <u>https://data.hrsa.gov/maps/map-tool/</u>, (last visited Jan 14, 2024).

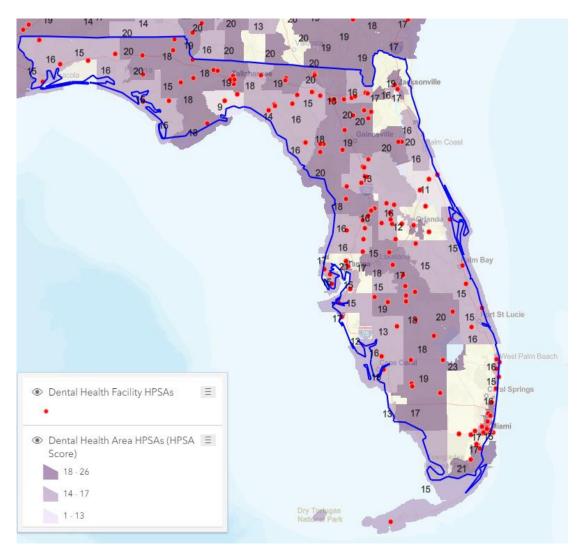
Mental Health HPSAs

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



Dental HPSAs

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

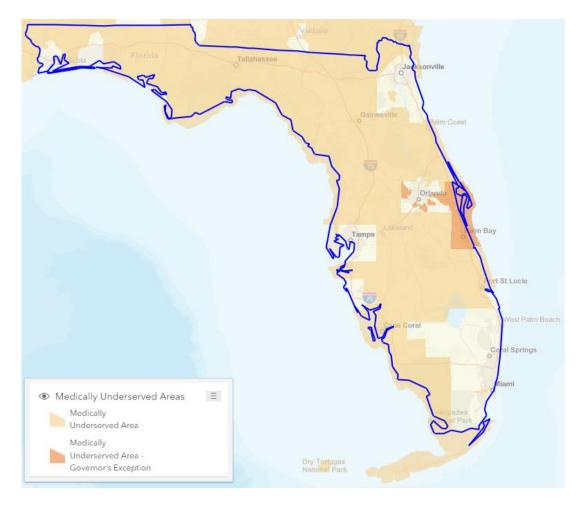


Medically Underserved Areas

MUAs identify an area with a lack of primary care access. MUAs have a shortage of primary care health services within geographic areas such as:

- A whole county
- A group of neighboring counties
- A group of urban census tracts
- A group of county or civil divisions.¹¹

Below is a map of the MUAs in Florida.



¹¹ National Health Service Corps, *Health Professional Shortage Areas (HPSAs) and Your Site, available at* <u>https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf</u>, (last visited Jan 14, 2024).

The Florida Physician Workforce

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

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

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

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

IHS Markit Report – Physician Supply and Demand Deficit

In 2021, HIS Markit prepared a report for the Safety Net Hospital Alliance of Florida and the Florida Hospital Association that examined Florida's statewide and regional physician workforce

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

with projections on workforce changes out to 2035.¹⁵ Between 2019 and 2035, the report estimates that while physician supply will increase by six percent overall and by three percent to four percent for primary care, the demand for physician services in Florida will grow by 27 percent.¹⁶ While there is already supply and demand deficits for physician services (estimated by 2019 numbers to be at 1,977 for primary care and 1,650 for non-primary care), the significant growth in the demand for physician services that may outpace the growth in the physician workforce over the next decade is estimated to create a shortfall of 7,872 in primary care physicians by 2035 and an overall decline in the adequacy for all non-primary care specialties from 95 percent in 2019 to 77 percent in 2035.¹⁷

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

Specialty	Supply	Demand ^a	Supply-Demand	% Adequacy •
Primary Care	22,900	30,773	-7,872	74%
Traditional Primary Care	15,440	21,413	-5,974	72%
Family Medicine	4,261	8,648	-4,387	49%
General Internal				
Medicine	6,917	7,797	-881	89%
Pediatric Medicine	3,824	3,870	-46	99%
Geriatric Medicine	437	1,097	-660	40%
Emergency Medicine	2,776	4,295	-1,519	65%
General Surgery	2,228	2,111	117	106%
Obstetrics & Gynecology	2,457	2,954	-497	83%
Non-Primary Care	33,959	44,011	-10,052	77%
Allergy & Immunology	276	284	-7	97%
Anesthesiology	3,164	3,818	-654	83%
Cardiology	2,644	3,276	-632	81%
Colorectal Surgery	164	234	-70	70%
Dermatology	1,111	1,044	67	106%
Endocrinology	587	834	-247	70%
Gastroenterology	1,284	1,486	-202	86%
Hematology & Oncology	1.654	2,091	-437	79%
Hospital Medicine	1,993	3,427	-1,434	58%
Infectious Diseases	429	1,167	-737	37%
Neonatology	367	454	-87	81%
Nephrology	758	1,272	-514	60%
Neurological Surgery	458	570	-112	80%
Neurology	1,485	1,314	170	113%
Ophthalmology	1,676	1,731	-55	97%
Orthopedic Surgery	1,751	1,961	-209	89%
Other Specialties	1,063	3,223	-2,160	33%
Otolaryngology	850	771	79	110%
Pathology	1,834	1,605	228	114%
Physical Medicine &		-		
Rehabilitation	832	1,313	-481	63%
Plastic Surgery	602	849	-247	71%
Psychiatry	2.037	3.267	-1.230	62%
Pulmonology & Critical		-		
Care	1,150	1,798	-648	64%
Radiation Oncology	511	715	-204	71%
Radiology	3,623	2,979	644	122%
Rheumatology	446	560	-114	80%
Thoracic Surgery	329	453	-124	73%
Urology	572	1,030	-459	55%
Vascular Surgery	308	485	-176	64%
Florida Total	56,859	74,784	-17,924	76%
Source: IHS Markit		,	-	© 2021 IHS Markit

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

¹⁶ *Id.* at V.

¹⁸ *Id.* at 10.

¹⁵ Florida Statewide and Regional Physician Workforce Analysis: 2019 to 2035: 2021 Update to Projections of Supply and Demand

¹⁷ *Id.* at VI.

Florida Center for Nursing

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

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

The Florida Nursing Workforce

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

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

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

 20 *Id*.

¹⁹ Florida Center for Nursing, *The State of the Nursing Workforce in Florida*, 2023, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., *available at*

https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download &EntryId=1957&PortalId=0&TabId=151 (last visited Jan 14, 2024).

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

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

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

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

FRAME

The FRAME program²⁵ offers student loan reimbursement to various health care practitioners to offset their educational expenses in order to entice them to practice in underserved locations where there are shortages of such practitioners. The Department of Health (DOH) is authorized to reimburse as follows:

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

²¹ The Department of Economic Opportunity, Bureau of Workforce Statistics and Economic Research, 2020- 2028 Employment Projections, updated Feb. 9, 2021, *2020 - 2028 College Projections Report, available at* https://lmsresources.labormarketinfo.com/college_projections/index.html (last visited Jan 14, 2024).

²² Florida Center for Nursing, *The State of the Nursing Workforce in Florida*, 2023, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., *available at*

https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download &EntryId=1957&PortalId=0&TabId=151 (last visited Jan 14, 2024).

²³ Florida Commerce, Bureau of Workforce Statistics and Economic Research, *Occupational Data Search*, 29-2061 Licensed *Practical or Vocational Nurses*, *available at* <u>https://floridajobs.org/economic-data/employment-projections/occupational-data-search</u> (last visited Jan 14, 2024).

²⁴ Florida Center for Nursing, *Florida Autonomous Practice 2020-2021, available at* <u>https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core Download</u> <u>&EntryId=1975&PortalId=0&TabId=151</u> (last visited Jan 14, 2024).

²⁵ Section 1009.65, F.S., titles the program the "Medical Education Reimbursement and Loan Repayment Program" however, the DOH and other stake holders refer to the program as the FRAME program. To reduce confusion, this analysis will refer to the program as the FRAME program.

²⁶ Primary care specialties are defined as obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties which may be identified by the DOH.

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

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

- Be a U.S. citizen;
- Possess a clear active Florida health care professional license;
- Provide in-person services to persons in an underserved location²⁷ in Florida;
- Not have received an award from any other State of Florida-funded student loan repayment program since July 1 of the previous year; and
- Have a qualified loan.²⁸

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

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

DSLR Program

Section 381.4019, F.S., establishes the Dental Student Loan Repayment Program (DSLR Program). The program requires the DOH to award up to \$50,000 to a dentist who, as required by DOH rule, demonstrates active employment in a public health program³¹ that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or medically underserved area. Current law caps the number of dentists allowed to receive awards at 10 per state fiscal year. The DOH has not implemented the DSLR Program yet, but intends to rework the FRAMEworks portal to implement the program by February 1, 2024.³²

²⁷ Fla. Admin. Code R. 64W-4.001 defines an "underserved location" as a public health program; a correctional facility; a Health Professional Shortage Area (HPSA) as designated by Federal Health Resources and Services Administration (HRSA) in a primary care discipline; a rural area as identified by the Federal Office of Rural Health Policy; a rural hospital as defined in s.395.602(2)(b), F.S.; a state hospital; or other state institutions that employ medical personnel.

²⁸ Rule 64W-4.001, F.A.C., defines a "qualified loan" as a federal and/or private student loan with a US-based lender that has a verified balance remaining which loan proceeds were used to pay educational expenses.

²⁹HRSA, *What is a Shortage Designation?*, *available at* <u>https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas</u>, (last visited Jan 14, 2024).

³⁰ Fla. Admin. Code R. 64W-4.005.

³¹ The section defines "public health program" as a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department.

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

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Health Care Screening Statutes

Section Number	Type of Screening	Text or Summary	Agency in Charge
381.815	Sickle-Cell disease	"Work cooperatively with not-for- profit centers to provide community- based education, patient teaching, and counseling and to encourage diagnostic screening."	DOH
381.0038	Requires needle exchange programs to provide HIV and hepatitis screenings, or referrals. Not state operated or funded.	"An exchange program must: Provide onsite counseling or referrals for drug abuse prevention, education, and treatment, and provide onsite HIV and viral hepatitis screening or referrals for such screening. If such services are offered solely by referral, they must be made available to participants within 72 hours."	DOH, however exchange programs are not state operated or funded.
381.004	HIV Testing	Requires the DOH to run HIV screening programs in each county.	DOH
381.0056	School Health Screenings	Includes vision, hearing, scoliosis, growth and development, health counseling, referrals for suspected or confirmed health problems, and preventative dental program.	County Health Departments in conjunction with District School Boards
381.91	Cancer Screenings	Community faith-based disease- prevention program to offer cancer screening, diagnosis, education, and treatment services to low-income populations throughout the state.	DOH operated from community health centers within the Health Choice Network

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

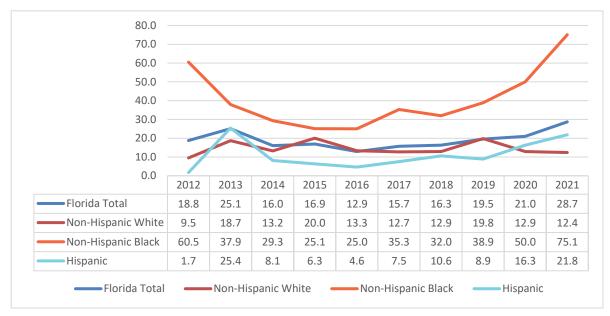
381.93	Breast and Cervical Cancer	"Mary Brogan Breast and Cervical Cancer Early Detection Program." The Department of Health, using available federal funds and state funds appropriated for that purpose, is authorized to establish the Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program to provide screening, diagnosis, evaluation, treatment, case management, and followup and referral to the Agency for Health Care Administration for coverage of treatment services.	DOH
381.932	Breast Cancer	 "Breast cancer early detection and treatment referral program." The purposes of the program are to: (a) Promote referrals for the screening, detection, and treatment of breast cancer among unserved or underserved populations. (b) Educate the public regarding breast cancer and the benefits of early detection. (c) Provide referral services for persons seeking treatment. "Underserved Population" defined as: 1. At or below 200 percent of the federal poverty level for individuals; 2. Without health insurance that covers breast cancer screenings; and 3. Nineteen to 64 years of age, inclusive. 	DOH
381.96	Wellness Screenings for women	"Wellness services" means services or activities intended to maintain and improve health or prevent illness and injury, including, but not limited to, high blood pressure screening, anemia testing, thyroid screening, cholesterol screening, diabetes screening, and assistance with smoking cessation.	Pregnancy Care Network (Contracted by DOH).

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

Maternal Mortality and Morbidity

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.³³ In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019.³⁴ The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births.³⁵ Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.³⁶ The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.³⁷

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.³⁸ Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida as evidenced in the following chart:



³³ U.S. Dep't of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health*, (Dec. 2020), *available at* <u>https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf</u> (last visited Jan 14, 2024).

 ³⁴ Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States*, 2021, (March 2023), *available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf* (last visited Jan 14, 2024).
 ³⁵ Id.

 $^{^{36}}$ Id.

³⁷ United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic*, (Oct. 2022), *available at https://www.gao.gov/assets/gao-23-105871.pdf* (last visited Jan 14, 2024).

³⁸ Presentation by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), *available at*

https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited Jan 14, 2024).

Severe Maternal Morbidity

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

The consequences of the increasing SMM prevalence, in addition to the health effects for the woman, are wide-ranging and include increased medical costs and longer hospitalization stays.⁴¹ The leading causes of SMM in 2021 were:

- Blood transfusion;
- Disseminated intravascular coagulation;
- Acute renal failure;
- Sepsis;
- Adult respiratory distress syndrome;
- Hysterectomy;
- Shock;
- Ventilation; and
- Eclampsia.⁴²

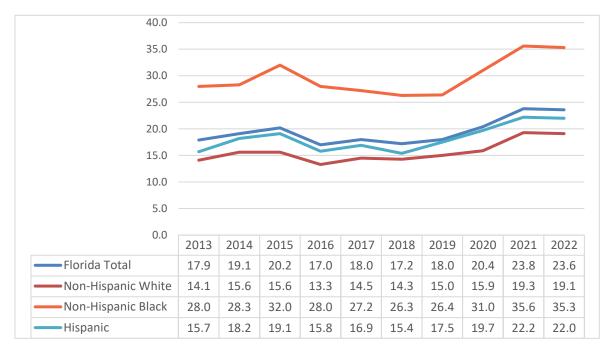
³⁹ Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), *available at*

https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited Jan 14, 2024).

⁴⁰ *Id.*, and CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), *available at* <u>https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html</u> (last visited Jan 14, 2024).

⁴¹ CDC, Severe Maternal Morbidity in the United States, (last rev. July 3, 2023), available at <u>https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html</u> (last visited Jan 14, 2024).

⁴² Florida Perinatal Quality Collaborative, *Opportunities for Florida Hospital Participation*, (Aug. 23, 2022), *available at* https://health.usf.edu/-/media/Files/Public-Health/Chiles-Center/FPQC/FPQC-Informational-Webinar-FINAL-23-AUG-22.ashx?la=en&hash=93B16B88819045E16DA5C84EEE3A6C416B3E457A (last visited Jan 14, 2024).



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

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

Telehealth

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

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

⁴³ Presentation by Kenneth Scheppke, M.D., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), *available at*

https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited Jan 14, 2024).

⁴⁴ Id.

⁴⁵ Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), *available at*

https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited Jan 14, 2024).

⁴⁶ American Telemedicine Association, *Telehealth Basics, available at* <u>https://www.americantelemed.org/resource/why-telemedicine/</u> (last visited Jan 14, 2024).

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

The Telehealth Minority Maternity Care Pilot Program

In 2021, the Legislature created the Telehealth Minority Maternity Care Pilot Program in Duval and Orange counties to increase positive maternal health outcomes in racial and ethnic minority populations.⁴⁹

The DOH received funding in the 2023-2024 FY⁵⁰ to expand the pilot program to an additional 18 counties.⁵¹ The additional counties are Brevard, Broward, Collier, Escambia, Hillsborough, Lake, Lee, Leon, Manatee, Marion, Miami-Dade, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, and Volusia.

The pilot programs use telehealth to coordinate with prenatal home visiting programs to provide the following services and education to eligible pregnant women⁵² up to the last day of their postpartum period:

- Referrals to Healthy Start's⁵³ coordinated intake and referral program to offer families prenatal home visiting services;
- Services and education addressing social determinants of health;⁵⁴
- Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in prenatal and postpartum periods;
- For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers; and
- Medical devices for prenatal women to conduct key components of maternal wellness checks.⁵⁵

002.pdf#Open%20in%20new%20window (last visited Jan 14, 2024).

⁴⁸ Section 456.47, F.S.

⁴⁹ Chapter 2021-238, Laws of Florida, codified at s. 381.2163, F.S.

⁵⁰ Chapter 2023-239, Laws of Florida, line item 435.

⁵¹ Florida Department of Health, Office of Minority Health, *Request for Applications: Programs to Reduce Severe Maternal Morbidity through Telehealth (SMMT) in Florida, RFA #22-002,* (April 19, 2023), *available at* <u>https://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/RFA22-</u>

⁵² An "eligible pregnant woman" is a pregnant woman who is receiving, or is eligible to receive, maternal or infant services from the DOH under ch. 381, F.S. or ch. 383, F.S.

⁵³ Healthy Start is a free home visiting program that provides education and care coordination to pregnant women and families of children under the age of three. The goal of the program is to lower risks factors associated with preterm birth, low birth weight, infant mortality, and poor development outcomes. *See* DOH, *Healthy Start, available at* https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html (last visited Jan 14, 2024).

⁵⁴ Social determinants of health refer to the conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. They are grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environments, and social and community context. *See* U.S. Dep't of Health and Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health, available at https://health.gov/healthypeople/priority-areas/social-determinants-health* (last visited Jan 15, 2024).

⁵⁵ Section 383.2163(3), F.S.

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

- Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers;
- The use of remote patient monitoring tools;
- How to screen for social determinants of health risks in prenatal and postpartum periods;
- Best practices to screen for, evaluate, and treat mental health conditions and substance use disorders, as needed; and
- Collection of information, recording, and evaluation activities for program and patient evaluations.⁵⁶

According to the DOH, since the program's implementation, it has served more than 2,500 women in Duval and Orange counties, and 95 percent of the participants have reported that the program addressed an unmet social need.⁵⁷ The five most prevalent critical factors were food scarcity, childcare, paid work opportunities, affordability and access to utilities such as the Internet, and access to stable housing.

Additionally, 71 percent of the enrolled women in Duval County and 85 percent of enrolled women in Orange County reported high satisfaction with the implementation of the technology in the pilot program.⁵⁸ The enrolled women were provided blood pressure cuffs, scales, and glucose monitors to remotely screen and treat common pregnancy-related complications.

Birth Centers

A birth center is any facility, institution, or place in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy, aside from an ambulatory surgical center, hospital, or part of a hospital.⁵⁹ Birth centers are licensed and regulated by the AHCA under ch. 383. F.S., and part II of ch. 408, F.S.

Birth centers must have a governing body responsible for the overall operation and maintenance of the birth center.⁶⁰ The governing body must develop and make available to all staff, clinicians, consultants, and licensing authorities, a manual that documents the policies, procedures, and protocols of the birth center.⁶¹

A birth center may accept only those patients who are expected to have normal pregnancies and deliveries. Prior to being accepted for care, the patient must sign an informed consent form.⁶² A

⁵⁶ Section 383.2163(4), F.S.

⁵⁷ Email correspondence from the DOH dated October 30, 2023 (on file with the Senate Committee on Health Policy). ⁵⁸ *Id.*

⁵⁹ Section 383.302(2), F.S.; Section 383.302(8), F.S. defines "low-risk pregnancy" as a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.

⁶⁰ Section 383.307, F.S.

⁶¹ Id.

⁶² Section 383.31, F.S. The informed consent form must advise the patient of the qualifications of the clinical staff, the risks related to out-of-hospital births, the benefits of out-of-hospital births, and the possibility of referral or transfer if complications arise during pregnancy or childbirth with additional costs for services rendered (Fla. Admin. Code R. 59A-11.010.)

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

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

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

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

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

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

- Have at least one clinical staff⁶⁷ member for every two clients in labor;
- Have a clinical staff member or qualified personnel⁶⁸ available on site during the entire time a client is in the birth center;
- Ensure that services during labor and delivery are provided by a physician, certified nurse midwife, or licensed midwife, assisted by at least one other staff member, under protocols developed by clinical staff;
- Ensure that all qualified personnel and clinical staff are trained in infant and adult resuscitation;
- Have qualified personnel or clinical staff who are able to perform neonatal resuscitation present during each birth;
- Maintain complete and accurate medical records;
- Evaluate the quality of care by reviewing clinical records;
- Review admissions with respect to eligibility, course of pregnancy and outcome, evaluation of services, condition of mother and newborn on discharge, or transfer to other providers; and
- Surveil infection risk and infection cases and promote preventive and corrective programs designed to minimize hazards.

⁶⁶ Fla. Admin. Code R. 59A-11.005(3).

⁶³ Section 383.318(1), F.S., and Fla. Admin. Code R. 59A-11.016(6).

⁶⁴ Section 383.318(1), F.S.

⁶⁵ Section 383.309, F.S.; The minimum standards for birth centers are contained in Fla. Admin. Code R. 59A-11.

⁶⁷ Section 383.302(3), F.S., defines "clinical staff" as individuals employed full-time or part-time by a birth center who are licensed or certified to provide care at childbirth.

⁶⁸ Fla. Admin. Code R. 59A-11.002(6) defines "qualified staff" as an individual who is trained and competent in the services that he or she provides and is licensed or certified when required by statute or professional standard.

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

A birth center may perform simple laboratory tests and collect specimens for tests that are requested pursuant to its protocol.⁷⁰ A birth center is exempt from the clinical laboratory licensure requirements under ch. 483, F.S., if the birth center employs no more than five physicians and its testing is conducted exclusively in connection with the diagnosis and treatment of patients of the birth center.⁷¹

Birth centers may perform surgical procedures that are normally performed during uncomplicated childbirths, such as episiotomies and repairs. Birth centers may not perform operative obstetrics or caesarean sections.⁷²

Birth centers may not administer general anesthesia or conduction anesthesia. Systemic analgesia and local anesthesia for pudendal block and episiotomy repair may be administered if procedures are outlined by the clinical staff and performed by personnel with statutory authority to do so.⁷³

Birth centers may not inhibit, simulate, or augment labor with chemical agents during the first or second stage of labor unless prescribed by personnel with the statutory authority to do so and in connection with and prior to an emergency transport.⁷⁴

Birth centers must provide postpartum care and evaluation that includes physical examination of the infant, metabolic screening tests, referral to pediatric care sources, maternal postpartum assessment, family planning, referral to secondary or tertiary care, and instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.⁷⁵ Additionally birth centers must provide a pamphlet created by the DOH on infant and childhood eye and vision disorders.

Birth centers must be designed to ensure adequate provision for birthing rooms, bath and toilet facilities, storage areas for supplies and equipment, examination areas, and reception or family areas.⁷⁶

Birth centers must comply with provisions of the Florida Building Code and Florida Fire Prevention Code applicable to birth centers.⁷⁷ The AHCA may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code that apply to birth centers when conducting inspections.⁷⁸

⁷³ *Id*.

⁶⁹ Section 383.312, F.S.

⁷⁰ Section 383.313, F.S.

⁷¹ Id.

⁷² Id.

⁷⁴ Id.

⁷⁵ Section 383.313(3), F.S.

⁷⁶ Section 383.308(1), F.S.

⁷⁷ Section 383.309(2), F.S.; Section 452 of the Florida Building Code provides requirements for birth centers.

⁷⁸ Id.

Birth centers must have the equipment necessary to provide low-risk maternity care and readily available equipment to initiate emergency procedures for mothers and infants during life-threatening events.⁷⁹ A birth center must transfer the patient to a hospital if an unforeseen complication arises during labor.⁸⁰ Each facility must have an arrangement with a local ambulance service for the transport of emergency patients to a hospital, which must be documented in the facility's policy and procedures manual.⁸¹

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

- The number of deliveries by birth weight;
- The number of maternity clients accepted for care and length of stay;
- The number of surgical procedures performed at the birth center by type;
- Maternal transfers, including the reasons for each transfer and whether it occurred intrapartum or postpartum, and the length of the subsequent hospital stay;
- Newborn transfers, including the reasons for each transfer, the birth weight, days in hospital, and Apgar score at five and ten minutes;⁸³
- Newborn deaths;
- Stillborn/fetal deaths; and
- Maternal deaths.

Birth centers must have written consultation agreements with each consultant who has agreed to provide advice and services to the birth center.⁸⁴ A consultant must be a licensed medical doctor or licensed osteopathic physician who is either certified or eligible for certification by the American Board of Obstetrics and Gynecology, or has hospital obstetrical privileges.⁸⁵ Consultation may be provided onsite or by telephone.⁸⁶

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

The AHCA may impose an administrative fine not to exceed \$500 per violation per day for the violation of any provision of the Birth Center Licensure Act, part II of chapter 408, or applicable rules.⁸⁸ The AHCA may also impose an immediate moratorium on elective admissions to any

⁸⁷ Section 383.3105, F.S.

⁷⁹ Section 383.308(2)(a), F.S.

⁸⁰ Section 383.316, F.S.

⁸¹ Id.

⁸² Fla. Admin. Code R. 59A-11.019, and AHCA Form 3130-3004, (Feb. 2015).

⁸³ Apgar is a quick test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score tells the health care provider how well the baby is doing outside the mother's womb. In rare cases, the test will be done 10 minutes after birth. See *Apgar Score*, Medline Plus, *available at* <u>https://medlineplus.gov/ency/article/003402.htm</u> (last visited on Dec. 8, 2023).

⁸⁴ Section 383.315(1), F.S.

⁸⁵ Section 383.302(4), F.S.

⁸⁶ Section 383.315(2), F.S.

⁸⁸ Section 383.33, F.S.

birth center when it determines that any condition in the facility presents a threat to the public health or safety.⁸⁹

The Florida Mental Health Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. ⁹⁰ The Baker Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.⁹¹ Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.⁹²

Involuntary Examination

An involuntary examination is required if there is reason to believe that the person has a mental illness and, because of his or her mental illness, has refused voluntary examination, is likely to refuse to care for himself or herself to the extent that such refusal threatens to cause substantial harm to his or her well-being and such harm is unavoidable through help of willing family members or friends, or will cause serious bodily harm to himself or herself or others in the near future based on recent behavior.⁹³

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;⁹⁴
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;⁹⁵ or
- A physician, clinical psychologist,⁹⁶ psychiatric nurse,⁹⁷ an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary

⁹⁷ Section 394.455(36), F.S., defines a "psychiatric nurse" as a Florida-licensed advanced practice registered nurse who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.

⁸⁹ Id.

⁹⁰ Sections 394.451-394.47892, F.S.

⁹¹ Section 394.459, F.S.

⁹² Sections 394.4625, 394.463, and 394.4655, F.S.

⁹³ Section 394.463(1), F.S.

⁹⁴ Section 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.

⁹⁵ Section 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.

⁹⁶ Section 394.455(5), F.S., defines a "clinical psychologist" as a Florida-licensed psychologist with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the U.S. Department of Veterans Affairs that qualifies as a receiving or treatment facility.

examination, including a statement of the practitioner's observations supporting such conclusion. 98

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

The patient must be examined by a physician, clinical psychologist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist to determine if the patient meets the criteria for involuntary services within 72 hours of the initiation of the involuntary examination.¹⁰⁰ A patient may be released only upon the documented approval of a psychiatrist or clinical psychologist. If the receiving facility is owned or operated by a hospital, health system, or nationally accredited community health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist.

Involuntary Placement

If an individual continues to be in need of services, a treatment facility may petition the court to order either involuntary inpatient treatment or involuntary outpatient treatment for the individual.¹⁰¹ Any petition for continued involuntary treatment, whether inpatient or outpatient, must be supported by the opinion of a psychiatrist, and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours and determined that the criteria for involuntary services are met.¹⁰² In a hearing on such petitions, a court may issue an order for involuntary outpatient services, involuntary inpatient services, or an involuntary assessment, appoint a guardian, or order the patient's discharge.¹⁰³

Voluntary Admissions

Baker Act receiving facilities may also admit any person 18 years of age or older making application by express and informed consent for admission, or any person age 17 or younger for whom such application is made by his or her guardian.¹⁰⁴ If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, a person 18 years of age or older may be admitted to the facility.¹⁰⁵ A person 17 years of age or younger may only be admitted after a clinical review to verify the voluntariness of the minor's assent.

⁹⁸ Section 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record. ⁹⁹ Section 394.455(40), F.S.

¹⁰⁰ Section 394.433(40), F.S.

¹⁰⁰ Section 394.463(2)(f)-(g), F.S.

¹⁰¹ See ss. 394.4655 and 394.467, F.S.

¹⁰² Sections 394.4655(3)-(4), F.S., for involuntary outpatient services, and ss. 394.467(2)-(4), F.S., for involuntary inpatient services.

¹⁰³ Section 394.4655(7), F.S., for involuntary outpatient services, and ss. 394.467(6), F.S., for involuntary inpatient services.

¹⁰⁴ Section 394.4625(1)(a), F.S.

 $^{^{105}}$ Id.

Psychologists

The practice of psychology is the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.¹⁰⁶ Psychological services may be rendered to individuals, couples, families, groups, and the public without regard to place of service.

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

- Hold a doctoral degree from a program accredited by the American Psychological Association;¹⁰⁸
- Have at least two years or 4,000 hours of supervised experience in the field of psychology;
- Pass the Examination for Professional Practice in Psychology; and
- Pass an examination on Florida laws and rules.¹⁰⁹

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

- Be a diplomate in good standing with the American Board of Professional Psychology and pass an examination on Florida laws and rules; or
- Hold a doctoral degree in psychology and have at least 10 years' experience as a licensed psychologist in any U.S. jurisdiction within the preceding 25 years.¹¹⁰

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

Psychiatric Nurses

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

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

¹⁰⁶ Section 490.003(4), F.S.

¹⁰⁷ Section 490.004, F.S.

¹⁰⁸ Alternatively, the applicant may have received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology. The burden is on the applicant to establish that this requirement has been met.

¹⁰⁹ Section 490.005, F.S., and Fla. Admin. Code R. 64B19-11.001.

¹¹⁰ Section 490.006, F.S.

¹¹¹ Chapter 2023-140, Laws of Florida, codified at s. 490.0075, F.S.

¹¹² Section 464.012(1), F.S.

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

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

In order to be recognized by the Board of Nursing, each specialty board must attest to the competency of nurses in the clinical specialty area, identify standards or scope of practice statements as appropriate for the specialty, require a written examination for certification, and require completion of a formal program prior to eligibility of examination.¹¹⁴

Mental Health Services in Florida

The Department of Children and Families (DCF) administers a statewide system of safety-net behavioral health services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services.

Managing Entities

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

Mobile Response Teams (MRTs)

MRTs are behavioral health crisis response mechanisms that can be beneficial to individuals, their family, and any involved first responder when an individual is experiencing a behavioral health crisis. MRTs provide on-demand, community-based crisis intervention services 24 hours a day, seven days per week, in any setting in which a behavioral health crisis is occurring.¹¹⁸ An MRT is most commonly a team of crisis-intervention trained professionals and paraprofessionals that use face-to-face professional and peer intervention, deployed in real time to the location of

https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited Nov. 27, 2023).

¹¹⁸ Department of Children and Families, *Mobile Response Teams Framework, (August 29, 2018), p. 7, available at* <u>https://www.myflfamilies.com/sites/default/files/2022-12/Mobile%20Response%20Framework.pdf</u> (last visited Nov. 28, 2023).

¹¹³ Fla. Admin. Code R. 64B9-4.002.

¹¹⁴ *Id*.

 ¹¹⁵ Section 394.9082, F.S.; Department of Children and Families, *Managing Entities, available at* <u>https://www.myflfamilies.com/services/samh/providers/managing-entities</u> (last visited Nov. 27, 2023).
 ¹¹⁶ Id.; Chapter 2001-191, Laws of Florida, and Chapter 2008-243, Laws of Florida.

¹¹⁷ Department of Children and Families, *Managing Entities, available at*

the person in crisis in order to achieve the best outcomes necessary for that individual, ensuring timely access to assessment, evaluation, support, and other services.¹¹⁹

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

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

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

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

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

¹²⁵ Department of Children and Families, *Triennial Plan for the Delivery of Mental Health and Substance Abuse Services:* State Fiscal Years 2023-2024 and 2025-2026, pg. 6, available at <u>https://www.google.com/url?client=internal-element-</u>cse&cx=b5f7422ffe5734ed7&q=https://www.myflfamilies.com/sites/default/files/2023-

<u>06/Substance%2520Abuse%2520%2526%2520Mental%2520Health%2520Services%2520Triennial%2520State%2520and%</u> <u>2520Regional%2520Master%2520Plan%2520%25202023-2025.pdf</u> (last visited Nov. 28, 2023). ¹²⁶ *Id*.

¹¹⁹ Id.

¹²⁰ Chapter 1996-169, Laws of Florida.

¹²¹ Section 394.457, F.S.

¹²² Chapter 2020-39, Laws of Florida, codified as section 394.495, F.S.

¹²³ Fla. Admin. Code R. 65E-5.400(6).

¹²⁴ Department of Children and Families, *Specialty Treatment Team Maps, Mobile Response Teams, available at* <u>https://www.myflfamilies.com/specialty-treatment-team-maps</u>, (last visited Nov. 28, 2023).

Offshore Usage of Clinical Training Opportunities

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

More than 70 percent of surveyed deans worried about having enough qualified specialty preceptors, and the response jumped to 87 percent for primary care preceptors. One reason for this is an increase in competition for clinical training opportunities from offshore medical schools. Such offshore medical schools may not be able to offer core clinical experiences where they are located. Instead they rely on training sites within the United States. In order to secure these sites, offshore medical schools will often pay the clinical locations such as hospitals in order to place their students there. Although most U.S. medical schools do not pay hospitals or other settings for clinical training, the AAMC survey of deans found that 44 percent of respondents felt moderate to severe pressure to do so.¹²⁷

Florida's Health Information Exchange Program

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

The FHIE electronically makes patient health information available to doctors, nurses, hospitals, and health care organizations when needed for patient care. The exchange of patient information is protected through strict medical privacy and confidential procedures. The FHIE is designed to improve the speed, quality, safety, and cost of patient care.¹²⁸

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

- 95 percent of Licensed Acute Care Hospitals
- 225 Skilled Nursing Facilities
- 64 Urgent Care Centers
- 22 Hospice Providers
- Five Crisis Stabilization Units
- Statewide Emergency Medical Services Treat-and-Release Providers

¹²⁷ So Many Medical Students, so Few Clerkship Sites, AAMCNEWS, Sep. 10, 2020, available at https://www.aamc.org/news/so-many-medical-students-so-few-clerkship-sites#:~:text=According%20to%20a%20new%20AAMC,sites%20even%20before%20the%20pandemic., (last visited Dec. 4, 2023).

¹²⁸ AHCA analysis document, on file with Senate Health Policy Committee staff.

• All 67 County Health Departments.¹²⁹

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

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

Although data sharing has grown and improved over time, there are several providers not sharing complete data sets due to various reasons such as workflow issues or turnover of staff that is familiar with FHIE needs. The incomplete data limits the ability for subscribers of ENS to have a complete picture of patient care. The incomplete data negatively impacts the AHCA's public health partners who are receiving data through the Florida HIE Services.¹³⁰

Emergency Department (ED) Diversion

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

In the United States, approximately 13 to 27 percent of ED visits can be addressed in ambulatory settings, including urgent care centers. Diverting these patients to the appropriate setting for care could decrease health care costs by \$4.4 billion. Some of the known drivers attributed to ED overuse are indigent populations, such as Medicaid enrollees, as well as others who may lack health insurance and access to timely and quality care, leaving hospitals with the financial and legal obligation to stabilize all patients who arrive in the ED.¹³²

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

¹²⁹ Id.

¹³⁰ *Id*.

¹³¹ Section 395.002(9), F.S.

¹³² The Journal of Urgent Care Medicine, *Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program, available at* <u>https://www.jucm.com/reducing-low-acuity-preventable-emergency-room-visits-by-utilizing-urgent-care-center-services-via-mobile-health-unit-diversion-program/</u> (last visited Dec. 5, 2023).

care resulting in a decrease in the overutilization of emergency services on health maintenance organizations and providers.¹³³

Currently, Florida Medicaid has developed and continues to create diversion tools and initiatives to decrease expenditures and improve the overall health of Medicaid recipients. Examples include the collection of encounter data for the analysis of PPEs, various initiatives, e.g., the Primary Care Initiative Program, the Integrated Behavioral Health initiative, etc., and the implementation of Statewide Medicaid Managed Care (SMMC) to maximize the delivery of health care through entities and mechanisms designed to contain costs, emphasize preventive and primary care, and promote access and continuity of care.¹³⁴

The Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.¹³⁵ The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.¹³⁶

Medicaid Provider Enrollment

Federal exceptions excluded, to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time the service is rendered. Practices must be fully operational before they can be enrolled as Medicaid providers. Every entity that provides Medicaid services to enrollees and all third-party software vendors offering services of any kind to providers must enroll as a Medicaid provider.¹³⁷

The AHCA and its fiscal agent, Gainwell Technologies, develop comprehensive education materials, including reference guides, to assist applicants with the enrollment process, as well as answer the questions of any providers interested in Medicaid enrollment, published on their respective websites.¹³⁸

Statewide Medicaid Managed Care

Medicaid enrollees generally receive benefits through one of two service-delivery systems: feefor-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each services provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services

¹³³ Section 641.31097(1), F.S.

¹³⁴ Section 409.9121, F.S.

¹³⁵ Medicaid.gov, *Medicaid, available at* <u>https://www.medicaid.gov/medicaid/index.html</u> (last visited Dec. 4, 2023).

¹³⁶ Section 20.42, F.S.

¹³⁷ Florida Agency for Health Care Administration & Gainwell Technologies, *Florida Medicaid Provider Enrollment* Application Guide, available at

https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Public%20Misc%20Files/Florida%20Medicaid%20Provid er%20Enrollment%20App%20Guide.pdf (last visited Dec. 6, 2023).

for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. In Florida, the majority of Medicaid enrollees receive their services through a managed care plan contracted with the AHCA under SMMC.¹³⁹

SMMC has three components: MMA, Long-Term Care (LTC), and Dental. Florida's SMMC benefits are authorized through federal waivers and are specifically required by the Florida Legislature in s. 409.973, F.S., and s. 409.98, F.S.¹⁴⁰ MMA plans provide preventive, acute, behavioral, therapeutic pharmacy, and transportation services to eligible recipients.¹⁴¹

Qualifying Community-Based Mobile Crisis Intervention Services

Section 9813 of the federal American Rescue Plan Act of 2021 (ARPA) amended Title XIX of the Social Security Act (Act) to add a new section 1947, authorizing states to provide qualifying community-based mobile crisis intervention services during the period beginning April 1, 2022, and ending March 31, 2027. States with approved coverage and reimbursement authority can receive 85 percent federal match for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period during which they meet the federally outlined conditions. States are permitted to disregard the provider agreement requirements at s. 1902(a)(27) of the Act that obligate states to enter into provider agreements with "every person or institution providing services under the State plan."¹⁴²

The Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration both describe mobile crisis services as readily available 24 hours a day, and seven days a week services that can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call to respond. The team may be composed of professionals and paraprofessionals, including trained peer support providers, who are educated in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis.¹⁴³

Primary Care Initiative Program

Under current law, managed care plans operating in the MMA component of SMMC must establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan is required to:¹⁴⁴

• Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider;

https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf (last visited Dec. 6, 2023). ¹⁴³ Id.

¹³⁹ Section 20.42, F.S.

¹⁴⁰ Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* <u>https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care</u> (last visited Dec. 5, 2023).

¹⁴¹ Florida Agency for Health Care Administration, A Snapshot of the Florida Statewide Medicaid Managed Care Program, available at <u>https://ahca.myflorida.com/content/download/9126/file/SMMC_Snapshot.pdf</u> (last visited Dec. 5, 2023).

¹⁴² Centers for Medicare & Medicaid Services, SHO # 21-008: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, available at

¹⁴⁴ Section 409.973(4), F.S.

- Assist new Medicaid enrollees in scheduling an appointment with a primary care provider within 30 days after enrollment in the plan, if possible;
- Report to the AHCA the number of enrollees assigned to each primary care provider within the plan's network;
- Report to the AHCA the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment; and
- Report to the AHCA the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Medicaid Encounter Data System

Currently, the AHCA operates a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in a managed care plan. Each plan must comply with the AHCA's reporting requirements for the Medicaid Encounter Data System, submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act (HIPAA) provisions for electronic claims, and submit encounter data in accordance with deadlines established by the AHCA. The managed care plans must certify the reported data is accurate and complete.¹⁴⁵

The AHCA is responsible for validating the data submitted by the plans and has developed methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of SMMC enrollees to allow comparison of service utilization among plans and against expected levels of use. Presently, the analysis is used to identify possible cases of inappropriate service utilization, such as higher-than-expected emergency department encounters¹⁴⁶ or PPEs, to improve access to quality health care services while also reducing expenditures.¹⁴⁷

Graduate Medical Education

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.¹⁴⁸ Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly

¹⁴⁵ Section 409.967(2)(e), F.S.

 $^{^{146}}$ Id.

¹⁴⁷ Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* <u>https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-</u>

External/AboutPPEs?%3Adisplay count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz share link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

¹⁴⁸ Graduate Medical Education That Meets the Nation's Health Needs, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited Nov. 30, 2023).

provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.¹⁴⁹

Every U.S. state requires at least one year of residency training to receive an unrestricted license to practice medicine, and some require two or three years. However, most physicians train beyond the minimum licensure requirement in order to become board certified in a "pipeline" specialty (i.e., those that lead to initial board certification). The number of pipeline training positions determines the total number of physicians that the entire continuum can produce. For many years, the number of U.S. residency slots has been larger than the number of U.S. medical graduates, so residency programs were filled in part by graduates of non-U.S. medical schools (including both U.S. and non-U.S. citizens). Now, with growth in the number and size of medical schools, the number of U.S. medical graduates is beginning to more closely approximate the current number of residency slots. In a recent survey conducted by the Association of American Medical Colleges (AAMC), 122 of 130 responding medical school deans reported some concern about the number of post-graduate training opportunities for their students.¹⁵⁰

Medicare Funding of GME

GME is largely funded through both the Medicare and the Medicaid programs. Until the enactment of the Balanced Budget Act (BBA) of 1997, Medicare support of GME was openended. Before the BBA, hospitals had a strong financial incentive to add new residency slots because each new position generated additional Medicare per-resident amount and indirect medical education revenues. In response to concerns about an oversupply of physicians and increasing Medicare costs, the BBA capped the number of Medicare-supported physician training slots.¹⁵¹

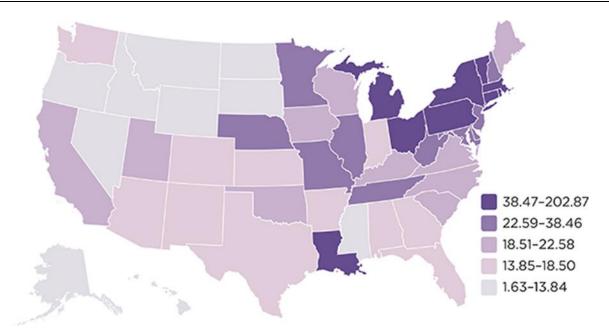
Hospitals are free to add residents beyond their cap, but these trainees do not generate additional Medicare revenues. The cap on Medicare funding was set at each hospital's resident count in the cost report period ending on or before December 31, 1996. With this step, the geographic distribution of Medicare-supported residencies was essentially frozen in place without regard for future changes in local or regional health workforce priorities or the geography or demography of the U.S. population. As seen in the following chart (showing the number of Medicare-funded training positions per 100,000 population), Medicare-supported slots are most highly concentrated in the Northeastern states, as is most of Medicare GME funding.¹⁵²

¹⁵⁰ Id.

¹⁵¹ *Id*.

¹⁵² *Id*.

¹⁴⁹ Id.



Medicaid Funding of GME

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

The SMRP allows both hospitals and federally qualified health centers (FQHCs)¹⁵⁷ that are accredited by the Accreditation Council for Graduate Medical Education (ACGME) to qualify for GME funding. In addition to the SMRP, the Legislature has allocated additional funding to GME through the Startup Bonus Program and the Slots for Doctors Program.

Startup Bonus Program (SBP)¹⁵⁸

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

¹⁵⁷ A federally qualified health center is a federally funded nonprofit health center or clinic that serves medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of a patient's ability to pay. Services are provided on a sliding scale fee based on household income.

¹⁵⁸ Section 409.909(5), F.S.

¹⁵³ Id.

¹⁵⁴ *Id*.

¹⁵⁵ Section 409.909, F.S.

¹⁵⁶ SFY 2023-24 Statewide Medicaid Residency Program Distribution, AHCA, available at

https://ahca.myflorida.com/content/download/23217/file/SFY%2023-24%20GME%20SMRP%20Calculation%20Clean.pdf, (last visited Nov. 30, 2023).

in statewide supply-and-demand deficit. For the purposes of the program, physician specialties in statewide supply-and-demand deficit are identified in the General Appropriations Act (GAA).¹⁵⁹

The Slots for Doctors Program (SDP)

The SDP requires the AHCA to annually allocate \$100,000 to hospitals and qualifying institutions for each newly created slot that is first filled on or after June 1, 2023, and remains filled thereafter.¹⁶⁰ The new slot must be accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit. The sections specifies that the program is designed to generate matching funds under the Medicaid program and distribute those funds to participating hospitals and qualifying institutions and that specialties and sub-specialties are those that are identified in the GAA.

Specialties and Sub-Specialties in Supply and Demand Deficit

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

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

¹⁵⁹ Chapter 2023-239, Laws of Florida

¹⁶⁰ Section 409.909(6), F.S.

- Rheumatology;
- Thoracic surgery;
- Urology; and
- Vascular surgery.

Ohio's Primary Care Workforce Initiatives (OPCWI)

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

Health centers may host students in the following disciplines: medicine, dentistry, advanced practice nursing, physician assisting, and behavioral health. These structured clinical experiences are designed to increase primary care capacity in some of the most underserved neighborhoods in Ohio. Located throughout the state, Ohio's FQHCs serve over 850,000 Ohioans each year. Participating health centers have, or commit to obtaining, national recognition as PCMHs so that students can experience an advanced primary care practice model.¹⁶¹

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

The OPCWI pays quarterly at an hourly rate determined by the type of provider:¹⁶²

Potentially Preventable Health Care Events (PPEs)

PPEs are encounters that could be prevented but lead to unnecessary health care services.¹⁶³

Potentially Preventable Hospital Emergency Department Visits

Potentially preventable hospital emergency department visits happen when a patient seeks services at an emergency department for a health condition that could have been prevented or

¹⁶¹ Y8 Ohio Primary Care Workforce Initiative (OPCWI) User Manual, Ohio Association of Community Health Centers, *available at* <u>Y8 OPCWI User Manual.pdf (ymaws.com)</u>, (last visited Dec. 4, 2023).

¹⁶² *Id.* at p. 6.

¹⁶³ Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives, available at* <u>https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3</u> <u>Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n</u> (last visited Dec. 4, 2023).

treated in a non-emergency setting.¹⁶⁴ The AHCA has identified a variety of causes that may result in these visits, e.g., failure to access primary care, lack of ambulatory care coordination, monitoring, or follow-up, inadequate and/or inaccessible nursing care for a nursing sensitive condition, etc.¹⁶⁵

Throughout federal fiscal year (FFY) 2019-2020, 294,220 potentially preventable emergency department visits were identified, compared to 388,257 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:¹⁶⁶

- Upper respiratory infections/otitis;
- Gastrointestinal diagnoses;
- Skin traumas;
- Abdominal pain;
- Viral illnesses;
- Level II musculoskeletal diagnoses;
- Level I respiratory diagnoses;
- Lower urinary tract infections;
- Skin tissue conditions; and
- Fevers.

Potentially Preventable Hospital Admissions

Potentially preventable hospital admissions are when a patient is admitted for necessary treatment to an acute care hospital¹⁶⁷, but the admission could have been avoided, or when a patient is admitted and could have been treated outside of an inpatient hospital setting.¹⁶⁸

Throughout federal fiscal year (FFY) 2019-2020, 71,541 potentially preventable hospital admissions were identified, compared to 67,048 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:¹⁶⁹

¹⁶⁴ Id.

<u>External/PPVsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz</u> <u>share_link&%3AshowAppBanner=false&%3AshowVizHome=n</u> (last visited Dec. 4, 2023).

¹⁶⁵ Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* <u>https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-</u>

External/AboutPPEs?%3Adisplay count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz share link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

¹⁶⁶ Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Emergency Room Visits* (PPVs) by Health Plan, available at <u>https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-</u>

¹⁶⁷ Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* <u>https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-</u>

External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_ link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

¹⁶⁸ Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives, available at* <u>https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3</u> <u>Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVi</u> <u>zHome=n</u> (last visited Dec. 4, 2023).

¹⁶⁹ Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Hospital Admissions (PPAs)* by Health Plan, available at https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-

<u>External/PPAsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz</u> <u>share_link&%3AshowAppBanner=false&%3AshowVizHome=n</u> (last visited Dec. 4, 2023).

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

Potentially Preventable Hospital Readmissions

Potentially preventable hospital readmissions are when a patient is readmitted to an acute care hospital for a reason that is clinically related to the initial hospitalization or from deficiencies in a post-hospital discharge follow-up after a prior acute care admission¹⁷⁰ within thirty days of a hospital discharge.¹⁷¹

Throughout FFY 2019-2020, 30,593 PPEs were identified with at least one potentially preventable hospital readmission, compared to 31,689 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:¹⁷²

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

¹⁷¹ Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-

External/AboutPPEs?%3Adisplay count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz share link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

¹⁷² Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Readmissions (PPRs) by Health Plan, available at* <u>https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-</u>

<u>External/PPRsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz</u> <u>share_link&%3AshowAppBanner=false&%3AshowVizHome=n</u> (last visited Dec. 4, 2023).

¹⁷⁰ Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3 Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVi <u>zHome=n</u> (last visited Dec. 4, 2023).

Acute Hospital Care at Home (AHCAH) Initiative

In response to the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services (CMS) provided a number of new flexibilities and waivers to ensure that acute hospital care could continue. One of these waivers was the AHCAH initiative, which allows capable hospitals to treat appropriately selected patients with inpatient-level care in their homes.¹⁷³

Specifically, CMS issued AHCAH flexibilities under the "Hospital Without Walls" initiative on November 25, 2020, which waived s. 482.23(b) and (b)(1) of the Medicare Hospital Conditions of Participation (CoPs), thereby suspending the requirement for nursing services to be provided on premises 24 hours a day, seven days a week, and for the immediate availability of a registered nurse (RN) for care of any hospital patient. Medicare inpatient payments did not change as a result of this waiver; payments to a hospital providing AHCAH services remained the same as if the care was provided in a traditional inpatient setting. This represented the first example of payment for this level of care at home for Medicare beneficiaries.¹⁷⁴

CMS has statutory authority under Section 1135 of the Social Security Act to grant either blanket (nationwide) or individual waivers. As such, one of CMS's first decisions was to require each AHCAH waiver approval to be at the hospital/CMS Certification Number level. While this potentially limited some high-quality outpatient-based organizations, hospital providers currently have existing inpatient quality infrastructure, reporting requirements, and appreciation for the consequences of poor execution, which are considered essential for successful implementation of this program. Given the rapid rollout of this waiver, CMS also recognized that consistent guidance and clear responsibility for patient care was paramount. It was decided that patient entry to AHCAH would be limited to patients seen in EDs or those already admitted to inpatient wards. This was a deliberate choice intended to limit variability and to assuage concerns about overutilization.¹⁷⁵

Waiver requests for AHCAH are divided into two categories:¹⁷⁶

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

Tier 1 hospitals are required to attest that specific services and safeguards will be in place and are required to report quality metrics monthly. Tier 2 hospitals are required to give detailed explanations of how each service and safeguard will be provided and are required to report on a weekly basis. Tier 2 hospitals are also presented to CMS leadership for final approval. Other than these differences, the requirements for approval are the same; hospitals are required to provide specific inpatient services for the at-home patient, to include pharmacy needs, infusions, respiratory care including oxygen delivery, diagnostic labs and radiology, patient transportation, food services, durable medical equipment, social work and care coordination, and physical, occupational, and speech therapy. Additionally, Tier 2 hospitals are required to detail their

¹⁷³ The New England Journal of Medicine Catalyst, *Acute Hospital Care at Home: The CMS Waiver Experience, available at* <u>https://catalyst.nejm.org/doi/pdf/10.1056/CAT.21.0338</u> (last visited Dec. 5, 2023).

¹⁷⁴ *Id*.

 $^{^{175}}$ Id.

¹⁷⁶ Id.

infusion processes and protocols, response times for oxygen delivery and nebulizer treatment, and how radiology services that cannot be delivered in the home will be provided.¹⁷⁷

Hospitals participating in the AHCAH initiative must also meet the following patient standards:¹⁷⁸

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

AHCAH has been credited with decreasing new hospital construction in Australia and has seen extensive international adoption. In the U.S., smaller-scale efforts within the Medicare Advantage and managed care Medicaid markets have proven successful with patients, providers, and payers. However, this level of care has not been widely implemented because of the lack of a reimbursement mechanism from CMS and several limitations with the CoPs. Using emergency authority, CMS was able to waive hospital CoPs for life safety code and physical environment, which allowed for patient care to be provided in an alternate care setting, such as a patient's home for certain approved hospitals. As of October 2021, these waiver flexibilities allowed CMS to implement AHCAH in 186 hospitals in 33 states across the country, treating 1,878 patients.¹⁷⁹

As of November 21, 2023, there are 12 participating Florida hospitals, approximately four percent of the AHCAH approved hospitals:¹⁸⁰

- Mayo Clinic Florida;
- Cleveland Clinic Hospital;
- Cleveland Clinic Martin North;
- Cleveland Clinic Indian River;
- Palm Bay Hospital;
- Holmes Regional Medical Center;
- Viera Hospital;
- Cape Canaveral Hospital;
- Keralty Hospital (formerly Westchester Hospital);
- Tampa General Hospital;

¹⁷⁷ Id.

¹⁷⁸ Id.

¹⁷⁹ Id.

¹⁸⁰ Centers for Medicare & Medicaid Services, *Acute Hospital Care at Home Resources, available at* <u>https://qualitynet.cms.gov/acute-hospital-care-at-home/resources</u> (last visited Dec. 5, 2023).

- Orlando Regional Medical Center; and
- AdventHealth Orlando.

These hospitals have been approved to offer acute inpatient services in the home, while continuing to receive Medicare reimbursement.¹⁸¹

Under the federal Consolidated Appropriations Act, 2023, the AHCAH initiative has been extended through December 31, 2024. Hospitals can continue to apply to participate in the initiative. If an individual is receiving care in a participating hospital and meets the requirements to receive inpatient care at home, they can continue to do so.¹⁸²

Licensure of Health Care Practitioners

The Division of Medical Quality Assurance (MQA), within the DOH has general regulatory authority over Florida's licensed health care practitioners. The MQA works in conjunction with 22 regulatory boards and four councils to license and regulate ten unique types of health care facilities and more than 40 health care professions.¹⁸³

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

The MQA is statutorily responsible for the following boards and professions established within the division and the DOH:¹⁸⁴

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, under the DOH as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;
- Nursing assistants, under the Board of Nursing as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;
- Midwifery, as provided under ch. 467, F.S.;
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.;
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.;
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.;

¹⁸¹ Id.

¹⁸² The New England Journal of Medicine Catalyst, *Acute Hospital Care at Home: The CMS Waiver Experience, available at* <u>https://catalyst.nejm.org/doi/pdf/10.1056/CAT.21.0338</u> (last visited Dec. 5, 2023).

¹⁸³ Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year* 2022-23, at 10, *available at* <u>https://www.floridahealth.gov/licensing-and-regulation/reports-and-</u>publications/MOAAnnualReport2022-2023.pdf (last visited Dec. 5, 2023).

¹⁸⁴ Section 456.001(4), F.S.

- Respiratory therapy, under the Board of Respiratory Care as provided under part V of ch. 468, F.S.;
- Dietetics and nutrition practice, under the Board of Medicine as provided under part X of ch. 468, F.S.;
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.;
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.;
- Electrolysis, under the Board of Medicine as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part I of ch. 483, F.S.;
- Medical physicists, under the DOH as provided under part II of ch. 483, F.S.;
- Genetic Counselors, under the DOH as provided under part III of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, under the Board of Psychology created under ch. 490, F.S.;
- School psychologists, under the Board of Psychology as provided under ch. 490, F.S.;
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.

The DOH and the practitioner boards have different roles in the regulatory system. Boards establish practice standards by rule, pursuant to statutory authority and directives. The DOH, on behalf of the professional boards, investigates complaints against practitioners.¹⁸⁵ The boards determine the course of action and any disciplinary action to take against a practitioner under the respective practice act.¹⁸⁶ For professions for which there is no board, the DOH determines the action and discipline to take against a practitioner and issues the final orders.¹⁸⁷

Board of Medicine

The Board of Medicine (BOM) is the state's regulatory arm for licensed allopathic medical doctors. The BOM is composed of 15 members appointed by the Governor and confirmed by the Senate for four year terms who serve until their successors are appointed.¹⁸⁸ Chapter 458, F.S., governs the licensure and regulation of the practice of allopathic medicine by the BOM in

¹⁸⁵ Department of Health, *Investigative Services, available at* <u>http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html</u> (last visited Dec. 5, 2023).

¹⁸⁶ Section 456.072(2), F.S.

¹⁸⁷ Professions that are regulated by the Department are certified master social workers, emergency medical technicians, genetic counselors, paramedics, radiologic technologists, and school psychologists. Florida Department of Health. *See:* Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year* 2022-23, at 10, *available at* <u>https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/MQAAnnualReport2022-2023.pdf</u> (last visited Dec. 5, 2023)...

¹⁸⁸ Section 458.307, F.S. Twelve members of the BOM must be licensed physicians in good standing who are state residents and who have been engaged in the active practice or teaching of medicine for at least four years immediately preceding their appointment. One of the physicians must be on the full-time faculty of a medical school in Florida. One physician must be in private practice and a full-time staff member of a statutory teaching hospital in Florida. One physician must be a graduate of a foreign medical school. One member must be a health care risk manager. One member must be age 60 or older. The remaining three members must be residents of Florida who are not, and never have been, licensed health care practitioners.

conjunction the DOH. The chapter provides, among other things, licensure requirements for medical school graduates, and licensure by endorsement requirements.

Board of Osteopathic Medicine

The Board of Osteopathic Medicine (BOOM) is the state's regulatory board for osteopathic physicians. The BOOM is composed of seven members appointed by the Governor and confirmed by the Senate.¹⁸⁹ Chapter, 459, F.S., governs licensure and regulation of the practice of osteopathic medicine by the BOOM, in conjunction the DOH. The chapter provides, among other things, general licensure requirements, including by examination for medical school graduates and licensure by endorsement requirements.

Financial Responsibility

Florida-licensed allopathic and osteopathic physicians are required to maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions.¹⁹⁰ Physicians who perform surgeries in a certain setting or have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than \$250,000 per claim.¹⁹¹ Other physicians must carry sufficient insurance or other financial responsibility in coverage amounts of not less than \$100,000 per claim.¹⁹² Certain physicians who are exempted from the requirement to carry professional liability insurance or other financial responsibility must provide notice to their patients.¹⁹³

With specified exceptions, the DOH must suspend, on an emergency basis, the license of any physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.¹⁹⁴

¹⁸⁹ Section 459.004, F.S. Five members of the board must be licensed osteopathic physicians in good standing who are Florida residents and who have been engaged in the practice of osteopathic medicine for at least four years immediately prior to their appointment. At least one member of the BOOM must be 60 years of age or older. The two members must be citizens of the state who are not, and have never been, licensed health care practitioners.

¹⁹⁰ Sections 458.320 and 459.0085, F.S.

¹⁹¹ Section 458.320(2) and 495.0085(2), F.S.

¹⁹² Sections 458.320(1) and 459.0085(1), F.S.

¹⁹³ Sections 458.320(5)(f) and 459.0085(g), F.S.

¹⁹⁴ Sections 458.320(8) and 459.0085(9), F.S.

Allopathic Licensure by Examination: U.S. and Canadian Trained M.D. Applicants¹⁹⁵

For an allopathic physician trained in the U.S. to be licensed by examination in Florida, an applicant must:¹⁹⁶

- Be at least 21 years of age;
- Be of good moral character;
- Not have committed an act or offense that would constitute the basis for disciplining a physician under s. 458.331, F.S.;
- Have completed two years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry;
- Have graduated from an allopathic medical school approved by an accrediting agency recognized by the U.S. Office of Education or recognized by a governmental body of a U.S. territorial jurisdiction;
- Have completed at least one year of approved residency training; and
- Have obtained a passing score on:
 - The USMLE;¹⁹⁷
 - A combination of the USMLE, the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX),¹⁹⁸ or the examination of the National Board of Medical Examiners (NBME) up to the year 2000; or
 - The SPEX exam,¹⁹⁹ if the applicant was licensed on the basis of a state board examination, is currently licensed in at least one other jurisdiction of the U.S. or Canada, and has practiced at least 10 years.

¹⁹⁹ The Federation of State Medical Boards of the United States, Inc., *SPEC Information Bulletin 2021, available at* <u>https://www.fsmb.org/siteassets/spex/pdfs/spex-information-bulletin.pdf</u> (last visited Nov. 29, 2023). The Special Purpose

¹⁹⁵ Canadian MDs and DOs who have graduated from acceptable medical schools as defined by the Model Standards for Medical Registration in Canada need only obtain permission to immigrate to come to the United States. Unlike foreign nationals of other countries, Canadians do not need visa stamps in their passports. Rather, Canadians need to receive permission to come to the U.S. and then present themselves for entry right at the border. Canadian physicians also do not need to obtain an ECFMG. A O. who graduates from one of the 17 Canadian medical schools accredited by the LCME with an M.D. or a D.O. certificate, which establishes equivalent medical education and fluency in English, and do not have to complete relevant board examinations. They are not considered to be foreign medical graduates. *See* Murthy Law Firm, U.S. Immigration Law, *Canadian Physicians and U.S. Immigration Policies, available at*

https://www.murthy.com/2019/08/08/canadian-physicians-and-u-s-immigration-policies/ (last visited Nov. 27, 2023). See also Medical Council of Canada, Acceptable medical schools as defined in the Model Standards for Medical Registration in Canada, available at https://mcc.ca/services/repository/acceptable-medical-schools-as-defined-in-the-model-standards-for-medical-registration-in-canada/ (last visited Nov. 27, 2023).

¹⁹⁶ Section 458.311(1), F.S.

¹⁹⁷ The USMLE is a three-step examination for medical licensure in the U.S. and is owned by the FSMB and the NBME. The USMLE assesses a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care. USMLE was created in response to the need for one path to medical licensure for allopathic physicians in the United States. Before USMLE, multiple examinations, the NBME Parts examination and the FLEX, offered paths to medical licensure. It was desirable to create one examination system accepted in every state, to ensure that all licensed MDs had passed the same assessment standards – no matter in which school or which country they had trained. Today all state medical boards utilize a national examination – USMLE for allopathic physicians, COMLEX-USA for osteopathic physician. See United States Medical Licensing Examination (USMLE), *Who is USMLE?, available at* https://www.usmle.org/about/ (last visited Nov. 9, 2023).

¹⁹⁸ The Federation of State Medical Boards of the United States, Inc., first gave the "Federation Licensing Examination" (FLEX) March 8, 1973, as a national licensing examination; and it was last given December 1993. *The Examination, available at* <u>https://sos.ms.gov/ACProposed/00014082b.pdf</u> (last visited Nov. 29, 2023).

Allopathic Licensure by Examination: Foreign-Trained Applicants

Current foreign-trained allopathic applicants must also meet the same requirements as U.S. and Canadian trained applicants related to age, character, background checks, prior disciplinary action, completion of post-secondary education, and obtaining a passing score on the USMLE, FLEX or SPEX, as applicable. Foreign trained applicants must also have:

- Graduated from a foreign allopathic medical school registered with the World Health Organization and certified pursuant to statute²⁰⁰ as meeting the standards required to accredit U.S. medical schools and have completed at least one year of approved residency training; or
- Graduated from a foreign allopathic medical school that has not been certified pursuant to statute;²⁰¹ have an active, valid certificate issued by the Educational Commission for Foreign Medical Graduated (ECFMG);²⁰² passed the ECFMG's examinations; and have completed an approved residency or fellowship of at least two years in one medical specialty area that counts towards board certification by the American Board of Medical Specialties.²⁰³

Foreign-Trained Medical Students and Medical Graduates Practicing in Florida

Certification and Residency Programs

Foreign physicians wishing to practice medicine in Florida must be licensed by the BOM or the BOOM. All doctors, including those trained outside the U.S., are required to pass all three parts of the U. S. Medical Licensing Examination (USMLE)²⁰⁴ in order to obtain a Florida medical license. An international medical graduate (IMG) must be certified by the ECFMG ²⁰⁵ in order to be eligible to enter U.S. graduate medical education programs (residency or fellowship), to take part III of the USMLE, and to enter the National Residency Match Program, or *The Match*.²⁰⁶

Examination (SPEX) was first given in 1988 and conceived by the Federation of State Medical Boards (FSMB) for state medical boards to use as an assessment tool when endorsing or granting licensing reciprocity to a physician licensed in another US state or Canadian province. State boards may require SPEX for endorsement of licensure, reinstatement of a license, or reactivation of a license after a period of inactivity. To take the SPEX you must hold, or have held at some point, an active, unrestricted medical license in the U.S. or Canada. Its purpose was later expanded to include cases in which state boards needed to assess a physician's competence before reinstating or reactivating a lapsed or suspended license. ²⁰⁰ See s. 458.314, F.S. There currently are no foreign medical schools certified under this section, according to the DOH, per email to Senate Health Policy Committee staff, on file with Senate Health Policy Committee.

 $^{^{201}}$ Id.

²⁰² Section 458.311, F.S., A graduate of a foreign medical school does not need to present an ECFMG certification or pass its exam if the IMG received his or bachelor's degree from an accredited U.S. college or university, studied at a medical school recognized by the World Health Organization, has completed all of the formal requirements of the foreign medical school, except the internship or social service requirements, and has completed an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and, has passed parts I and II of the National Board Medical Examiners licensing examination or the ECFMG equivalent examination.

²⁰³ Section 458.311, F.S.

²⁰⁴ Fla. Admin. Code Rs. 64B8-3.003, and 64B15-10.002 (2023).

²⁰⁵ The Educational Commission for Foreign Medical Graduates, ECFMG, About Us, available at

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

²⁰⁶ National Residency Patch Program, Who We Are, available at <u>https://www.nrmp.org/about/</u> (last visited Nov. 29, 2023).

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

- Evaluates the qualifications of international medical graduates (IMGs) and foreign students for entry into U.S. medical schools;
- Evaluates and verifies international medical schools;
- Evaluates and verifies physician credentials related to medical education, training, and licensure;
- Evaluates, and verifies clinical skills of international medical graduates and foreign trained physicians;
- Certifies the readiness of international medical graduates and students for entry into United States medical school through an evaluation of their qualifications; and
- Evaluates the needs of international medical graduates to become acculturated.²⁰⁷

To become certified by ECFMG, an IMG must pass the first two parts of the USMLE and two separate exams testing clinical and communication skills.²⁰⁸ Once a physician receives an ECFMG certification, he or she may apply for a residency or fellowship and enter THE MATCH.²⁰⁹

Allopathic Restricted Licenses

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

In 1986 the Legislature created requirements for Cuban-licensed medical doctors which authorized the BOM to issue a one-year restricted license to any Cuban-licensed medical physician who passed the Florida BOM examination and met certain criteria. It also provided that the Florida BOM examination could be translated into a foreign language at the request of at least five applicants. However, by rule, the BOM adopted the FLEX as the official Florida board examination, which could not be translated into another language.²¹⁰ This pathway for Cuban

²⁰⁷ The Educational Commission for Foreign Medical Graduates, ECFMG, *About Us, available at* <u>https://www.ecfmg.org/about/</u> (last visited Nov. 29, 2023).

²⁰⁸ The Educational Commission for Foreign Medical Graduates, ECFMG, *Certification, available at* <u>https://www.ecfmg.org/certification/</u> (last visited Nov. 29, 2023).

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

²¹⁰ Section 458.311(6)(1986 Supp. F.S. 1985).

licensed physicians was repealed in 1995, but expired on its own terms effective October 1, 1993.²¹¹

In 1989, the Legislature created a pathway to full medical licensure for Nicaraguan-licensed physicians which required the BOM to issue a two-year restricted license to any Nicaraguan-licensed doctor who applied before July 1, 1992, met certain criteria, applied before July 1, 1992, and completed a specific course, or specific review course, passed the FLEX or USMLE examination. This pathway was repealed by its terms October 1, 1991.²¹²

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

- Certain foreign-licensed physicians;²¹³
- BOM designated areas of critical need;²¹⁴ and
- Certain experienced foreign trained physicians.²¹⁵

Restricted Licenses for Certain Foreign Licensed Physicians

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

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

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

Restricted Licenses For Certain Experienced Foreign-Trained Physicians

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

²¹¹ Section 20, Laws of Florida, ch. 95-145.

²¹² Section 458. 311(10), F.S. (1989). Sections 1 and 42, Laws of Florida, ch. 89- 374.

²¹³ Section 458.3115, F.S.

²¹⁴ Section 458.310, F.S.

²¹⁵ Section 458.3124, F.S.

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

Applicants for restricted medical licenses under s. 458.310, F.S., are granted without examination, if the applicant agrees to enter into a contract for at least 24 months solely in the employ of a state or a federally funded community health center or migrant health center, at the current salary level for that position, in a BOM designated areas of critical need; and the applicant:²¹⁶

- Meets the requirements for licensure by examination;²¹⁷ and
- Has actively practiced medicine in another jurisdiction for at least two of the immediately preceding four years or has completed board-approved postgraduate training within the year receding submission of the application.

This type of restricted licensee also requires an applicant to take and pass the licensure examination prior to the completion of the 24-month practice period.²¹⁸ If this restricted licensee breaches the terms of his or her contract he or she is prohibited from being licensed as a physician in Florida.²¹⁹The BOM may issue up to 100 of this type of restricted licenses annually.²²⁰

Temporary Certificates for Practice in Areas of Critical Need

Current law does not authorize the BOOM to issue restricted licenses, but both the BOM and the BOOM may issue a temporary certificate to practice in areas of critical need to an allopathic or osteopathic physicians who will practice in those areas. An applicant for a temporary certificate must:²²¹

- Be actively licensed to practice medicine in any jurisdiction of the U.S.;
- Be employed by, or practice in, a county health department, correctional facility, Department of Veterans' Affairs clinic, federally-funded community health care center, or any other agency or institution designated by the State Surgeon General and provides health care to underserved populations; or
- Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's workforce as determined by the Surgeon General.

The BOM and the BOOM are authorized to administer an abbreviated oral examination to determine a physician's competency. A written examination is not required.²²² The boards may deny the application, issue the temporary certificate with reasonable restrictions, or require the applicant to meet any reasonable conditions of the BOM or BOOM prior to issuing the temporary certificate if it has been more than three years since the applicant has actively practiced and the respective board determines the applicant lacks clinical competency, adequate skills, necessary medical knowledge, or sufficient clinical decision-making.²²³

- ²¹⁹ Section 458.310(4), F.S.
- ²²⁰ Section 458.310(2), F.S.

²²² Id.

²¹⁶ Section 458.310, F.S.

²¹⁷ Section 458.311, F.S.

²¹⁸ Section 458.310(3), F.S.

²²¹ Sections 458.315, and 459.0076, F.S.

²²³ Sections 458.315(3)(b) and 459.0076(3)(b), F.S.

Fees for the temporary certificate for practice in areas of critical need include a \$300 application fee and \$429 initial licensure fee; however, these fees may be waived if the individual is not compensated for his or her practice.²²⁴ The temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.²²⁵ However, the boards must review the temporary certificate holder at least annually to ensure that he or she is in compliance with the practice act and rules adopted thereunder.²²⁶ A board may revoke or restrict the temporary certificate for practice in areas of critical need if noncompliance is found.²²⁷

Currently there are 913 out-of-state physicians with current and active temporary certificates to practice in areas of critical need in Florida. Between 2020 and 2023 the BOM has received the following numbers of applications per year, and issued the following number of temporary certificates to out-of-state physicians wishing to practice in Florida in areas of critical need.²²⁸

Temporary Certificates to Practice in Areas

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

Limited Licenses

Both the BOM and the BOOM are authorized to issue limited licenses. Licensed allopathic physicians are issued limited licenses to practice in areas of critical need, and licensed osteopathic physicians are issued limited licenses to practice in areas of critical need or medically underserved areas, though the process and authorizations for each are slightly different.²²⁹

An allopathic physician wishing to obtain a limited license to practice in the employ of a public or private 501(c)(3) non-profit²³⁰ agency or institution located in a BOM determined area of critical medical need, must submit an application and fee, unless the applicant includes an employer's statement that the position is uncompensated, in which case all fees are waives, and demonstrates:

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

If it has been more than three years since the limited license applicant has been in active practice, the full-time director of the county health department, or a BOM approved licensed physician, must supervise the applicant for six months after licensure, unless the BOM determines that a

²²⁴ Fla. Admin. Code Rs. 64B8-3.003, and 64B15-10.002 (2023).

²²⁵ Sections 458.315(3), and 459.0076(3), F.S.

²²⁶ Sections 458.315(3)(c), and 459.0076(3)(c), F.S.

²²⁷ Id.

²²⁸ Email from the DOH, *Temporary certificate for practice in areas of critical need*, Nov. 1, 2023, (on file with the Committee on Health Policy).

²²⁹ Sections 458.317 and 459.0075, F.S.

 $^{^{230}}$ Section 501(c)(3) of the Internal Revenue Code.

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

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

The BOOM is also authorized to issue limited licenses to certain osteopathic physicians who will only practice in areas of critical need or in medically underserved areas. A limited license may be issued to an osteopathic physician who:²³¹

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

If it has been more than three years since the osteopathic limited license applicant has actively practiced medicine, the full-time director of the local county health department must supervise the applicant for at least six months after the issuance of the limited license unless the BOOM determines a shorter period will be sufficient.²³²

The BOOM must review the practice of each osteopathic physician who holds a limited license at least biennially to ensure that he or she is in compliance with the practice act and rules adopted thereunder.²³³

Board of Nursing

In Florida all professional nursing is regulated by the Board of Nursing (BON) under the Nurse Practice Act.²³⁴ The BON consists of 13 members appointed by the Governor and confirmed by the Senate; and promulgates rules for the eligibility criteria for all applicants to be licensed as licensed practical nurses (LPNs), registered nurses (RNs), advanced practice registered nurses (APRNs)²³⁵ and autonomous advanced practice registered nurses (autonomous APRNs) and the applicable regulatory standards for the various nursing practices. Additionally, the BON is

²³¹ Section 459.0075, F.S., and Fla. Admin. Code R. 64B15-12.005 (2023).

²³² Section 459.0075(2), F.S.

²³³ Section 459.0075(5), F.S.

²³⁴ Chapter 465, Part I, F.S.

²³⁵ Section 464.012, F.S. In 2018, the Florida Legislature changed the occupational title from "Advanced Registered Nurse Practitioner" to "Advanced Practice Registered Nurse," and reclassified a CNS as a type of APRN (see ch. 2018-106, Laws of Florida).

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

Advanced Practice Registered Nurses

An APRN is any person licensed in this state to practice professional nursing and who is licensed in an advanced nursing practice, including certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric nurses.²³⁶ As of December 6, 2023, there were 62,545 licensed APRNs in the state who practice in the following nursing specialties:²³⁷

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

Section 464.003(2), F.S., defines the term "advanced or specialized nursing practice" to include, in addition to practices of professional nursing that registered nurses (RNs) are authorized to perform, advanced-level nursing acts approved by the BON as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.²³⁸ In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain *medical acts*, as opposed to *nursing* acts, as trained and authorized within the framework of an established protocol with a supervisory physician.²³⁹

To be eligible to be licensed as an APRN, an applicant must be licensed as a RN, have a master's degree or higher in a clinical nursing specialty with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a BON-approved nursing specialty board.²⁴⁰ A nursing specialty board must:²⁴¹

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

²³⁶ Section 464.003(3), F.S.

²³⁷ Email from the DOH, *Registered Autonomous APRNs under 464.0123 and Certified APRNs under Section 464.012 F.S.*, Dec. 6, 2023, (on file with the Committee on Health Policy).

²³⁸ Section 464.012(3)-(4), F.S.

²³⁹ Section 464.003, F.S., and s. 464.012, F.S.

²⁴⁰ Section 464.012(1), F.S., and Fla. Admin. Code R. 64B9-4.002 (2023).

²⁴¹ Fla. Admin. Code R.64B9-4.002(3), (2023).

APRNs may perform only nursing practices, and medical practices they have been trained for and are delineated in a written protocol with a physician. A physician providing primary health care services may supervise APRNs in up to four medical offices,²⁴² in addition to the physician's primary practice location. If the physician provides specialty health care services, then only two medical offices in addition to the physician's primary practice location may be supervised.²⁴³ A special limitation applies to dermatology services. If the physician offers services other than plastic surgery), at a medical office that is not the physician's primary practice location, then the physician may only supervise one medical office.²⁴⁴

In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs to prescribe controlled substances beginning in 2017.²⁴⁵ The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,²⁴⁶ as well as requiring CE credits related to controlled substances prescribing. Under a written protocol with a physician, an APRN may:

- Prescribe, dispense, administer, or order any drug;²⁴⁷
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by BON rule;
- Order diagnostic tests and physical and occupational therapy;
- Perform certain physical examinations previously reserved to physicians and physician assistants, such as examinations of pilots;²⁴⁸ and
- Perform certain acts within his or her specialty.²⁴⁹

Autonomous APRN Practice

Current law authorizes an APRN who meets certain eligibility criteria to engage in autonomous practice only in primary care, which includes family practices, general pediatrics and general internal medicine, as defined by BON rule, without a supervising physician or written protocol with a physician.²⁵⁰ The BON has defined primary care by rule to include the "physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance,

²⁴² The supervision limitations do not apply in certain facilities such as hospitals, colleges of medicine or nursing, nonprofit family-planning clinics, rural and federally qualified health centers, nursing homes, assisted living facilities, continuing care facilities, retirement communities, clinics providing anesthesia services, rural health clinics, community-based health care settings, student health care centers, school health clinics, or other government facilities. Sections 458.348(3)(e), and 459.025(3)(e), F.S.

²⁴³ Sections 458.348, and 459.025, F.S.

²⁴⁴ Id.

²⁴⁵ Chapter 2016-224, Laws of Florida.

²⁴⁶ Pursuant to s. 893.03(2), F.S., a schedule II substance has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. In Florida, an APRN may only prescribe a 7-day supply of a schedule II controlled substance, except the limitation does not apply to certain psychiatric prescribing psychiatric medications. Section 456.42, F.S., limits the amount of schedule II opioids that may be prescribed for acute pain by any prescriber to a 3-day supply, with certain exceptions.

²⁴⁷ Controlled substances may only be prescribed or dispensed if the APRN has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.
²⁴⁸ Section 310.081, F.S.

²⁴⁹ Sections 464.012(3)-(4), and 464.003, F.S.

²⁵⁰ Section 464.0123(3)(a)1., F.S.

counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions."²⁵¹

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

- Completed at least 3,000 clinical practice hours or clinical instructional hours²⁵² supervised by a physician with an active license within the five year period immediately preceding the registration request;
- Not have been subject to any disciplinary action during the five years immediately preceding the application;
- Completed three graduate-level semester hours, *or the equivalent*, in pharmacology and three graduate-level semester hours, *or the equivalent*, in differential diagnosis within the five year period preceding the registration request;²⁵³ and
- Any other registration requirements provided by BON rule.

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

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

An autonomous APRN registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN and RN. To maintain autonomous APRN registration, an autonomous APRN must complete at least 10 hours of BON approved CE for each biennial renewal in addition to the 30 hours of CE required for renewal of the APRN license.²⁵⁴

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

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

²⁵¹ Fla. Admin. Code R. 64B9-4.001(12), (2023).

²⁵² The bill defines "clinical instruction" as education provided by faculty in a clinical setting in a graduate program leading to a master's or doctoral degree in a clinical nursing specialty area.

²⁵³ See Fla. Admin. Code R. 64B9-4.020(3),(2023) where the BON defined, by rule, *the equivalent of* three graduate-level semester hours in pharmacology and *the equivalent of* three graduate-level semester hours in differential diagnosis as equal to forty-five (45) Continuing Education credits offered in those areas by the entities set forth in Section 464.013(3)(b), F.S. and Fla. Admin. Code R. 64B9-4.002(2), (2023).

²⁵⁴ Current law provides an exception to the 10 hours of CE in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.

in primary care practice is authorized to perform the following without supervision or a written protocol with a physician:²⁵⁵

- Admit, discharge, or manage the care of a patient requiring the services of a health care facility, as authorized under federal law or BON rule;
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician, except for the certification required for the use of medical marijuana; ²⁵⁶
- Certify causes of death and sign, correct, and file death certificates;
- Subject a person to involuntary examination under the Baker Act;²⁵⁷ and
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

A certified nurse midwife may perform midwifery services²⁵⁸ autonomously only if he or she has a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician. An autonomous APRN may not perform any surgical procedures that go below the subcutaneous tissue.

Current law imposes safeguards to ensure autonomous APRNs practice safely, similar to those for physicians.²⁵⁹ It defines an adverse incident as an event over which the APRN could exercise control and which is associated with a nursing intervention, rather than a condition for which such intervention occurred, which results in at least one of the following:

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

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

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

- 9,933 certified nurse practitioner (CNP);
- 83 certified nurse midwife (CNM);
- 20 clinical nurse specialist (CNS);
- 72 certified registered nurse anesthetist (CRNA); or
- 1,093 certified psychiatric nurse.²⁶⁰

²⁵⁵ Section 464.0123(3), F.S.

²⁵⁶ Section 381.986, F.S.

²⁵⁷ Section 394.463, F.S.

²⁵⁸ See s 464.012(4)(c), F.S.

²⁵⁹ See ss. 458.351 and 459.026, F.S.

²⁶⁰ Email from the DOH, Autonomous APRNs, Dec. 5, 2023, (on file with the Committee on Health Policy).

Regulation of Audiology and Speech-Language Pathology

Audiologists and speech-language pathologists are licensed and regulated by Board of Speech-Language Pathology and Audiology pursuant to Part I of ch. 468, F.S. To qualify for licensure, an applicant must:²⁶¹

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

An audiologist or speech-language pathologist who holds a valid license in another U.S. state or jurisdiction may apply for licensure by endorsement if the criteria for issuance of such license were substantially equivalent or more stringent than Florida's requirements.²⁶² Additionally, an individual who holds a valid certificate of clinical competence of the American Speech-Language and Hearing Association or board certification in audiology from the American Board of Audiology qualifies for licensure.²⁶³

The current licensure application fee is \$75 and is non-refundable.²⁶⁴ If a license is approved, the initial license fee is \$200.

Regulation of Physical Therapy

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

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

²⁶¹ Florida Department of Health, Board of Speech-Language Pathology and Audiology, *available at* <u>https://floridasspeechaudiology.gov/licensing/</u> (last visited Dec. 7, 2023). The necessary semester hours needed for an academic degree vary depending on when the degree was earned.

²⁶² Section 468.1185(3)(a), F.S.

²⁶³ Section 468.1185(3)(b), F.S.

²⁶⁴ Florida Department of Health, Board of Speech-Language Pathology and Audiology, *available at* <u>https://floridasspeechaudiology.gov/licensing/</u> (last visited Dec. 7, 2023).

- For a physical therapist assistant, has received a degree as a physical therapist assistant from a physical therapist assistant educational program accredited by the Commission on Accreditation in Physical Therapy or was enrolled between July 1, 2014, and July 1, 2016, in a physical therapist assistant school in Florida which was accredited at the time of enrollment and graduated no later than July 1, 2018;
- Pass the appropriate licensure examination developed by the Federation of State Boards of Physical Therapy within five attempts;²⁶⁵ and
- Pass an examination on Florida laws and rules.²⁶⁶

An applicant may be entitled to licensure without examination if he or she holds an active license in another jurisdiction and presents evidence of having passed a licensing examination of another jurisdiction.²⁶⁷ The board must determine that the standards of that other jurisdiction are as high as the standards in Florida.

Licensure Discipline

Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations under the Division of Medical Quality Assurance (MQA) in DOH. Section 456.072, F.S., specifies acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Chapter 456, F.S., and the individual practice acts identify actions that constitute grounds for which disciplinary actions may be taken against a health care license. Some portions of the licensure discipline process are public and some are confidential.²⁶⁸

MQA reviews complaints to determine if the complaint is legally sufficient.²⁶⁹ A determination of legal sufficiency is made if the ultimate facts show that a violation has occurred.²⁷⁰ The complaint is forwarded for investigation if it is found to be legally sufficient. MQA notifies the complainant by letter to advise whether the complaint will be investigated, additional information is needed, or the complaint is being closed because it is not legally sufficient.²⁷¹ Complaints that involve an immediate threat to public safety are given the highest priority.

A probable cause panel of the appropriate board reviews all evidence and information gathered during the investigation and determines whether the case should be escalated to a formal administrative complaint, closed with a letter of guidance, or dismissed.²⁷² If a formal

 $^{^{265}}$ If an applicant fails the licensure examination five times, he or she is precluded from licensure, regardless of the jurisdiction through which the examination is taken.

²⁶⁶ Sections 486.031 and 486.102, F.S., and Fla. Admin. Code R. 64B17-3.002.

²⁶⁷ Section 486.081, F.S., and Fla. Admin. Code R. 64B17.3001(3).

²⁶⁸ Florida Department of Health, Division of Medical Quality Assurance, *Enforcement Process, available at* <u>https://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/process-chart.pdf</u> (last visited Dec. 7, 2023).

²⁶⁹ Section 456.073, F.S.

²⁷⁰ Florida Department of Health, *Administrative Complaint Process – Consumer Services, available at* <u>https://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html</u> (last visited Dec. 7, 2023).

²⁷¹ Id.

²⁷² Florids Department of Health, Medical Quality Assurance, *A Quick Guide to the MQA Disciplinary Process Probable Cause Panels, available at* <u>http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/documents/a-quick-guide-to-the-mqa-disciplinary-process.pdf</u> (last visited Dec. 7, 2023).

administrative complaint is filed and it involves disputed issues of material fact, the case may be heard before an administrative law judge (ALJ) and the ALJ will issue a recommended order.²⁷³ The issue of whether a licensee has violated the laws and rules regulating the profession, including determining the reasonable standard of care, is a conclusion of law determined by the board.²⁷⁴ The appropriate board will issue a final order in each disciplinary case.²⁷⁵

Interstate Licensing Compacts

An interstate compact is a contract between two or more states. It carries the force of law and may establish uniform guidelines, standards, or procedures for the compact's member states.²⁷⁶ Interstate compacts addressing regulatory matters may be structured quite differently. There are generally two types of compact models: mutual recognition and expedited licensure.²⁷⁷

Under a mutual recognition model, a health care practitioner receives a multistate license from the compact state in which the licensee has established residence or purchases "privileges" from the compact.²⁷⁸ The multistate license authorizes the holder to practice in any of the other states who are members of the compact, as long as he or she maintains residence in the state in which he or she is initially licensed. Licensees are generally bound to the renewal and continuing education requirements of the state in which they reside.²⁷⁹ The Nurse Licensure Compact, Physical Therapy Licensure Compact, and the Audiology and Speech-Language Pathology Interstate Compact are examples of mutual recognition compacts.

An expedited licensure model requires a health care practitioner to apply for licensure in each state they intend to practice, but the compact makes the application process more efficient by providing centralization application requirements.²⁸⁰ Under this model, officials in the applicant's principal state of licensure determine if the applicant qualifies for expedited licensure; and if so, the applicant may receive an expedited license from other member states. The Interstate Medical Licensure Compact for physicians is an expedited licensure model.

Florida has enacted three health care practitioner compacts – the Nurse Licensure Compact enacted in 2016,²⁸¹ the Professional Counselors Licensure Compact enacted in 2022,²⁸² and the Psychology Interjurisdictional Compact enacted in 2023.²⁸³

²⁷⁷ The Council for State Governments, *Occupational Licensure: Interstate Compacts in Action, available at* <u>https://licensing.csg.org/wp-content/uploads/2019/07/OccpationalInterstateCompacts-InAction_Web.pdf</u> (last visited Dec. 7, 2023).

 279 Id.

- ²⁸¹ Section 464.0095, F.S.
- ²⁸² Section 491.017, F.S.

²⁷³ Section 456.073(5), F.S.

²⁷⁴ Id.

²⁷⁵ Section 456.073(6), F.S.

²⁷⁶ See Audiology and Speech Language Pathology Interstate Compact, What is a Compact?, *available at* <u>https://aslpcompact.com/wp-content/uploads/2019/08/80057-What-is-a-Compact_Final.pdf</u> (last visited Dec. 7, 2023).

 $^{^{2023}}$). 278 Id.

 $^{^{280}}$ Id.

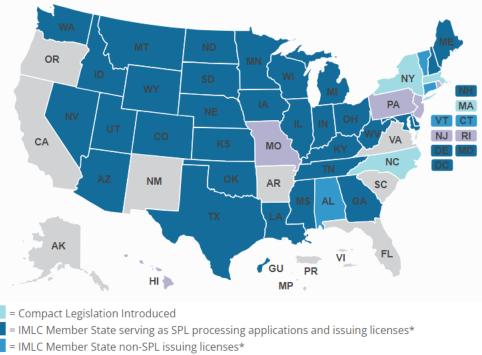
²⁸³ Section 490.0075, F.S.

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC) offers an expedited pathway to licensure for qualified physicians.²⁸⁴ Physicians complete a single application and receive separate licenses from each state they intend to practice. The issuance of the license remains based in the individual state. Under the IMLC, a physician must:

- Designate a state of principal license;
- Have graduated from an accredited medical school or a school listed in the International Medical Education, or its equivalent;
- Have successfully completed accredited graduate medical education;
- Passed each component of the United States Medical Licensing Examination, Comprehensive Osteopathic Medical Licensing Examination of the United States, or equivalent examination;
- Hold a current specialty or a time-unlimited certification;
- Not have a history of disciplinary action or controlled substance action against his or her medical license;
- Not have any criminal history;
- Not currently be under investigation; and
- Pay a \$700 application fee to the IMLC.²⁸⁵

The IMLC became operational in 2017 and has been enacted by 37 states, the District of Columbia, and the territory of Guam, as seen in the illustration below.²⁸⁶



IMLC Passed; Implementation In Process or Delayed*

 286 Id.

 ²⁸⁴ IMLC, A Faster Pathway to Physician Licensure, available at <u>https://www.imlcc.org/a-faster-pathway-to-physician-licensure/</u> (last visited Dec. 7, 2023).
 ²⁸⁵ Id.

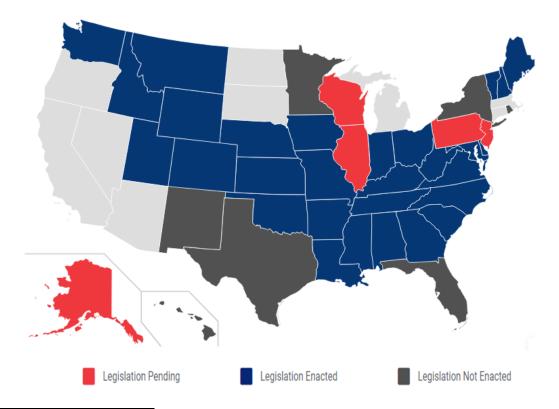
Audiology and Speech-Language Pathology Interstate Compact

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

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

- An active, unencumbered license in his or her own state;
- Earned an accredited degree;
- Completed a supervised practicum and approved national examination;
- For speech-language pathologist, complete a supervised post-graduate professional experience;
- No disqualifying criminal history; and
- A valid Social Security Number or National Practitioner Identifier.²⁸⁷

Although the ASLP Compact began operations in 2022, it is not anticipated to be fully operational and processing applications for compact privileges until early 2024.²⁸⁸ Twenty-nine states have enacted the ASLP Compact, as seen in the illustration below.

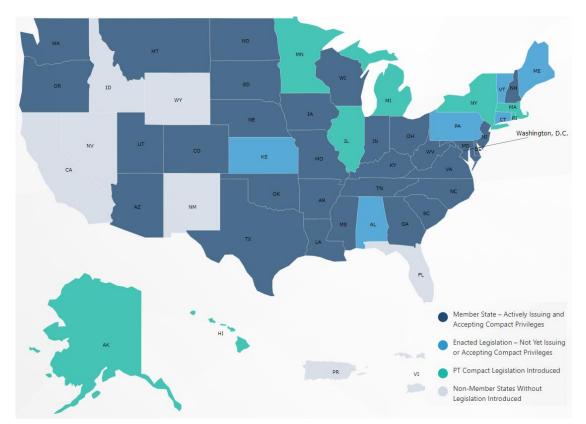


 ²⁸⁷ ASLP Compact, *Frequently Asked Questions, available at https://aslpcompact.com/faq/* (last visited Dec. 7, 2023).
 ²⁸⁸ ASLP Compact, *ASLP-IC: Audiology & Speech-Language Pathology Interstate Compact, available at https://aslpcompact.com/* (last visited Dec. 7, 2023).

Physical Therapy Compact

The Physical Therapy Compact (PT Compact) is a mutual recognition compact that allows a physical therapist or physical therapist assistant who holds a license in his or her home state to apply for privileges to practice in another member state under the PT Compact.²⁸⁹ To be eligible for compact privileges, a physical therapist or physical therapist assistant, must:

- Hold a current, valid, unencumbered license in his or her home state, which must be actively issuing and accepting compact privileges;
- Not have had any disciplinary action against his or her license within the previous two years;
- Successfully complete a jurisprudence examination, if required by the member state for which the applicant is seeking privileges; and
- Pay the \$45 PT Compact fee and the fee charged by the member state, if any.²⁹⁰



The PT Compact has been enacted by 37 states as seen in the illustration below.²⁹¹

²⁸⁹ PT Compact, *How to Get Compact Privileges, available at* <u>https://ptcompact.org/How-to-Get-Privileges</u> (last visited Dec. 7, 2023).

²⁹⁰ *Id*. See also, PT Compact, *Fee and Jurisprudence Table, available at* <u>https://ptcompact.org/Compact-Privilege-Fee-Jurisprudence-and-Waiver-Table</u> (last visited Dec. 7, 2023).

²⁹¹ PT Compact, *Compact Map, available at https://ptcompact.org/ptc-states* (last visited Dec. 7, 2023).

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Sovereign Immunity for Charitable Care

Section 766.1115, F.S., creates the "Access to Health Care Act" to provide protections against liability for health care providers who offer free quality medical services to underserved populations in Florida. The act provides that a health care provider that executes a contract with a governmental contractor²⁹² to provide health care services is considered an agent of the state for sovereign immunity purposes when acting under the scope of duties under the contract and may not be named as a defendant in any action arising out of medical care or treatment provided under the contracts entered into. For the purposes of the Access to Health Care Act, a health care provider includes:

- A birth center.
- An ambulatory surgical center.
- A hospital.
- A medical doctor, osteopathic physician, or PA.
- A chiropractic physician.
- A podiatric physician.
- A registered nurse, nurse midwife, licensed practical nurse (LPN), or APRN or any facility which employs nurses to supply all or part of the care delivered.
- A midwife.
- A health maintenance organization.
- A health care professional association and its employees or a corporate medical group and its employees.
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
- A dentist or dental hygienist.
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.²⁹³
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the listed professionals.

Developmental Research Laboratory Schools

Developmental research laboratory schools (lab schools) are an established category of public schools that provide sequential instruction and are affiliated with a college of education within the state university of closet geographic proximity.²⁹⁴ Lab schools are required to establish admission processes that are designed to result in a representative sample of the public school enrollment based on gender, race, socioeconomic status, and academic ability.²⁹⁵ As part of a lab

²⁹² "Governmental contractor" is defined as the DOH, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.

²⁹³ "Low-Income" is defined as A person who is Medicaid-eligible under Florida law; a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.

²⁹⁴ Section 1002.32(2), F.S.

²⁹⁵ Section 1002.32(4), F.S.

school's mission, there must be an emphasis on mathematics, science, computer science, and foreign languages.²⁹⁶ Additionally, as part of the lab school's primary goal, the school is required to enhance instruction and research in such specialized subjects by using the resources available on the university's campus. Currently, there are four universities that have lab schools:²⁹⁷

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

A university is limited to one lab school, except for a charter lab school or one that serves military families near a military installation.²⁹⁸ State universities operate four charter lab schools, which are Florida State University Charter Lab K-12 School in Broward County, Florida Atlantic University Charter Lab K-12 School in Palm Beach County, Florida Atlantic University Charter Lab K-12 School in St. Lucie County²⁹⁹ and the Florida State University Collegiate School in Bay County.³⁰⁰ In considering an application to establish a charter lab school, a state university must consult with the district school board of the county in which the school is located. If a state university denies or does not act on the application, the applicant may appeal such decision to the State Board of Education (SBE).³⁰¹

III. Effect of Proposed Changes:

FRAME and DSLR Program

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

Specific to the DSLR Program, the bill expands the program to include dental hygienists and to include private dental practices that are located in dental health professional shortage areas as eligible practice locations for dentists and dental hygienists who want to apply for reimbursement. The bill specifies that the annual award for a qualifying dentist or dental hygienist is 20 percent of his or her principal loan amount at the time that he or she applies for the program, but may not be more than \$50,000 per year for dentists or \$7,500 per year for dental hygienists, and specifies that a dentist or dental hygienist may receive up to five such awards and that the awards are not required to be awarded in consecutive years.

Specific to the FRAME program, the bill expands the list of eligible practitioners to include mental health professionals, such as licensed clinical social workers, licensed marriage and

³⁰¹ Section 1002.33(6)(g), F.S.

²⁹⁶ Section 1002.34(3), F.S.

²⁹⁷ Florida Department of Education, *Superintendents, available at* <u>https://www.fldoe.org/accountability/data-sys/school-dis-data/superintendents.stml</u> (last visited Dec. 5, 2023).

²⁹⁸ Section 1002.32(2), F.S.

²⁹⁹ Id.

³⁰⁰ Florida State University, *The Collegiate School Panama City, available at https://tcs.fsu.edu/* (last visited Dec. 5, 2023).

family therapists, licensed mental health counselors, and licensed psychologists. The bill consolidates autonomous APRNs with the other practitioner types, eliminates specific requirements for such APRNs to qualify for the program, and eliminates the requirement that APRNs practice in primary care to qualify. The bill lengthens the amount of time over which awards may be given from year-to-year to over four years and increases the maximum award amounts for every practitioner as follows (the following amounts reflect the total amount awarded over four years):

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

The bill specifies that a practitioner may only receive an award for one four-year period, that the years are not required to be consecutive, and requires the DOH to award 25 percent of the practitioner's principal loan amount at the time he or she applies for the program at the end of each year.

For both FRAME and the DSLR Program, the bill requires that practitioners provide 25 hours of volunteer primary care or dental services in a free clinic, as defined in s. 766.1115, F.S., that is located in an underserved area or through another volunteer program operated by the state pursuant to part IV of ch. 110, F.S. Specific to the DSLR Program, dentists and dental hygienists may volunteer at pro bono opportunities approved by the Board of Dentistry. In order to qualify, the hours must be verifiable in a manner determined by the DOH.

Additionally, the bill requires the AHCA to seek federal authority to use Title XIX³⁰² matching funds for FRAME and the DSLR Program, and the bill provides a sunset date for both programs of July 1, 2034.

Student Loan Repayment Program Reporting

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

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

The bill also requires the DOH to contract with an independent third party to develop and conduct a study to evaluate the effectiveness of FRAME and the DSLR Program. The bill

³⁰² Title XIX of the federal Social Security Act creates the Medicaid program and provides federal matching funds for states that participate in Medicaid

requires the DOH to begin collecting the data needed by January 1, 2025, and submit the study to the Governor and the Legislature by January 1, 2030. Practitioners who receive payments under either FRAME or the DSLR Program must furnish any information requested by the DOH for the study or the DOH's annual reporting requirements.

Health Care Screening and Services Grant Program

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

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

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

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

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

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

Advanced Birth Centers

The bill amends multiple sections of the Florida statutes related to birth center licensure to create a new designation for birth centers as advanced birth centers (ABC). The bill defines an ABC as

a licensed birth center designated as an advanced birth center which may perform trial of labor after cesarean deliveries for screened patients who qualify, planned low-risk cesarean deliveries, and anticipated vaginal deliveries for laboring patients from the beginning of the 37th week of gestation through the end of the 41st week of gestation. The bill also adds a definition for the term "medical director" to mean a person who holds an active unrestricted license as a physician under ch. 458 or ch. 459, F.S.

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

- Be operated and staffed 24 hours per day, 7 days per week.
- Employ two medical directors to oversee the activities of the center, one of whom must be a board-certified obstetrician and one of whom must be a board-certified anesthesiologist.
- Have at least one properly equipped, dedicated surgical suite for the performance of cesarean deliveries.
- Employ at least one registered nurse and ensure that at least one registered nurse is present in the center at all times and has the ability to stabilize and facilitate the transfer of patients and newborn infants when appropriate.
- Enter into a written agreement with a blood bank for emergency blood bank services and have written protocols for the management of obstetrical hemorrhage which include provisions for emergency blood transfusions. If a patient admitted to an advanced birth center receives an emergency blood transfusion at the center, the patient must immediately thereafter be transferred to a hospital for further care.
- Meet all standards adopted by rule for birth centers, unless specified otherwise, and advanced birth centers pursuant to s. 383.309, F.S.
- Comply with the Florida Building Code and Florida Fire Prevention Code standards for ambulatory surgical centers.
- Qualify for, enter into, and maintain a Medicaid provider agreement with the AHCA pursuant to s. 409.907, F.S., and provide services to Medicaid recipients according to the terms of the provider agreement.

The bill requires the AHCA to establish in rule a procedure for designating birth centers as ABCs and states that standards adopted for such designation must be, at a minimum, equivalent to the minimum standards for ASCs and include standards for quality of care, blood transfusions, and sanitary conditions for food handling and food service. The bill also grants the AHCA authority to develop additional standards as it deems necessary for patient safety.

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

Laboratory Services

ABCs are required to have an onsite clinical laboratory which is, at a minimum, capable of testing for hematology, metabolic screening, liver function, and coagulation studies. The ABC is authorized to collect specimens for those tests that are requested under protocol and may perform any tests authorized by the AHCA in rule. Laboratories in ABCs must be appropriately certified

by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

Surgical Services

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

Administration of Analgesia and Anesthesia

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

Intrapartal Use of Chemical Agents

The bill authorizes the use of chemical agents to inhibit, stimulate, or augment labor during the first or second stage of labor at an ABC if prescribed by personnel who have the statutory authority to do so. Labor may be induced at the 39th week of gestation for a patient with a documented Bishop score of eight or greater.³⁰³

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

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

³⁰³ The Bishop scoring system is based on a digital cervical exam of a patient with a zero point minimum and 13 point maximum. The scoring system utilizes cervical dilation, position, effacement, consistency of the cervix, and fetal station. A Bishop score of 8 or greater is considered to be favorable for induction, or the chance of a vaginal delivery with induction is similar to spontaneous labor. A score of 6 or less is considered to be unfavorable if an induction is indicated cervical ripening agents may be utilized. See Wormer KC, Bauer A, Williford AE. Bishop Score. [Updated 2023 Sep 4]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-., *available at* https://www.ncbi.nlm.nih.gov/books/NBK470368/, (last visited Dec. 5, 2023).

Hospital Requirements

Prohibition on Accepting Payments for Clinicals

The bill amends s. 395.1055, F.S., to require a hospital to give priority to students from a medical school located in Florida if the hospital accepts payment from any medical school directly, or indirectly, related to allowing students from the medical school to obtain clinical hours or instruction at the hospital.

Nonemergent Care Access Plans

The bill also requires all hospitals with emergency departments (ED), including hospital-based off-campus EDs, to submit a Nonemergent Care Access Plan (NCAP) to the AHCA for assisting a patient with gaining access to appropriate care settings when the patient presents at the ED with nonemergent health care needs or indicates when receiving a medical screening examination, triage, or treatment at the hospital that he or she lacks regular access to primary care. Starting July 1, 2025, the plan must be approved by the AHCA prior to first licensure or licensure renewal. The bill requires that a hospital with an approved NCAP must submit data to the AHCA demonstrating the effectiveness of its plan as part of the licensure renewal process and must update the plan as necessary, or as directed by the AHCA, before each licensure renewal.

The bill specifies that the NCAP must include procedures that ensure the plan does not conflict or interfere with the hospital's duties and responsibilities under s. 395.1041, F.S., or 42 U.S.C. s. 1395dd³⁰⁴ and must include procedures to educate patients about care that would be best provided in a primary care setting. Additionally, an NCAP must include at least one of the following:

- A partnership agreement with one or more nearby FQHCs or other primary care settings. The goal of the agreement must include, but need not be limited to:
 - Identifying patients who present at the ED for nonemergent care, care that would best be provided in a primary care setting, or emergency care that could potentially have been avoided through the regular provision of primary care; and
 - Proactively establishing a relationship between such patient and the FQHC or other primary care setting so that the patient develops a medical home at such setting for nonemergent and preventative health care services.
- The establishment, construction, and operation of a hospital-owned urgent care center colocated in or adjacent to the hospital ED. The hospital may, if appropriate for the patient's needs, seek to divert to the urgent care center a patient who presents at the ED needing nonemergent health care services and subsequently help the patient obtain follow-up primary care, as appropriate for the patient.

³⁰⁴ 42 U.S.C. s. 1395dd refers to the federal Emergency Medical Treatment & Labor Act (EMTALA). In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay. EMTALA imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented. *See* <u>https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatmentlabor-act</u> (last visited Jan. 13, 2024).

Additionally, for patients enrolled in the Medicaid program and are members of a Medicaid managed care plan, the NCAP must include outreach to that patient's managed care plan and coordination with the plan to establish a relationship between the patient and a primary care setting. The AHCA is required to establish a process for the hospital to share the patient's updated contact information with the managed care plan.

The bill specifies that the bill's NCAP requirement may not be construed to preclude a hospital from complying with its duties under s. 395.1041, F.S., or 42 U.S.C. s. 1395dd.

Participation in the Florida Health Information Exchange (FHIE) program

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

Statewide Medicaid Residency Program (SMRP)

Slots for Doctors Program

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

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

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

Reporting Requirements

The bill amends s. 409.909, F.S., to require any hospital or qualifying institution³⁰⁵ that receives state funds under the SMRP, including, but not limited to intergovernmental transfers, to annually report data to the AHCA.

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

- The sponsoring institution for the resident position. As used in this section, the term "sponsoring institution" means an organization that oversees, supports, and administers one or more resident positions.
- The year the position was created and the current program year of the resident who is filling the position.

³⁰⁵ A qualifying institution is defined in s. 409.909, F.S., as a federally Qualified Health Center holding an Accreditation Council for Graduate Medical Education institutional accreditation.

- Whether the position is currently filled and whether there has been any period of time when it was not filled.
- The specialty or subspecialty for which the position is accredited and whether the position is a fellowship position.
- Each state funding source that was used to create the position or is being used to maintain the position, and the general purpose for which the funds were used.

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

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

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

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

Residency Exit Survey

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

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

Graduate Medical Education Committee (GMEC)

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

- Three deans, or their designees, from medical schools in this state, appointed by the chair of the Council of Florida Medical School Deans.
- Four members appointed by the Governor, one of whom is a representative of the Florida Medical Association or the Florida Osteopathic Medical Association who has supervised or is currently supervising residents, one of whom is a member of the Florida Hospital Association, one of whom is a member of the Safety Net Hospital Alliance, and one of whom is a physician licensed under ch. 458 or ch. 459, F.S., practicing at a qualifying institution.

- Two members appointed by the Secretary of Health Care Administration, one of whom represents a teaching hospital as defined in s. 408.07, F.S., and one of whom is a physician who has supervised or is currently supervising residents.
- Two members appointed by the State Surgeon General, one of whom must represent a teaching hospital as defined in s. 408.07, F.S., and one of whom is a physician who has supervised or is currently supervising residents or interns.
- Two members, one appointed by the President of the Senate and one appointed by the Speaker of the House of the Representatives.

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

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

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

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

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

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

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

The bill defines the following terms:

- "Preceptor" to mean a Florida-licensed health care practitioner who directs, teaches, supervises, and evaluates the learning experience of a resident or student during a clinical rotation.
- "Primary care specialty" to mean general internal medicine, family medicine, obstetrics and gynecology, general pediatrics, psychiatry, geriatric medicine, or any other specialty the agency identifies as primary care.
- "Qualified facility" to mean an FQHC, community mental health center, rural health clinic, or certified community behavioral health clinic.

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

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

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

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

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

- A medical or dental resident at a rate of \$50 per hour.
- A first-year medical student at a rate of \$27 per hour.
- A second-year medical student at a rate of \$27 per hour.
- A third-year medical student at a rate of \$29 per hour.
- A fourth-year medical student at a rate of \$29 per hour.
- A dental student at a rate of \$22 per hour.
- An APRN student at a rate of \$22 per hour.
- A PA student at a rate of \$22 per hour.
- A dental hygiene student at a rate of \$15 per hour.
- A behavioral health student at a rate of \$15 per hour.

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

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

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

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

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

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

Florida Center for Nursing Annual Report

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

Charitable Care at Free Clinics

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

Lab Schools

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

LINE

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

Telehealth Minority Maternity Care Pilot Program

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

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

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

The bill clarifies that the program is not required to be run through county health departments, that program providers can provide both telehealth and in-home services, and that Healthy Start may refer prospective clients to the program as well as receive referrals from the program.

Clinical Psychologists

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

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

However, the bill retains a three-year clinical experience requirement for a clinical psychologist to:

- Authorize the transfer of a voluntary patient to an involuntary status;
- Authorize the discharge of a patient;
- Authorize the release of a patient after completion of an involuntary examination;
- Provide a second opinion to support a recommendation that a patient receive involuntary outpatient services;
- Provide a statement to the court in a proceeding justifying a request to continue involuntary outpatient services beyond the time ordered;

- Provide a second opinion to support a recommendation that a patient be involuntarily admitted for inpatient services; and
- Diagnose a child as psychotic or severely emotionally disturbed, if the clinical psychologist has specialty training and experience working with children.

Psychiatric Nurses

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

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

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

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

Mobile Response Teams

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

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

• Triage and rapid crisis intervention within 60 minutes;

- Provision of and referral to evidence-based services that are responsive to the needs of the individual and family;
- Screening, assessment, early identification, care-coordination; and
- Confirmation that the individual who received mobile crisis response was connected to a service provider and prescribed medications, if needed.

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

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

Potentially Preventable Health Care Events

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

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

Medicaid Managed Care Plans: Primary Care Initiative

The bill amends s. 409.973, F.S., to ensure MMA plans assist new enrollees with initial primary care physician appointments until scheduled as a requirement of the plan's primary care initiative program. Additionally, the bill requires MMA plans to report any delay of 30 or more days in scheduling a new enrollee with a primary care appointment and the reason for the delay and to seek to ensure that all such enrollees have at least one primary care appointment per year.

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

Acute Hospital Care at Home

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

Additional Path to Florida Licensure for Foreign-Trained Allopathic Physicians

The bill amends s. 458. 311, F.S., relating to the licensure of a foreign-trained allopathic physician or an applicant for licensure who has not met all of the requirements normally needed for licensure by examination. For the latter case, such licensure pathways are provided in subsection (8) of that statute which, under current law, authorizes the BOM to issue restricted or probationary licenses under certain conditions.

The bill amends subsections (1) and (3) of s. 458. 311, F.S., to provide that current licensure pathways for foreign-trained physicians in those subsections are open only to graduates of a foreign medical school that has not been excluded from consideration under s. 458.314(8), F.S., which is amended later in the bill, as described below.

The bill also amends s. 458.311(8), F.S., to authorize the BOM to:

- Certify for licensure a person desiring to be licensed as an allopathic physician who has held an active medical faculty certificate under s. 458.3145, F.S., for at least three years and has held a full-time faculty appointment for at least three consecutive years to teach in a program of medicine at a medical school located in Florida that is listed under s. 458.3145(1)(i), F.S.; and
- Certify an application for licensure submitted by a graduate of a foreign medical school that has not been excluded from consideration under s. 458.314(8), F.S., if the graduate has not completed an approved residency, which is normally required for unrestricted licensure, but meets the following criteria:
 - Has an active, unencumbered license to practice medicine in a foreign country;
 - Has actively practiced medicine during the entire four-year period preceding the date of the licensure application submission;
 - Has completed a residency or substantially similar postgraduate medical training in a country recognized by his or her licensing jurisdiction which is substantially similar to a residency program accredited by the Accreditation Council for Graduate Medical Education, as determined by the BOM;
 - Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination used by that commission; and
 - Has an offer for full-time employment as a physician from a health care provider that operates in this state.

The bill requires that a physician licensed under this latter pathway must maintain his or her employment with his or her original employer, or with another health care provider that also operates at a location within the state, for at least two consecutive years. In this context, the term "health care provider" means a health care professional, health care facility, or entity licensed or certified to provide health services in this state as recognized by the BOM. Such licensed physicians must notify the BOM within five business days after any change of employer.

Restricted Allopathic Medical License

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

Certification of Foreign Educational Institutions

The bill amends s. 458.314(8), F.S., to authorize the BOM, at its own discretion, to exclude any foreign medical school that fails to apply for certification under that section, from being considered as an institution that provides medical education that is reasonably comparable to similar accredited institutions in the U.S.

Medical Faculty Certificates for Allopathic Physicians

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

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

Temporary Certificates to Practice in Areas of Critical Need

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

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

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

The bill authorizes the BON to issue a temporary APRN certificate to practice in areas of critical need as those areas are determined by the State Surgeon General, which may include, but are not

limited to, health professional shortage areas designated by the U.S. Department of Health and Human Services.

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

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

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

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

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

The bill provides that an APRN's temporary certificate to practice in areas of critical need is only valid so long as the State Surgeon General maintains the determination that the critical need that supported the issuance of the temporary certificate remains a critical need.

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

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

The bill waives all licensure fees, and neurological injury compensation assessments, for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit

an affidavit from the employing agency or institution stating that the APRN will not receive any compensation for any health care services that he or she provides.

Limited Licenses for Graduate Assistant Physicians

The bill amends ss. 458.317 and 459.0075, F.S.; to create limited licenses for both allopathic and osteopathic graduate assistant physicians (GAPs). The BOM and the BOOM, respectively, must issue a GAP a limited license for a duration of two years to an applicant who meets all of the following:

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

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

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

The bill authorizes a GAP to apply for a one-time renewal for one additional year of his or her limited license provided he or she submits to the appropriate board documentation of:

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

The bill specifies that a practitioner is only eligible for one GAP licensure period of up to two years with the optional one-year renewal.

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

- May supervise no more than two GAPS with limited licenses;
- Must be physically present at the location where the GAP's services are rendered; and
- Must draft the protocol to specify the duties and responsibilities of the limited licensed GAP as specified by board rule, and must ensure that:
 - There is a process for the evaluation of the limited licensed GAP's performance;
 - The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the GAP's level of competency;
 - The limited licensed GAP's prescriptive authority is governed by the physician-drafted protocol and may not exceed that of his or her supervising physician; and
 - Any prescriptions and orders issued by the GAP must identify both the GAP and the supervising physician.

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

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

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

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

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

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

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

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

The bill authorized the BON to adopt rules to prescribe transfer-of-care conditions, monitor for excessive transfers, conduct reviews of adverse maternal and neonatal outcomes, and monitor the autonomous APRN certified nurse midwives engaged in autonomous practice; and eliminates the requirement that an autonomous APRN certified nurse midwife must have a written patient transfer agreement with a hospital and a written referral agreement with a physician to engage in nurse midwifery.

Multistate Compacts

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

Interstate Medical Licensure Compact

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

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

IMLC Eligibility

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

- Have graduated from a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;
- Have passed each component of the USMLE or the Commission on Osteopathic Medicine Licensing Exam (COMLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

- Have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;
- Hold a specialty certification or time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Board of Osteopathic Specialties; however, the time-unlimited specialty certificate does not have to be maintained once the physician is initially determined eligible through the expedited Compact process;
- Possess a full and unrestricted license to engage in the practice of medicine issued by a member board;
- Have never been convicted or received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
- Have never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license;
- Have never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and
- Not be under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

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

IMLC Application and Issuance of Expedited Licensure

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

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

Upon completion of eligibility verification process with the member state, applicants suitable for an expedited license are directed to complete the registration process with the IMLC Commission. After completing the registration process, the member board will issue an expedited license to the physician. The license authorizes the physician to practice medicine in the issuing state consistent with the laws and regulations of the issuing member board and member state.

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

The compact authorizes the IMLC Commission to adopt rules regarding the application process, including the payment of any applicable fees and the issuance of an expedited license.

IMLC Renewal and Continued Participation

To renew a compact license the physician must:

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

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

IMLC Disciplinary Actions

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

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

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

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

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

the action under the laws of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the 90-day suspension period.

Additional Provisions Related to the Enactment of the IMLC

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

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

Audiology and Speech-Language Pathology Interstate Compact

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

ASLP Compact Purpose

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

ASLP Compact State Participation

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

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

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

Each member state must require an applicant to obtain or retain a license in his or her home state and meet the home state's qualifications for licensure or licensure renewal, as well as any other state laws.

To be eligible for compact privileges, an audiologist must:

- Meet one of the following educational requirements:
 - On or before December 31, 2007, have graduated with a master's or doctorate degree in audiology or an equivalent degree from an accredited program; or
 - On or after January 1, 2008, have graduated with a doctorate degree in audiology or an equivalent degree from an accredited program; or
 - Have graduated from an audiology program in a foreign institution of higher education for which the degree program and the institution have been approved by the authorized accrediting body in the applicable country and the degree program has been verified by an independent credentials review agency to be comparable to a state licensing boardapproved program.
- Have completed a supervised clinical practicum from an accredited educational institution or its cooperating programs.

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

- Meet one of the following educational requirements:
 - Have graduated with a master's degree from a speech-language pathology program from an accredited program; or
 - Have graduated from a speech-language pathology program in a foreign institution of higher education for which the degree program and the institution have been approved by the authorized accrediting body in the applicable country and the degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.
- Have completed a supervised clinical practicum from an accredited educational institution or its cooperating programs.
- Have completed a supervised postgraduate professional experience as required by the commission.

All applicants for compact privileges must:

- Have successfully passed a national examination approved by the commission.
- Hold an active, unencumbered license.
- Have not been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession.
- Have a valid United States social security number or National Provider Identifier number.

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

privileges in a member state, the audiologist and speech-language pathologist is subject to the jurisdiction of the licensing boards, courts, and laws of that state.

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

ASLP Compact Privileges

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

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

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

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

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

ASLP Compact Privileges to Practice Telehealth

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

ASLP Compact Active Duty Military Personnel or Their Spouses

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

ASLP Compact Adverse Action

A remote state may:

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

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

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

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

Additional Provisions Related to the Enactment of the ASLP Compact

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

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

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

Physical Therapy Compact

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

PT Compact Purpose

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

State Participation in the PT Compact

To participate in the PT Compact, a state must:

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

• Have continuing competence requirements as a condition of license renewal.

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

PT Compact Privileges

To exercise compact privileges, a licensee must:

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

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

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

Active Duty Military Personnel and Their Spouses

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

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

Adverse Action

The home state has exclusive power to impose adverse action against a license issued by that state. The home state may take adverse action based on investigation information received from a remote state, in accordance with its own procedures for imposing adverse action. The PT

Compact does not override a member's state decision to participate in an alternative program in lieu of adverse action.

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

A remote state may:

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

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

Additional Provisions Related to the Enactment of the PT Compact

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

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

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

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

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

Coordinated Data System

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

Compact Commission

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

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

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

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

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

The compacts will indemnify their executive directors and its employees, subject to the approval of the state's attorney general or other appropriate legal counsel, in any civil action seeking to impose liability arising out of the performance of duties within such person's scope of

employment. To the extent not covered by the state involved, the employees and representatives are held harmless in the amount of any settlement or judgement, arising out of out of the performance of duties within such person's scope of employment and not a result of intentional or willful and wanton misconduct.

Rulemaking Functions

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

Oversight of Interstate Compact

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

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

Default Procedures

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

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

If the defaulting state fails to cure the default, a commission must terminate the state from the respective compact after all other means of securing compliance are exhausted. A cure of the default does not relieve a defaulting state of its obligations under the compact. The affected commission must notify the governor, the majority and minority leaders of the defaulting state's legislature, and each member state of its intent to terminate.

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

Dispute Resolution

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

Withdrawal and Dissolution

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

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

Dissolution

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

Severability and Construction

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

Binding Effect of Compact and Other Laws

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

The actions of the compact commissions are binding on the member states, including all promulgated rules and the adopted bylaws of the commissions. All agreements between a Commission and a member state are binding in accordance with their terms. The bill makes conforming changes to Florida Statutes related to enacting the three compacts.

Appropriations

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

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

All three compacts permit their commissions to meet in closed, nonpublic meetings under certain circumstances or to discuss certain topics. Under the compacts, all minutes and documents of a closed meeting must remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

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

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

The multistate compacts enacted in Florida under the bill authorize their commissions to adopt reasonable rules to effectively and efficiently achieve the purposes of the compacts, and these rules carry the force of law in member states, which is potentially an unlawful delegation of legislative authority. If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the commissions.

The Legislature delegated similar rulemaking powers to compact commissions when it adopted the compact language for the Nurse Licensure Compact, Professional Counselors Licensure Compact, and the Psychology Interjurisdictional Compact into statute. The rules adopted by these compacts are now applicable to Florida without the Legislature's subsequent approval, similar to what the state would encounter with the enactment of multistate compacts under the bill and the included rulemaking provisions. In the case of these compacts, should Florida find that rules adopted by any of the three commissions are not acceptable, the compacts provide a mechanism for a majority of state legislatures to override commission rules. Furthermore, the state maintains the ability to withdraw from any of the compacts.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

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

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

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

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

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

C. Government Sector Impact:

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

CS/SB 7016 provides the following appropriations for the 2024-2025 state fiscal year:

- The sum of \$50 million in recurring funds from the General Revenue Fund is appropriated to the DOH for FRAME.
- The sum of \$13.2 million in recurring funds from the General Revenue Fund is appropriated to the DOH for the DSLR Program.
- The sum of \$23,357,876 in recurring funds from the General Revenue Fund is appropriated to the DOH to expand statewide the telehealth minority maternity care program. This appropriation directs the DOH to establish 15 regions in which to implement the program statewide based on the location of hospitals providing obstetrics and maternity care and pertinent data from nearby counties for severe maternal morbidity and maternal mortality. The DOH must identify the criteria for selecting providers for regional implementation and, at a minimum, consider the maternal level of care designations for hospitals within the regions, the neonatal intensive care unit levels of hospitals within the regions, and the experience of community-based organizations to screen for and treat common pregnancy-related complications.

- The sum of \$40 million in recurring funds from the General Revenue Fund is appropriated to the AHCA to implement the TEACH Funding Program.
- The sum of \$2 million in recurring funds from the General Revenue Fund is appropriated to the University of Florida, Florida State University, Florida Atlantic University, and Florida Agricultural and Mechanical University for the purpose of implementing lab school articulated health care programs. Each state university will receive \$500,000 from this appropriation.
- The sum of \$5 million in recurring funds from the General Revenue Fund is appropriated to the Department of Education for the purpose of implementing the Linking Industry to Nursing Education (LINE) Fund.
- The sums of \$29,841,000 in recurring funds from the General Revenue Fund and \$40,159,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA for the Slots for Doctors Program.
- The sums of \$42,630,000 in recurring funds from the Grants and Donations Trust Fund and \$57,370,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide to statutory teaching hospitals as defined in s. 408.07(46), F.S., meeting certain criteria, distributed according to specified parameters.
- The sums of \$64,928,943 in recurring funds from the General Revenue Fund and \$87,379,156 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping (DRG) reimbursement methodology and increase the existing marginal cost percentages for transplant pediatrics, pediatrics, and neonates.
- The sums of \$83,456,275 in recurring funds from the General Revenue Fund and \$112,312,609 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community Based Services Waiver category to the Agency for Persons with Disabilities to provide a uniform iBudget Waiver provider rate increase. The sum of \$195,768,884 in recurring funds from the Medical Care Trust Fund is appropriated in the Home and Community Based Services Waiver category to the AHCA to establish budget authority for Medicaid services.
- The sum of \$11,525,152 in recurring funds from the General Revenue Fund is appropriated to the Department of Children and Families to enhance crisis diversion through mobile response teams by adding an additional 16 mobile response teams to ensure coverage in every county.
- The sum of \$10 million in recurring funds from the General Revenue Fund is appropriated to the DOH to implement the Health Care Screening and Services Grant Program.
- The sum of \$150,000 in nonrecurring funds from the General Revenue Fund and \$150,000 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the AHCA to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers.
- The sum of \$2.4 million in recurring funds from the General Revenue Fund is appropriated to the AHCA for the purpose of providing behavioral health family navigators in state-licensed specialty hospitals providing comprehensive acute care services to children pursuant to s. 395.002(28), F.S., to help facilitate early access to

mental health treatment. Each licensed specialty hospital will receive \$600,000 from this appropriation.

- Effective October 1, 2024, the sums of \$14,888,903 in recurring funds from the General Revenue Fund and \$20,036,979 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for dental care services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of \$12,238,469 in recurring funds from the General Revenue Fund, \$127,300 in recurring funds from the Refugee Assistance Trust Fund, and \$16,641,433 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of \$14,580,660 in recurring funds from the General Revenue Fund and \$19,622,154 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of \$9,666,352 in recurring funds from the General Revenue Fund and \$13,008,646 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.
- Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$585,758 in recurring funds and \$1,673,421 in nonrecurring funds from the General Revenue Fund, \$928,001 in recurring funds and \$54,513 in nonrecurring funds from the Health Care Trust Fund, \$100,000 in nonrecurring funds from the Administrative Trust Fund, and \$585,758 in recurring funds and \$1,573,421 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the AHCA, and 20 full-time equivalent positions with the associated salary rate of 1,247,140 are authorized for the purpose of implementing the AHCA's duties under the bill.
- Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$2,389,146 in recurring funds and \$1,190,611 in nonrecurring funds from the General Revenue Fund and \$1,041,578 in recurring funds and \$287,633 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the DOH, and 25 full-time equivalent positions with the associated salary rate of 1,739,740, are authorized for the purpose of implementing the DOH's duties under the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

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

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

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

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

This bill repeals section 458.3124 of the Florida Statutes.

IX. Additional Information:

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

CS by Fiscal Policy on January 11, 2024.

The CS:

- Amends the DSLR Program to allow volunteering at pro bono opportunities approved by the Board of Dentistry and to clarify that award years are not required to be consecutive.
- Amends the FRAME program to remove the requirement that an APRN must practice in primary care to qualify for the program (which will make more APRNs eligible) and clarifies that award years are not required to be consecutive.
- Amends the Health Care Screening and Services Grant Program to exclude statutorily-required newborn screenings from the Internet-based portal the DOH is directed to create under the bill.
- Amends the Telehealth Minority Maternity Program to clarify that the program is not required to be run through county health departments, that program providers can provide both telehealth and in-home services, and that Healthy Start may refer prospective clients to the program as well as receive referrals from the program.
- Gives the AHCA rule-making authority to develop additional requirements or standards for ABCs as the agency deems necessary for patient safety.

- Amends the minimum standards required for a mobile crisis response service to highlight crisis diversion as the overarching focus.
- Requires a mobile response team to confirm a connection with a service provider and whether needed medications were prescribed, instead of performing general follow-up at specified time frames.
- Reworks the prohibition on medical schools paying hospitals for clinical hours to, instead, require hospitals to give priority to medical students from medical schools located in Florida.
- Re-titles the underlying bill's Emergency Department Diversion Plan as the Nonemergent Care Access Plan (NCAP). Specifies that the requirement to have an NCAP does not affect a hospital's duties under EMTALA or the similar requirements under Florida law. Eliminates the underlying bill's option that a hospital may contract with a nearby urgent care center in order to satisfy the NCAP requirement.
- Adds dental residents and dental hygiene students to the TEACH program and authorizes eligible facilities to be reimbursed at \$50 and \$15 per hour, respectively.
- Requires Medicaid managed care plans to report to the AHCA if a new enrollee has not scheduled a primary care visit within 30 days of enrolling and the reason for the delay. Requires plans to seek to ensure that new enrollees have at least one primary care appointment per year.
- Clarifies that the BOM may grant unrestricted licensure to a foreign-trained physician who has not completed the residency program required under current law if the BOM determines that the applicant has completed a substantially similar postgraduate training program that meets U.S. and Florida standards. Also authorizes the BOM to grant unrestricted licensure to a physician licensed out-of-state or by a foreign country who has held an active medical faculty certificate and has taught at a Florida medical school for at least three years.
- Specifies that GAP licensure is no longer available after an initial GAP license expires, regardless of whether the opportunity for a one-year renewal was exercised.
- Includes a technical amendment to remove "chartered by the state" from language allowing private nursing schools to qualify.
- Updates the Federal Medical Assistance Percentages (FMAP) used to determine the amount of federal matching funds for Medicaid provider rate increases included in the bill based on results from the Social Services Estimating Conference meeting held on January. 8, 2024.
- Clarifies that the reimbursement methodology utilized for the bill's Medicaid hospital maternal care rate increase will be incorporated in this year's GAA. This is standard practice, as the GAA annually establishes the methodology for all hospital inpatient reimbursements.
- Provides the AHCA with funding for 20 full-time equivalent positions and the DOH with funding for 25 full-time equivalent positions to support the implementation of the bill.

B. Amendments:

None.

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



LEGISLATIVE ACTION

Senate House . Comm: RCS 01/11/2024 The Committee on Fiscal Policy (Burton) recommended the following: Senate Amendment (with title amendment) Delete lines 688 - 1050 and insert: shortage area or a medically underserved area, through another volunteer program operated by the state pursuant to part IV of chapter 110, or through a pro bono program approved by the Board of Dentistry. In order to meet the requirements of this paragraph, the volunteer hours must be verifiable in a manner determined by the department.

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11 (3) The department shall award funds from the loan program 12 to repay the student loans of a dentist or dental hygienist who 13 meets the requirements of subsection (2). (a) An award shall be 20 percent of a dentist's or dental 14 hygienist's principal loan amount at the time he or she applied 15 16 for the program but may not exceed \$50,000 per year per eligible 17 dentist or \$7,500 per year per eligible dental hygienist. 18 (b) Only loans to pay the costs of tuition, books, dental 19 equipment and supplies, uniforms, and living expenses may be 20 covered. 21 (c) All repayments are contingent upon continued proof of 22 eligibility and must be made directly to the holder of the loan. 23 The state bears no responsibility for the collection of any 24 interest charges or other remaining balances. 25 (d) A dentist or dental hygienist may receive funds under 26 the loan program for at least 1 year, up to a maximum of 5 27 awards pursuant to paragraph (a), one award for each year he or 28 she maintains eligibility for the program for the entire year. 29 Such awards are not required to be awarded in consecutive years, 30 and, if a dentist or dental hygienist loses eligibility pursuant 31 to subsection (4) for the current year, he or she may reapply 32 for the program in a future year once he or she has regained 33 eligibility. (c) The department shall limit the number of new dentists 34 35 participating in the loan program to not more than 10 per fiscal 36 year. 37 (4) A dentist or dental hygienist is not no longer eligible 38 to receive funds under the loan program if the dentist or dental

39 hygienist:

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40	(a) Is no longer employed by a public health program <u>or</u>
41	private practice that meets the requirements of subsection (2)
42	or does not verify, in a manner determined by the department,
43	that he or she has volunteered his or her dental services for
44	the required number of hours.
45	(b) Ceases to participate in the Florida Medicaid program.
46	(c) Has disciplinary action taken against his or her
47	license by the Board of Dentistry for a violation of s. 466.028.
48	(5) <u>A dentist or dental hygienist who receives payment</u>
49	under the program shall furnish information requested by the
50	department for the purpose of the department's duties under s.
51	381.4021.
52	(6) The department shall adopt rules to administer the loan
53	program.
54	(7) (6) Implementation of the loan program is subject to
55	legislative appropriation.
56	(8) The Agency for Health Care Administration shall seek
57	federal authority to use Title XIX matching funds for this
58	program.
59	(9) This section is repealed on July 1, 2034.
60	Section 2. Section 1009.65, Florida Statutes, is
61	transferred, renumbered as section 381.402, Florida Statutes,
62	and amended to read:
63	<u>381.402</u> 1009.65 Florida Reimbursement Assistance for
64	Medical Education Reimbursement and Loan Repayment Program
65	(1) To support the state Medicaid program and to encourage
66	qualified medical professionals to practice in underserved
67	locations where there are shortages of such personnel, there is
68	established the Florida Reimbursement Assistance for Medical

594-01956-24

69	Education Reimbursement and Loan Repayment Program. The function
70	of the program is to make payments that offset loans and
71	educational expenses incurred by students for studies leading to
72	a medical or nursing degree, medical or nursing licensure, or
73	advanced practice registered nurse licensure or physician
74	assistant licensure.
75	(2) The following licensed or certified health care
76	practitioners professionals are eligible to participate in the
77	this program:
78	(a) Medical doctors with primary care specialties. $ au$
79	(b) Doctors of osteopathic medicine with primary care
80	specialties.
81	(c) Advanced practice registered nurses registered to
82	engage in autonomous practice under s. 464.0123., physician
83	assistants, licensed practical nurses and registered nurses, and
84	(d) Advanced practice registered nurses with primary care
85	specialties such as certified nurse midwives.
86	(e) Physician assistants.
87	(f) Mental health professionals, including licensed
88	clinical social workers, licensed marriage and family
89	therapists, licensed mental health counselors, and licensed
90	psychologists.
91	(g) Licensed practical nurses and registered nurses.
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93	Primary care medical specialties for physicians include
94	obstetrics, gynecology, general and family practice, geriatrics,
95	internal medicine, pediatrics, psychiatry, and other specialties
96	which may be identified by the Department of Health.
97	(3) From the funds available, the Department of Health

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98 shall make payments as follows: 99 (a) 1. For a 4-year period of continued proof of practice in 100 an area specified in paragraph (b), up to \$150,000 for 101 physicians, up to \$90,000 for advanced practice registered 102 nurses registered to engage in autonomous practice under s. 103 464.0123 and practicing autonomously, up to \$75,000 for advanced practice registered nurses and physician assistants, up to 104 105 \$75,000 for mental health professionals, and up to \$45,000 106 \$4,000 per year for licensed practical nurses and registered 107 nurses. Each practitioner is eligible to receive an award for 108 only one 4-year period of continued proof of practice; however, 109 the 4 years of practice are not required to be consecutive. At 110 the end of each year that a practitioner participates in the 111 program, the department shall award 25 percent of a 112 practitioner's principal loan amount at the time he or she 113 applied for the program, up to \$10,000 per year for advanced 114 practice registered nurses and physician assistants, and up to 115 \$20,000 per year for physicians. Penalties for noncompliance are 116 shall be the same as those in the National Health Services Corps 117 Loan Repayment Program. Educational expenses include costs for 118 tuition, matriculation, registration, books, laboratory and other fees, other educational costs, and reasonable living 119 120 expenses as determined by the Department of Health. 121 (b) 2. All payments are contingent on continued proof of: 122 1.a. Primary care practice in a rural hospital as an area 123 defined in s. 395.602(2)(b) τ or an underserved area designated 124 by the Department of Health, provided the practitioner accepts

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b. For practitioners other than physicians, practice in

Medicaid reimbursement if eligible for such reimbursement; or

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127 other settings, including, but not limited to, a nursing home 128 facility as defined in s. 400.021, a home health agency as 129 defined in s. 400.462, or an intermediate care facility for the 130 developmentally disabled as defined in s. 400.960. Any such 131 setting must be located in, or serve residents or patients in, 132 an underserved area designated by the Department of Health and 133 must provide services to Medicaid patients.

2. Providing 25 hours annually of volunteer primary care services in a free clinic as specified in s. 766.1115(3)(d)14. or through another volunteer program operated by the state pursuant to part IV of chapter 110. In order to meet the requirements of this subparagraph, the volunteer hours must be verifiable in a manner determined by the department.

(c) Correctional facilities, state hospitals, and other state institutions that employ medical personnel <u>must</u> shall be designated by the Department of Health as underserved locations. Locations with high incidences of infant mortality, high morbidity, or low Medicaid participation by health care professionals may be designated as underserved.

146 (b) Advanced practice registered nurses registered to 147 engage in autonomous practice under s. 464.0123 and practicing 148 in the primary care specialties of family medicine, general pediatrics, general internal medicine, or midwifery. From the 149 150 funds available, the Department of Health shall make payments of 151 up to \$15,000 per year to advanced practice registered nurses 152 registered under s. 464.0123 who demonstrate, as required by 153 department rule, active employment providing primary care 154 services in a public health program, an independent practice, or 155 a group practice that serves Medicaid recipients and other low-

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156 income patients and that is located in a primary care health 157 professional shortage area. Only loans to pay the costs of 158 tuition, books, medical equipment and supplies, uniforms, and 159 living expenses may be covered. For the purposes of this 160 paragraph:

1. "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration or a rural area as defined by the Federal Office of Rural Health Policy.

2. "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or any other publicly funded or nonprofit health care program designated by the department.

(4) (2) The Department of Health may use funds appropriated for the Medical Education Reimbursement and Loan Repayment program as matching funds for federal loan repayment programs such as the National Health Service Corps State Loan Repayment Program.

(5) A health care practitioner who receives payment under the program shall furnish information requested by the department for the purpose of the department's duties under s. 381.4021.

181 <u>(6) (3)</u> The Department of Health may adopt any rules 182 necessary for the administration of the <u>Medical Education</u> 183 <u>Reimbursement and Loan Repayment</u> program. The department may 184 also solicit technical advice regarding conduct of the program

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185	from the Department of Education and Florida universities and
186	Florida College System institutions. The Department of Health
187	shall submit a budget request for an amount sufficient to fund
188	medical education reimbursement, loan repayments, and program
189	administration.
190	(7) The Agency for Health Care Administration shall seek
191	federal authority to use Title XIX matching funds for this
192	program.
193	(8) This section is repealed on July 1, 2034.
194	Section 3. Section 381.4021, Florida Statutes, is created
195	to read:
196	381.4021 Student loan repayment programs reporting
197	(1) For the student loan repayment programs established in
198	ss. 381.4019 and 381.402, the department shall annually provide
199	a report, beginning July 1, 2024, to the Governor, the President
200	of the Senate, and the Speaker of the House of Representatives
201	which, at a minimum, details all of the following:
202	(a) The number of applicants for loan repayment.
203	(b) The number of loan payments made under each program.
204	(c) The amounts for each loan payment made.
205	(d) The type of practitioner to whom each loan payment was
206	made.
207	(e) The number of loan payments each practitioner has
208	received under either program.
209	(f) The practice setting in which each practitioner who
210	received a loan payment practices.
211	(2)(a) The department shall contract with an independent
212	third party to develop and conduct a design study to evaluate
213	the impact of the student loan repayment programs established in

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214	ss. 381.4019 and 381.402, including, but not limited to, the
215	effectiveness of the programs in recruiting and retaining health
216	care professionals in geographic and practice areas experiencing
217	shortages. The department shall begin collecting data for the
218	study by January 1, 2025, and shall submit the results of the
219	study to the Governor, the President of the Senate, and the
220	Speaker of the House of Representatives by January 1, 2030.
221	(b) The department shall participate in a provider
222	retention and information system management multistate
223	collaborative that collects data to measure outcomes of
224	education debt support-for-service programs.
225	(3) This section is repealed on July 1, 2034.
226	Section 4. Section 381.9855, Florida Statutes, is created
227	to read:
228	381.9855 Health Care Screening and Services Grant Program;
229	portal
230	(1)(a) The Department of Health shall implement a Health
231	Care Screening and Services Grant Program. The purpose of the
232	program is to expand access to no-cost health care screenings or
233	services for the general public facilitated by nonprofit
234	entities. The department shall do all of the following:
235	1. Publicize the availability of funds and enlist the aid
236	of county health departments for outreach to potential
237	applicants at the local level.
238	2. Establish an application process for submitting a grant
239	proposal and criteria an applicant must meet to be eligible.
240	3. Develop guidelines a grant recipient must follow for the
241	expenditure of grant funds and uniform data reporting
242	requirements for the purpose of evaluating the performance of

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243	grant recipients.
244	(b) A nonprofit entity may apply for grant funds in order
245	to implement new health care screening or services programs that
246	the entity has not previously implemented.
247	(c) A nonprofit entity that has previously implemented a
248	specific health care screening or services program at one or
249	more specific locations may apply for grant funds in order to
250	provide the same or similar screenings or services at new
251	locations or through a mobile health clinic or mobile unit in
252	order to expand the program's delivery capabilities.
253	(d) An entity that receives a grant under this section
254	must:
255	1. Follow Department of Health guidelines for reporting on
256	expenditure of grant funds and measures to evaluate the
257	effectiveness of the entity's health care screening or services
258	program.
259	2. Publicize to the general public and encourage the use of
260	the health care screening portal created under subsection (2).
261	(e) The Department of Health may adopt rules for the
262	implementation of this subsection.
263	(2)(a) The Department of Health shall create and maintain
264	an Internet-based portal to direct the general public to events,
265	organizations, and venues in this state from which health
266	screenings or services may be obtained at no cost or at a
267	reduced cost and for the purpose of directing licensed health
268	care practitioners to opportunities for volunteering their
269	services to conduct, administer, or facilitate such health
270	screenings or services. The department may contract for the
271	creation or maintenance of the portal with a third-party vendor.

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272 (b) The portal must be easily accessible by the public, not require a sign-up or login, and include the ability for a member 273 274 of the public to enter his or her address and obtain localized 275 and current data on opportunities for screenings and services 276 and volunteer opportunities for health care practitioners. The 277 portal must include, but need not be limited to, all statutorily created screening programs, other than newborn screenings 278 279 established under chapter 383, which are funded and operational under the department's authority. The department shall 280 281 coordinate with county health departments so that the portal 282 includes information on such health screenings and services 283 provided by county health departments or by nonprofit entities 284 in partnership with county health departments. 285 (c) The department shall include a clear and conspicuous 286 link to the portal on the homepage of its website. The 287 department shall publicize the portal to, and encourage the use

288 of the portal by, the general public and shall enlist the aid of 289 county health departments for such outreach.

Section 5. Section 383.2163, Florida Statutes, is amended to read:

292 383.2163 Telehealth minority maternity care program pilot 293 programs. By July 1, 2022, The department shall establish a 294 statewide telehealth minority maternity care pilot program that 295 in Duval County and Orange County which uses telehealth to 296 expand the capacity for positive maternal health outcomes in 297 racial and ethnic minority populations. The department may 298 enlist shall direct and assist the county health departments in 299 Duval County and Orange County to assist with program 300 implementation implement the programs.

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

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

(b) "Eligible pregnant woman" means a pregnant woman who is 304 receiving, or is eligible to receive, maternal or infant care 305 services from the department under chapter 381 or this chapter.

(c) "Health care practitioner" has the same meaning as in s. 456.001.

308 (d) "Health professional shortage area" means a geographic 309 area designated as such by the Health Resources and Services Administration of the United States Department of Health and 311 Human Services.

(e) "Indigenous population" means any Indian tribe, band, or nation or other organized group or community of Indians recognized as eligible for services provided to Indians by the United States Secretary of the Interior because of their status as Indians, including any Alaskan native village as defined in 43 U.S.C. s. 1602(c), the Alaska Native Claims Settlement Act, as that definition existed on the effective date of this act.

(f) "Maternal mortality" means a death occurring during pregnancy or the postpartum period which is caused by pregnancy or childbirth complications.

(g) "Medically underserved population" means the population 322 323 of an urban or rural area designated by the United States 324 Secretary of Health and Human Services as an area with a 325 shortage of personal health care services or a population group 326 designated by the United States Secretary of Health and Human 327 Services as having a shortage of such services.

328 (h) "Perinatal professionals" means doulas, personnel from 329 Healthy Start and home visiting programs, childbirth educators,

COMMITTEE AMENDMENT

Florida Senate - 2024 Bill No. SB 7016



330 community health workers, peer supporters, certified lactation 331 consultants, nutritionists and dietitians, social workers, and other licensed and nonlicensed professionals who assist women 332 333 through their prenatal or postpartum periods.

334 (i) "Postpartum" means the 1-year period beginning on the last day of a woman's pregnancy. 335

336 (j) "Severe maternal morbidity" means an unexpected outcome 337 caused by a woman's labor and delivery which results in significant short-term or long-term consequences to the woman's 339 health.

340 (k) "Technology-enabled collaborative learning and capacity 341 building model" means a distance health care education model 342 that connects health care professionals, particularly 343 specialists, with other health care professionals through 344 simultaneous interactive videoconferencing for the purpose of 345 facilitating case-based learning, disseminating best practices, 346 and evaluating outcomes in the context of maternal health care.

(2) PURPOSE. - The purpose of the program pilot programs is to:

(a) Expand the use of technology-enabled collaborative learning and capacity building models to improve maternal health outcomes for the following populations and demographics:

1. Ethnic and minority populations.

2. Health professional shortage areas.

354 3. Areas with significant racial and ethnic disparities in 355 maternal health outcomes and high rates of adverse maternal 356 health outcomes, including, but not limited to, maternal 357 mortality and severe maternal morbidity.

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4. Medically underserved populations.

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5. Indigenous populations.

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360 (b) Provide for the adoption of and use of telehealth 361 services that allow for screening and treatment of common 362 pregnancy-related complications, including, but not limited to, 363 anxiety, depression, substance use disorder, hemorrhage, 364 infection, amniotic fluid embolism, thrombotic pulmonary or 365 other embolism, hypertensive disorders relating to pregnancy, 366 diabetes, cerebrovascular accidents, cardiomyopathy, and other cardiovascular conditions. 367

(3) TELEHEALTH SERVICES AND EDUCATION.—The program pilot programs shall adopt the use of telehealth or coordinate with prenatal home visiting programs, or both, to provide all of the following services and education to eligible pregnant women up to the last day of their postpartum periods, as applicable:

(a) Referrals to Healthy Start's coordinated intake and referral program to offer families prenatal home visiting services. <u>The program may also accept referrals from the Healthy</u> <u>Start program of eligible pregnant women seeking services</u> offered under the program.

379 380 And the title is amended as follows: 381 Delete lines 8 - 71 and insert: 382 383 dental hygienists under the program; revising 384 requirements for the distribution of awards under the 385 program; deleting the maximum number of new 386 practitioners who may participate in the program each fiscal year; specifying that dentists and dental 387

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388 hygienists are not eligible to receive funds under the 389 program unless they provide specified documentation; 390 requiring practitioners who receive payments under the 391 program to furnish certain information requested by 392 the department of Health; requiring the Agency for 393 Health Care Administration to seek federal authority 394 to use specified matching funds for the program; 395 providing for future repeal of the program; transferring, renumbering, and amending s. 1009.65, 396 397 F.S.; renaming the Medical Education Reimbursement and 398 Loan Repayment Program as the Florida Reimbursement 399 Assistance for Medical Education Program; revising the 400 types of providers who are eligible to participate in 401 the program; revising requirements for the 402 distribution of funds under the program; making 403 conforming and technical changes; requiring 404 practitioners who receive payments under the program 405 to furnish certain information requested by the 406 department; requiring the agency to seek federal authority to use specified matching funds for the 407 408 program; providing for future repeal of the program; 409 creating s. 381.4021, F.S.; requiring the department 410 to provide annual reports to the Governor and the 411 Legislature on specified student loan repayment 412 programs; providing requirements for the report; 413 requiring the department to contract with an 414 independent third party to develop and conduct a 415 design study for evaluating the effectiveness of specified student loan repayment programs; specifying 416

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417 requirements for the design study; requiring the 418 department to begin collecting data for the study and 419 submit the study results to the Governor and the 420 Legislature by specified dates; requiring the 421 department to participate in a certain multistate 422 collaborative for a specified purpose; providing for 423 future repeal of the requirement; creating s. 424 381.9855, F.S.; requiring the department to implement 42.5 a Health Care Screening and Services Grant Program for 426 a specified purpose; specifying duties of the 427 department; authorizing nonprofit entities to apply 428 for grant funds to implement new health care screening 429 or services programs or mobile clinics or units to 430 expand the program's delivery capabilities; specifying 431 requirements for grant recipients; authorizing the 432 department to adopt rules; requiring the department to 433 create and maintain an Internet-based portal to 434 provide specified information relating to available 435 health care screenings and services and volunteer 436 opportunities; authorizing the department to contract 437 with a third-party vendor to create and maintain the 438 portal; specifying requirements for the portal; 439 requiring the department to coordinate with county 440 health departments for a specified purpose; requiring 441 the department to include a clear and conspicuous link 442 to the portal on the homepage of its website; 443 requiring the department to publicize and encourage 444 the use of the portal and enlist the aid of county health departments for such outreach; amending s. 445

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446 383.2163, F.S.; expanding the telehealth minority 447 maternity care program from a pilot program to a statewide program; authorizing the department to 448 449 enlist, rather than requiring the department to 450 direct, county health departments to assist in program implementation; authorizing the department to receive 451 452 certain referrals from the Healthy Start program; 453 requiring the department to submit

LEGISLATIVE ACTION

Senate House . Comm: RCS 01/11/2024 The Committee on Fiscal Policy (Burton) recommended the following: 1 Senate Amendment (with title amendment) 2 3 Delete line 1222 4 and insert: 5 section as an advanced birth center. The agency may develop any requirements or standards it deems necessary for patient safety 6 7 which advanced birth centers must meet as a condition of the 8 designation. 9 ======== T I T L E A M E N D M E N T ============= 10

COMMITTEE AMENDMENT

Florida Senate - 2024 Bill No. SB 7016



11	And the title is amended as follows:
12	Delete line 87
13	and insert:
14	designated as advanced birth centers; authorizing the
15	agency to develop certain additional requirements or
16	standards for advanced birth centers; amending s.

LEGISLATIVE ACTION

Senate House . Comm: RCS 01/11/2024 The Committee on Fiscal Policy (Burton) recommended the following: Senate Amendment Delete lines 1435 - 1446 and insert: which focuses on crisis diversion and the reduction of involuntary commitment under this chapter. The structure must require, but need not be limited to, the following: a. Triage and rapid crisis intervention within 60 minutes; b. Provision of and referral to evidence-based services that are responsive to the needs of the individual and the

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COMMITTEE AMENDMENT

Florida Senate - 2024 Bill No. SB 7016

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11	individual's family;
12	c. Screening, assessment, early identification, and care
13	coordination; and
14	d. Confirmation that the individual who received the mobile
15	crisis response was connected to a service provider and
16	prescribed medications, if needed.

House



LEGISLATIVE ACTION

Senate . Comm: RCS . 01/11/2024 . .

The Committee on Fiscal Policy (Burton) recommended the following:

Senate Amendment (with title amendment)

Delete lines 1846 - 1905

and insert:

(i) A hospital that accepts payment from any medical school in exchange for, or directly or indirectly related to, allowing students from the medical school to obtain clinical hours or instruction at that hospital gives priority to medical students enrolled in a medical school listed in s. 458.3145(1)(i),

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regardless of such payments.

11	(j) All hospitals with an emergency department, including
12	hospital-based off-campus emergency departments, submit to the
13	agency for approval a nonemergent care access plan (NCAP) for
14	assisting patients gain access to appropriate care settings when
15	they either present at the emergency department with nonemergent
16	health care needs or indicate, when receiving a medical
17	screening examination, triage, or treatment at the hospital,
18	that they lack regular access to primary care. Effective July 1,
19	2025, such NCAP must be approved by the agency before the
20	hospital may receive initial licensure or licensure renewal
21	occurring after that date. A hospital with an approved NCAP must
22	submit data to the agency demonstrating the effectiveness of its
23	plan as part of the licensure renewal process and must update
24	the plan as necessary, or as directed by the agency, before each
25	licensure renewal. An NCAP must include:
26	1. Procedures that ensure the plan does not conflict or
27	interfere with the hospital's duties and responsibilities under
28	s. 395.1041 or 42 U.S.C. s. 1395dd;
29	2. Procedures to educate patients about care that would be
30	best provided in a primary care setting and the importance of
31	receiving regular primary care; and
32	3. At least one of the following:
33	a. A partnership agreement with one or more nearby
34	federally qualified health centers or other primary care
35	settings. The goals of such partnership agreement must include,
36	but need not be limited to, identifying patients who have
37	presented at the emergency department for nonemergent care, care
38	that would best be provided in a primary care setting, or
39	emergency care that could potentially have been avoided through

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40 the regular provision of primary care, and, if such a patient 41 indicates that he or she lacks regular access to primary care, 42 proactively establishing a relationship between the patient and 43 the federally qualified health center or other primary care 44 setting so that the patient develops a medical home at such 45 setting for nonemergent and preventative health care services. b. The establishment, construction, and operation of a 46 47 hospital-owned urgent care center colocated within or adjacent 48 to the hospital emergency department location. After the 49 hospital conducts a medical screening examination, and if appropriate for the patient's needs, the hospital may seek to 50 51 divert to the urgent care center a patient who presents at the 52 emergency department needing nonemergent health care services. 53 An NCAP with procedures for diverting a patient from the 54 emergency department in this manner must include procedures for 55 assisting such patients in identifying appropriate primary care 56 settings, providing a current list, with contact information, of 57 such settings within 20 miles of the hospital location, and 58 subsequently assisting the patient in arranging for a follow-up 59 examination in a primary care setting, as appropriate for the 60 patient. 61 62 For such patients who are enrolled in the Medicaid program and are members of a Medicaid managed care plan, the hospital's NCAP 63 64 must include outreach to the patient's Medicaid managed care 65 plan and coordination with the managed care plan for 66 establishing a relationship between the patient and a primary 67 care setting as appropriate for the patient, which may include a federally qualified health center or other primary care setting 68

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COMMITTEE AMENDMENT

Florida Senate - 2024 Bill No. SB 7016

69	with which the hospital has a partnership agreement. For such a
70	Medicaid enrollee, the agency shall establish a process for the
71	hospital to share updated contact information for the patient,
72	if such information is in the hospital's possession, with the
73	patient's managed care plan. This paragraph may not be construed
74	to preclude a hospital from complying with s. 395.1041 or 42
75	<u>U.S.C. s. 1395dd.</u>
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77	======================================
78	And the title is amended as follows:
79	Delete lines 166 - 179
80	and insert:
81	adopt rules ensuring that hospitals that accept
82	certain payments give enrollment priority to certain
83	medical students, regardless of such payments, and
84	requiring certain hospitals to submit a nonemergent
85	care access plan (NCAP) to the agency for approval
86	before initial licensure or licensure renewal;
87	requiring that, beginning on a specified date, such
88	NCAPs be approved before a license may be issued or
89	renewed; requiring such hospitals to submit specified
90	data to the agency as part of the licensure renewal
91	process and update their NCAPs as needed, or as
92	directed by the agency, before each licensure renewal;
93	specifying requirements for NCAPs; requiring the
94	agency to establish a process for hospitals to share
95	certain information with certain patients' managed
96	care plans; providing construction; amending s.
97	408.051,



LEGISLATIVE ACTION

Senate Comm: WD 01/11/2024 House

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The Committee on Fiscal Policy (Thompson) recommended the following:

Senate Amendment to Amendment (520732) (with title amendment)

After line 75

insert:

Section 27. Subsection (13) is added to section 409.904, Florida Statutes, to read:

409.904 Optional payments for eligible persons.—The agency may make payments for medical assistance and related services on behalf of the following persons who are determined to be

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11	eligible subject to the income, assets, and categorical
12	eligibility tests set forth in federal and state law. Payment on
13	behalf of these Medicaid eligible persons is subject to the
14	availability of moneys and any limitations established by the
15	General Appropriations Act or chapter 216.
16	(13) An adult described in 42 U.S.C. s.
17	1396a(a)(10)(A)(i)(VIII).
18	
19	======================================
20	And the title is amended as follows:
21	Delete line 97
22	and insert:
23	409.904, F.S.; extending Medicaid eligibility to
24	specified adults; amending s. 408.051,

LEGISLATIVE ACTION

Senate House . Comm: RCS 01/11/2024 The Committee on Fiscal Policy (Burton) recommended the following: Senate Amendment Delete lines 2139 - 2198 and insert: 2. Dental residents. 3. Advanced practice registered nursing students pursuing a primary care specialty. 4. Nursing students. 5. Allopathic or osteopathic medical students. 6. Dental students.

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11	7. Dental hygiene students.
12	8. Physician assistant students.
13	9. Behavioral health students, including students studying
14	psychology, clinical social work, marriage and family therapy,
15	or mental health counseling.
16	(b) Meet and maintain all requirements to operate an
17	accredited residency program if the qualified facility operates
18	a residency program.
19	(c) Obtain and maintain accreditation from an accreditation
20	body approved by the agency if the qualified facility provides
21	clinical rotations.
22	(d) Ensure that clinical preceptors meet agency standards
23	for precepting students, including the completion of any
24	training required by the agency.
25	(e) Submit quarterly reports to the agency by the first day
26	of the second month following the end of a quarter to obtain
27	reimbursement. At a minimum, the report must include all of the
28	following:
29	1. The type of residency or clinical rotation offered by
30	the qualified facility, the number of residents or students
31	participating in each type of clinical rotation or residency,
32	and the number of hours worked by each resident or student each
33	month.
34	2. Evaluations by the residents and student participants of
35	the clinical experience on an evaluation form developed by the
36	agency.
37	3. An itemized list of administrative costs associated with
38	the operation of the clinical training program, including
39	accreditation costs and other costs relating to the creation,

40	implementation, and maintenance of the program.	
41	4. A calculation of lost revenue associated with operating	
42	the clinical training program.	
43	(4) TRAININGThe agency, in consultation with the	
44	Department of Health, shall develop, or contract for the	
45	development of, training for preceptors and make such training	
46	available in either a live or electronic format. The agency	
47	shall also provide technical support for preceptors.	
48	(5) REIMBURSEMENTQualified facilities may be reimbursed	
49	under this section only to offset the administrative costs or	
50	lost revenue associated with training students, allopathic	
51	residents, or osteopathic residents who are enrolled in an	
52	accredited educational or residency program based in this state.	
53	(a) Subject to an appropriation, the agency may reimburse a	
54	qualified facility based on the number of clinical training	
55	hours reported under subparagraph (3)(e)1. The allowed	
56	reimbursement per student is as follows:	
57	1. A medical or dental resident at a rate of \$50 per hour.	
58	2. A first-year medical student at a rate of \$27 per hour.	
59	3. A second-year medical student at a rate of \$27 per hour.	
60	4. A third-year medical student at a rate of \$29 per hour.	
61	5. A fourth-year medical student at a rate of \$29 per hour.	
62	6. A dental student at a rate of \$22 per hour.	
63	7. An advanced practice registered nursing student at a	
64	rate of \$22 per hour.	
65	8. A physician assistant student at a rate of \$22 per hour.	
66	9. A behavioral health student at a rate of \$15 per hour.	
67	10. A dental hygiene student at a rate of \$15 per hour.	

LEGISLATIVE ACTION

Senate House • Comm: RCS • 01/11/2024 . • • • The Committee on Fiscal Policy (Burton) recommended the following: Senate Amendment to Amendment (640470) Delete line 51 and insert: residents, osteopathic residents, or dental residents who are enrolled in an

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LEGISLATIVE ACTION

Senate House . Comm: RCS 01/11/2024

The Committee on Fiscal Policy (Burton) recommended the following:

Senate Amendment (with title amendment)

Delete lines 2311 - 2447

and insert:

5 initial appointment with the primary care provider. If possible, such enrollee's initial the appointment should be made within 30 6 7 days after enrollment in the plan. If an initial appointment is 8 not made within such 30-day period, the plan must continue 9 assisting the enrollee to schedule an initial appointment and must report the delay and the reason for the delay to the

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agency. The plan shall seek to ensure that such an enrollee has 11 12 at least one appointment annually with his or her primary care 13 provider. 14 (c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network. 15 16 (d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within 17 18 their first year of enrollment. 19 (e) Report to the agency the number of emergency room 20 visits by enrollees who have not had at least one appointment 21 with their primary care provider. 22 (f) Coordinate with a hospital that contacts the plan under 23 the requirements of s. 395.1055(1)(j) for the purpose of 24 establishing the appropriate delivery of primary care services 25 for the plan's members who present at the hospital's emergency 26 department for nonemergent care or emergency care that could 27 potentially have been avoided through the regular provision of 28 primary care. The plan shall coordinate with such member and the 29 member's primary care provider for such purpose. 30 Section 32. The Agency for Health Care Administration shall 31 seek federal approval necessary to implement an acute hospital 32 care at home program in the state Medicaid program which is 33 substantially consistent with the parameters specified in 42 34 U.S.C. s. 1395cc-7(a)(2) and (3). 35 Section 33. Paragraph (f) of subsection (1) and subsections 36 (3) and (8) of section 458.311, Florida Statutes, are amended to 37 read: 38 458.311 Licensure by examination; requirements; fees.-

(1) Any person desiring to be licensed as a physician, who



40 does not hold a valid license in any state, shall apply to the 41 department on forms furnished by the department. The department 42 shall license each applicant who the board certifies:

43 (f) Meets one of the following medical education and 44 postgraduate training requirements:

1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting agency recognized by the United States Office of Education or is a graduate of an allopathic medical school or allopathic college within a territorial jurisdiction of the United States recognized by the accrediting agency of the governmental body of that jurisdiction;

b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of Spoken English of the Educational Testing Service or a similar test approved by rule of the board; and

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c. Has completed an approved residency of at least 1 year.

2.a. Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to s. 458.314 as having met the standards required to accredit medical schools in the United States or reasonably comparable standards;

b. If the language of instruction of the foreign medical
school is other than English, has demonstrated competency in
English through presentation of the Educational Commission for
Foreign Medical Graduates English proficiency certificate or by
a satisfactory grade on the Test of Spoken English of the
Educational Testing Service or a similar test approved by rule



69 of the board; and

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c. Has completed an approved residency of at least 1 year. 3.a. Is a graduate of an allopathic foreign medical school which has not been certified pursuant to s. 458.314 <u>and has not</u> been excluded from consideration under s. 458.314(8);

b. Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination utilized by that commission; and

c. Has completed an approved residency of at least 1 year; however, after October 1, 1992, the applicant shall have completed an approved residency or fellowship of at least 2 years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties.

(3) Notwithstanding the provisions of subparagraph (1)(f)3., a graduate of a foreign medical school that has not been excluded from consideration under s. 458.314(8) need not present the certificate issued by the Educational Commission for Foreign Medical Graduates or pass the examination utilized by that commission if the graduate:

91 (a) Has received a bachelor's degree from an accredited92 United States college or university.

(b) Has studied at a medical school which is recognized by the World Health Organization.

(c) Has completed all of the formal requirements of the foreign medical school, except the internship or social service requirements, and has passed part I of the National Board of

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98 Medical Examiners examination or the Educational Commission for99 Foreign Medical Graduates examination equivalent.

(d) Has completed an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion has passed part II of the National Board of Medical Examiners examination or the Educational Commission for Foreign Medical Graduates examination equivalent.

(8) When the board determines that any applicant for licensure has failed to meet, to the board's satisfaction, each of the appropriate requirements set forth in this section, it may enter an order requiring one or more of the following terms:

(a) Refusal to certify to the department an application for licensure, certification, or registration;

(b) Certification to the department of an application for licensure, certification, or registration with restrictions on the scope of practice of the licensee; or

(c) Certification to the department of an application for licensure, certification, or registration with placement of the physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another physician;

(d) Certification to the department of a person desiring to be licensed as a physician under this section who has held an active medical faculty certificate under s. 458.3145 for at least 3 years and has held a full-time faculty appointment for

COMMITTEE AMENDMENT

Florida Senate - 2024 Bill No. SB 7016

533656

127	at least 3 consecutive years to teach in a program of medicine
128	listed under s. 458.3145(1)(i); or
129	(e) Certification to the department of an application for
130	licensure submitted by a graduate of a foreign medical school
131	that has not been excluded from consideration under s.
132	458.314(8) if the graduate has not completed an approved
133	residency under sub-subparagraphs (1)(f)2.c. or 3.c. but meets
134	the following criteria:
135	1. Has an active, unencumbered license to practice medicine
136	in a foreign country;
137	2. Has actively practiced medicine during the entire 4-year
138	period preceding the date of the submission of a licensure
139	application;
140	3. Has completed a residency or substantially similar
141	postgraduate medical training in a country recognized by his or
142	her licensing jurisdiction which is substantially similar to a
143	residency program accredited by the Accreditation Council for
144	Graduate Medical Education, as determined by the board;
145	4. Has had his or her medical credentials evaluated by the
146	Educational Commission for Foreign Medical Graduates, holds an
147	active, valid certificate issued by that commission, and has
148	passed the examination used by that commission; and
149	5. Has an offer for full-time employment as a physician
150	from a health care provider that operates in this state. For the
151	purposes of this paragraph, the term "health care provider"
152	means a health care professional, health care facility, or
153	entity licensed or certified to provide health services in this
154	state as recognized by the board.
155	

594-01959A-24

533656

156	An applicant who is not certified for unrestricted licensure
157	under this paragraph may be certified by the board under
158	paragraph (b) or paragraph (c), as applicable. A physician
159	licensed after receiving certification under this paragraph must
160	maintain his or her employment with the original employer or
161	with another health care provider that operates in this state,
162	at a location within this state, for at least 2 consecutive
163	years after licensure, in accordance with rules adopted by the
164	board. Such physician must notify the board within 5 business
165	days after any change of employer.
166	Delete lines 3383 - 3457.
167	
168	=========== T I T L E A M E N D M E N T =================================
169	And the title is amended as follows:
170	Delete lines 245 - 256
171	and insert:
172	initial appointment with a primary care provider and
173	report certain information to the agency; requiring
174	plans to seek to ensure that such enrollees have at
175	least one primary care appointment annually; requiring
176	such plans to coordinate with hospitals that contact
177	them for a specified purpose; requiring the plans to
178	coordinate with their members and members' primary
179	care providers for such purpose; requiring the agency
180	to seek federal approval necessary to implement an
181	acute hospital care at home program meeting specified
182	criteria; amending s. 458.311, F.S.; revising an
183	education and training requirement for physician
184	licensure; exempting foreign-trained applicants for
	I

Page 7 of 8

594-01959A-24



185	physician licensure from the residency requirement if
186	they meet specified criteria; providing that
187	applicants who do not meet the specified criteria may
188	be certified for restricted licensure under certain
189	circumstances; providing
190	Delete line 339
191	and insert:
192	ss. 381.4018 and 395.602,

LEGISLATIVE ACTION

Senate House . Comm: RCS 01/11/2024 The Committee on Fiscal Policy (Burton) recommended the following: Senate Amendment (with title amendment) Delete line 2761 and insert: programs. The one-time renewal terminates after 1 year. A graduate assistant physician who has received a limited license under this subsection is not eligible to apply for another limited license, regardless of whether he or she received a onetime renewal under this paragraph.

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263	310
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11	Delete line 2927
12	and insert:
13	programs. The one-time renewal terminates after 1 year. A
14	graduate assistant physician who has received a limited license
15	under this subsection is not eligible to apply for another
16	limited license, regardless of whether he or she received a one-
17	time renewal under this paragraph.
18	
19	======================================
20	And the title is amended as follows:
21	Delete line 285
22	and insert:
23	of such licenses; providing that limited licensed
24	graduate assistant physicians are not eligible to
25	apply for another limited license; authorizing limited
26	licensed
	l

Page 2 of 2

LEGISLATIVE ACTION

Senate				House
Comm: RCS		•		
01/11/2024		•		
		•		
		•		
The Committee on	Fiscal Policy	(Burton)	recommended	the
following:	-			
Senate Ameno	dment			
Delete line	3303			
and insert:				
which is located	in this state	and lice	nsed	
1				

House



LEGISLATIVE ACTION

Senate . Comm: RCS . 01/11/2024

The Committee on Fiscal Policy (Burton) recommended the following:

Senate Amendment

Delete lines 6657 - 6784

and insert:

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Section 85. Effective July 1, 2024, for the 2024-2025 fiscal year, the sums of \$29,841,000 in recurring funds from the General Revenue Fund and \$40,159,000 in recurring funds from the Medical Care Trust Fund are appropriated in the Graduate Medical Education category to the Agency for Health Care Administration for the Slots for Doctors Program established in s. 409.909,



11 Florida Statutes.

12 Section 86. Effective July 1, 2024, for the 2024-2025 13 fiscal year, the sums of \$42,630,000 in recurring funds from the 14 Grants and Donations Trust Fund and \$57,370,000 in recurring 15 funds from the Medical Care Trust Fund are appropriated in the 16 Graduate Medical Education category to the Agency for Health 17 Care Administration to provide to statutory teaching hospitals as defined in s. 408.07(46), Florida Statutes, which provide 18 highly specialized tertiary care, including comprehensive stroke 19 20 and Level 2 adult cardiovascular services; NICU II and III; and adult open heart; and which have more than 30 full-time 21 22 equivalent (FTE) residents over the Medicare cap in accordance 23 with the CMS-2552 provider 2021 fiscal year-end federal Centers 24 for Medicare and Medicaid Services Healthcare Cost Report, HCRIS 25 data extract on December 1, 2022, worksheet E-4, line 6 minus worksheet E-4, line 5, shall be designated as a High Tertiary 26 27 Statutory Teaching Hospital and be eligible for funding calculated on a per Graduate Medical Education resident-FTE 28 29 proportional allocation that shall be in addition to any other 30 Graduate Medical Education funding. Of these funds, \$44,562,400 31 shall be first distributed to hospitals with greater than 500 unweighted fiscal year 2022-2023 FTEs. The remaining funds shall 32 33 be distributed proportionally based on the total unweighted fiscal year 2022-2023 FTEs. Payments to providers under this 34 35 section are contingent upon the nonfederal share being provided 36 through intergovernmental transfers in the Grants and Donations 37 Trust Fund. In the event the funds are not available in the 38 Grants and Donations Trust Fund, the State of Florida is not 39 obligated to make payments under this section.

40	Section 87. Effective July 1, 2024, for the 2024-2025
41	fiscal year, the sums of \$64,928,943 in recurring funds from the
42	General Revenue Fund and \$87,379,156 in recurring funds from the
43	Medical Care Trust Fund are appropriated to the Agency for
44	Health Care Administration to establish a Pediatric Normal
45	Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis
46	Related Grouping (DRG) reimbursement methodology and increase
47	the existing marginal cost percentages for transplant
48	pediatrics, pediatrics, and neonates. The fiscal year 2024-2025
49	General Appropriations Act shall establish the DRG reimbursement
50	methodology for hospital inpatient services as directed in s.
51	409.905(5)(c), Florida Statutes.
52	Section 88. Effective October 1, 2024, for the 2024-2025
53	fiscal year, the sums of \$14,888,903 in recurring funds from the
54	General Revenue Fund and \$20,036,979 in recurring funds from the
55	Medical Care Trust Fund are appropriated to the Agency for
56	Health Care Administration to provide a Medicaid reimbursement
57	rate increase for dental care services. Health plans that
58	participate in the Statewide Medicaid Managed Care program shall
59	pass through the fee increase to providers in this
60	appropriation.
61	Section 89. Effective July 1, 2024, for the 2024-2025
62	fiscal year, the sums of \$83,456,275 in recurring funds from the
63	General Revenue Fund and \$112,312,609 in recurring funds from
64	the Operations and Maintenance Trust Fund are appropriated in
65	the Home and Community-Based Services Waiver category to the
66	Agency for Persons with Disabilities to provide a uniform
67	iBudget Waiver provider rate increase. The sum of \$195,768,884
68	in recurring funds from the Medical Care Trust Fund is
	I

69	appropriated in the Home and Community-Based Services Waiver
70	category to the Agency for Health Care Administration to
71	establish budget authority for Medicaid services.
72	Section 90. Effective July 1, 2024, for the 2024-2025
73	fiscal year, the sum of \$11,525,152 in recurring funds from the
74	General Revenue Fund is appropriated in the Grants and Aids -
75	Community Mental Health Services category to the Department of
76	Children and Families to enhance crisis diversion through mobile
77	response teams established under s. 394.495, Florida Statutes,
78	by adding an additional 16 mobile response teams to ensure
79	coverage in every county.
80	Section 91. Effective July 1, 2024, for the 2024-2025
81	fiscal year, the sum of \$10 million in recurring funds from the
82	General Revenue Fund is appropriated to the Department of Health
83	to implement the Health Care Screening and Services Grant
84	Program established in s. 381.9855, Florida Statutes, as created
85	by this act.
86	Section 92. Effective July 1, 2024, for the 2024-2025
87	fiscal year, the sum of \$150,000 in nonrecurring funds from the
88	General Revenue Fund and \$150,000 in nonrecurring funds from the
89	Medical Care Trust Fund are appropriated to the Agency for
90	Health Care Administration to contract with a vendor to develop
91	a reimbursement methodology for covered services at advanced
92	birth centers. The agency shall submit the reimbursement
93	methodology and estimated fiscal impact to the Executive Office
94	of the Governor's Office of Policy and Budget, the chair of the
95	Senate Appropriations Committee, and the chair of the House
96	Appropriations Committee no later than December 31, 2024.
97	Section 93. Effective July 1, 2024, for the 2024-2025



98 fiscal year, the sum of \$2.4 million in recurring funds from the 99 General Revenue Fund is appropriated to the Agency for Health 100 Care Administration for the purpose of providing behavioral 101 health family navigators in state-licensed specialty hospitals 102 providing comprehensive acute care services to children pursuant 103 to s. 395.002(28), Florida Statutes, to help facilitate early 104 access to mental health treatment. Each licensed specialty 105 hospital shall receive \$600,000 from this appropriation. 106 Section 94. Effective October 1, 2024, for the 2024-2025 107 fiscal year, the sums of \$12,238,469 in recurring funds from the General Revenue Fund, \$127,300 in recurring funds from the 108 109 Refugee Assistance Trust Fund, and \$16,641,433 in recurring 110 funds from the Medical Care Trust Fund are appropriated to the 111 Agency for Health Care Administration to provide a Medicaid 112 reimbursement rate increase for private duty nursing services 113 provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed 114 Care program shall pass through the fee increase to providers in 115 116 this appropriation. 117 Section 95. Effective October 1, 2024, for the 2024-2025 118 fiscal year, the sums of \$14,580,660 in recurring funds from the 119 General Revenue Fund and \$19,622,154 in recurring funds from the 120 Medical Care Trust Fund are appropriated to the Agency for 121 Health Care Administration to provide a Medicaid reimbursement 122 rate increase for occupational therapy, physical therapy, and 123 speech therapy providers. Health plans that participate in the 124 Statewide Medicaid Managed Care program shall pass through the 125 fee increase to providers in this appropriation. 126 Section 96. Effective October 1, 2024, for the 2024-2025

f	fiscal year, the sums of \$9,666,352 in recurring funds from the
	General Revenue Fund and \$13,008,646 in recurring funds from th
M	Medical Care Trust Fund are appropriated to the Agency for
E	Health Care Administration to provide a Medicaid reimbursement
	ate increase for Current Procedural Terminology codes 97153 at
9	97155 related to behavioral analysis services. Health plans th
-	participate in the Statewide Medicaid Managed Care program sha
2	bass through the fee increase to providers in this
Э	appropriation.
	Section 97. Effective July 1, 2024, for the 2024-2025
f	fiscal year, the sums of \$585,758 in recurring funds and
5	51,673,421 in nonrecurring funds from the General Revenue Fund
Ş	928,001 in recurring funds and \$54,513 in nonrecurring funds
Ē	From the Health Care Trust Fund, \$100,000 in nonrecurring fund
E	from the Administrative Trust Fund, and \$585,758 in recurring
f	Funds and \$1,573,421 in nonrecurring funds from the Medical Ca
Ι	Trust Fund are appropriated to the Agency for Health Care
2	Administration, and 20 full-time equivalent positions with the
Э	associated salary rate of 1,247,140 are authorized for the
С	ourpose of implementing this act.
	Section 98. Effective July 1, 2024, for the 2024-2025
f	fiscal year, the sums of \$2,389,146 in recurring funds and
Ş	31,190,611 in nonrecurring funds from the General Revenue Fund
а	and \$1,041,578 in recurring funds and \$287,633 in nonrecurring
f	funds from the Medical Quality Assurance Trust Fund are
а	appropriated to the Department of Health, and 25 full-time
e	equivalent positions with the associated salary rate of
1	,739,740, are authorized for the purpose of implementing this
2	act.

By the Committee on Health Policy

588-01852-24

20247016

1 A bill to be entitled 2 An act relating to health care; amending s. 381.4019, F.S.; revising the purpose of the Dental Student Loan 3 Repayment Program; defining the term "free clinic"; including dental hygienists in the program; revising eligibility requirements for the program; specifying limits on award amounts for and participation of dental hygienists under the program; deleting the 8 ç maximum number of new practitioners who may 10 participate in the program each fiscal year; 11 specifying that dentists and dental hygienists are not 12 eligible to receive funds under the program unless 13 they provide specified documentation; requiring 14 practitioners who receive payments under the program 15 to furnish certain information requested by the 16 Department of Health; requiring the Agency for Health 17 Care Administration to seek federal authority to use 18 specified matching funds for the program; providing 19 for future repeal of the program; transferring, 20 renumbering, and amending s. 1009.65, F.S.; renaming 21 the Medical Education Reimbursement and Loan Repayment 22 Program as the Florida Reimbursement Assistance for 23 Medical Education Program; revising the types of 24 providers who are eligible to participate in the 25 program; revising requirements for the distribution of 26 funds under the program; making conforming and 27 technical changes; requiring practitioners who receive 28 payments under the program to furnish certain 29 information requested by the department; requiring the

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

1	588-01852-24 20247016_
30	agency to seek federal authority to use specified
31	matching funds for the program; providing for future
32	repeal of the program; creating s. 381.4021, F.S.;
33	requiring the department to provide annual reports to
34	the Governor and the Legislature on specified student
35	loan repayment programs; providing requirements for
36	the report; requiring the department to contract with
37	an independent third party to develop and conduct a
38	design study for evaluating the effectiveness of
39	specified student loan repayment programs; specifying
40	requirements for the design study; requiring the
41	department to begin collecting data for the study and
42	submit the study results to the Governor and the
43	Legislature by specified dates; requiring the
44	department to participate in a certain multistate
45	collaborative for a specified purpose; providing for
46	future repeal of the requirement; creating s.
47	381.9855, F.S.; requiring the department to implement
48	a Health Care Screening and Services Grant Program for
49	a specified purpose; specifying duties of the
50	department; authorizing nonprofit entities to apply
51	for grant funds to implement new health care screening
52	or services programs or mobile clinics or units to
53	expand the program's delivery capabilities; specifying
54	requirements for grant recipients; authorizing the
55	department to adopt rules; requiring the department to
56	create and maintain an Internet-based portal to
57	provide specified information relating to available
58	health care screenings and services and volunteer
I	Page 2 of 234
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CODING: Words stricken are deletions; words underlined are additions.

588-01852-24 20247016 59 opportunities; authorizing the department to contract 60 with a third-party vendor to create and maintain the 61 portal; specifying requirements for the portal; 62 requiring the department to coordinate with county 63 health departments for a specified purpose; requiring 64 the department to include a clear and conspicuous link 65 to the portal on the homepage of its website; 66 requiring the department to publicize and encourage 67 the use of the portal and enlist the aid of county 68 health departments for such outreach; amending s. 69 383.2163, F.S.; expanding the telehealth minority 70 maternity care program from a pilot program to a 71 statewide program; requiring the department to submit 72 annual reports to the Governor and the Legislature; 73 providing requirements for the reports; amending s. 74 383.302, F.S.; defining the terms "advanced birth 75 center" and "medical director"; revising the 76 definition of the term "consultant"; creating s. 77 383.3081, F.S.; providing requirements for birth 78 centers designated as advanced birth centers with 79 respect to operating procedures, staffing, and 80 equipment; requiring advanced birth centers to enter 81 into a written agreement with a blood bank for 82 emergency blood bank services; requiring that a 83 patient who receives an emergency blood transfusion at 84 an advanced birth center be immediately transferred to 85 a hospital for further care; requiring the agency to 86 establish by rule a process for birth centers to be 87 designated as advanced birth centers; amending s.

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[588-01852-24 20247016_
88	383.309, F.S.; providing minimum standards for
89	advanced birth centers; amending s. 383.313, F.S.;
90	making technical and conforming changes; creating s.
91	383.3131, F.S.; providing requirements for laboratory
92	and surgical services at advanced birth centers;
93	providing conditions for administration of anesthesia;
94	authorizing the intrapartal use of chemical agents;
95	amending s. 383.315, F.S.; requiring advanced birth
96	centers to employ or maintain an agreement with an
97	obstetrician for specified purposes; amending s.
98	383.316, F.S.; requiring advanced birth centers to
99	provide for the transport of emergency patients to a
100	hospital; requiring each advanced birth center to
101	enter into a written transfer agreement with a local
102	hospital or an obstetrician for such transfers;
103	requiring birth centers and advanced birth centers to
104	assess and document transportation services and
105	transfer protocols annually; amending s. 383.318,
106	F.S.; providing protocols for postpartum care of
107	clients and infants at advanced birth centers;
108	amending s. 394.455, F.S.; revising definitions;
109	amending s. 394.457, F.S.; requiring the Department of
110	Children and Families to adopt certain minimum
111	standards for mobile crisis response services;
112	amending s. 394.4598, F.S.; authorizing certain
113	psychiatric nurses to provide opinions to the court
114	for the appointment of guardian advocates; authorizing
115	certain psychiatric nurses to consult with guardian
116	advocates for purposes of obtaining consent for
I	Page 4 of 234
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	588-01852-24 2024701	6
117	treatment; amending s. 394.4615, F.S.; authorizing	
118	psychiatric nurses to make certain determinations	
119	related to the release of clinical records; amending	
120	s. 394.4625, F.S.; requiring certain treating	
121	psychiatric nurses to document specified information	
122	in a patient's clinical record within a specified	
123	timeframe of his or her voluntary admission for mental	
124	health treatment; requiring clinical psychologists who	
125	make determinations of involuntary placement at	
126	certain mental health facilities to have specified	
127	clinical experience; authorizing certain psychiatric	
128	nurses to order emergency treatment for certain	
129	patients; amending s. 394.463, F.S.; authorizing	
130	certain psychiatric nurses to order emergency	
131	treatment of certain patients; requiring a clinical	
132	psychologist to have specified clinical experience to	
133	approve the release of an involuntary patient at	
134	certain mental health facilities; amending s.	
135	394.4655, F.S.; requiring clinical psychologists to	
136	have specified clinical experience in order to	
137	recommend involuntary outpatient services for mental	
138	health treatment; authorizing certain psychiatric	
139	nurses to recommend involuntary outpatient services	
140	for mental health treatment; providing an exception;	
141	authorizing psychiatric nurses to make certain	
142	clinical determinations that warrant bringing a	
143	patient to a receiving facility for an involuntary	
144	examination; making a conforming change; amending s.	
145	394.467, F.S.; requiring clinical psychologists to	

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	588-01852-24 20247016
146	have specified clinical experience in order to
147	recommend involuntary inpatient services for mental
148	health treatment; authorizing certain psychiatric
149	nurses to recommend involuntary inpatient services for
150	mental health treatment; providing an exception;
151	amending s. 394.4781, F.S.; revising the definition of
152	the term "psychotic or severely emotionally disturbed
153	child"; amending s. 394.4785, F.S.; authorizing
154	psychiatric nurses to admit individuals over a certain
155	age into certain mental health units of a hospital
156	under certain conditions; requiring the agency to seek
157	federal approval for Medicaid coverage and
158	reimbursement authority for mobile crisis response
159	services; requiring the Department of Children and
160	Families to coordinate with the agency to provide
161	specified education to contracted mobile response team
162	services providers; amending s. 394.875, F.S.;
163	authorizing certain psychiatric nurses to prescribe
164	medication to clients of crisis stabilization units;
165	amending s. 395.1055, F.S.; requiring the agency to
166	adopt rules ensuring that hospitals do not accept
167	certain payments and requiring certain hospitals to
168	submit an emergency department diversion plan to the
169	agency for approval before initial licensure or
170	licensure renewal; providing that, beginning on a
171	specified date, such plan must be approved before a
172	license may be issued or renewed; requiring such
173	hospitals to submit specified data to the agency on an
174	annual basis and update their plans as needed, or as
	Page 6 of 234

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	588-01852-24 20247016
175	directed by the agency, before each licensure renewal;
176	specifying requirements for the diversion plans;
177	requiring the agency to establish process for
178	hospitals to share certain information with certain
179	patients' managed care plans; amending s. 408.051,
180	F.S.; requiring certain hospitals to make available
181	certain data to the agency's Florida Health
182	Information Exchange program for a specified purpose;
183	authorizing the agency to adopt rules; amending s.
184	409.909, F.S.; authorizing the agency to allocate
185	specified funds under the Slots for Doctors Program
186	for existing resident positions at hospitals and
187	qualifying institutions if certain conditions are met;
188	requiring hospitals and qualifying institutions that
189	receive certain state funds to report specified data
190	to the agency annually; defining the term "sponsoring
191	institution"; requiring such hospitals and qualifying
192	institutions, beginning on a specified date, to
193	produce certain financial records or submit to certain
194	financial audits; providing applicability; providing
195	that hospitals and qualifying institutions that fail
196	to produce such financial records to the agency are no
197	longer eligible to participate in the Statewide
198	Medicaid Residency Program until a certain
199	determination is made by the agency; requiring
200	hospitals and qualifying institutions to request exit
201	surveys of residents upon completion of their
202	residency; providing requirements for the exit
203	surveys; creating the Graduate Medical Education
	Page 7 of 234

 $\textbf{CODING: Words } \underline{stricken} \text{ are deletions; words } \underline{underlined} \text{ are additions.}$

	588-01852-24 20247016_
204	Committee within the agency; providing for membership
205	and meetings of the committee; requiring the
206	committee, beginning on a specified date, to submit an
207	annual report to the Governor and the Legislature
208	detailing specified information; requiring the agency
209	to provide administrative support to assist the
210	committee in the performance of its duties and to
211	provide certain information to the committee; creating
212	s. 409.91256, F.S.; creating the Training, Education,
213	and Clinicals in Health (TEACH) Funding Program for a
214	specified purpose; providing legislative intent;
215	defining terms; requiring the agency to develop an
216	application process and enter into certain agreements
217	to implement the program; specifying requirements to
218	qualify to receive reimbursements under the program;
219	requiring the agency, in consultation with the
220	Department of Health, to develop, or contract for the
221	development of, specified training for, and to provide
222	assistance to, preceptors; providing for reimbursement
223	under the program; requiring the agency to submit an
224	annual report to the Governor and the Legislature;
225	providing requirements for the report; requiring the
226	agency to contract with an independent third party to
227	develop and conduct a design study for evaluating the
228	impact of the program; specifying requirements for the
229	design study; requiring the agency to begin collecting
230	data for the study and submit the study results to the
231	Governor and the Legislature by specified dates;
232	authorizing the agency to adopt rules; requiring the
	Page 8 of 234

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	588-01852-24 20247016
233	agency to seek federal approval to use specified
234	matching funds for the program; providing for future
235	repeal of the program; amending s. 409.967, F.S.;
236	requiring the agency to produce a specified annual
237	report on patient encounter data under the statewide
238	managed care program; providing requirements for the
239	report; requiring the agency to submit the report to
240	the Governor and the Legislature by a specified date;
241	authorizing the agency to contract with a third-party
242	vendor to produce the report; amending s. 409.973,
243	F.S.; requiring Medicaid managed care plans to
244	continue assisting certain enrollees in scheduling an
245	initial appointment with a primary care provider;
246	requiring such plans to coordinate with hospitals that
247	contact them for a specified purpose; requiring the
248	plans to coordinate with their members and members'
249	primary care providers for such purpose; requiring the
250	agency to seek federal approval necessary to implement
251	an acute hospital care at home program meeting
252	specified criteria; amending s. 458.311, F.S.;
253	revising an education and training requirement for
254	physician licensure; exempting foreign-trained
255	applicants for physician licensure from the residency
256	requirement if they meet specified criteria; providing
257	certain employment requirements for such applicants;
258	requiring such applicants to notify the Board of
259	Medicine of any changes in employment within a
260	specified timeframe; repealing s. 458.3124, F.S.,
261	relating to restricted licenses of certain experienced
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	38-01852-24 2024701
262	foreign-trained physicians; amending s. 458.314, F.S.;
263	authorizing the board to exclude certain foreign
264	medical schools from consideration as an institution
265	that provides medical education that is reasonably
266	comparable to similar accredited institutions in the
267	United States; providing construction; deleting
268	obsolete language; amending s. 458.3145, F.S.;
269	revising criteria for medical faculty certificates;
270	deleting a cap on the maximum number of extended
271	medical faculty certificates that may be issued at
272	specified institutions; amending ss. 458.315 and
273	459.0076, F.S.; authorizing temporary certificates for
274	practice in areas of critical need to be issued to
275	physician assistants, rather than only to physicians,
276	who meet specified criteria; making conforming and
277	technical changes; amending ss. 458.317 and 459.0075,
278	F.S.; specifying who may be considered a graduate
279	assistant physician; creating limited licenses for
280	graduate assistant physicians; specifying criteria a
281	person must meet to obtain such licensure; requiring
282	the Board of Medicine and the Board of Osteopathic
283	Medicine, respectively, to establish certain
284	requirements by rule; providing for a one-time renewal
285	of such licenses; authorizing limited licensed
286	graduate assistant physicians to provide health care
287	services only under the direct supervision of a
288	physician and pursuant to a written protocol;
289	providing requirements for, and limitations on, such
290	supervision and practice; providing requirements for

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	588-01852-24 20247016
291	the supervisory protocols; providing that supervising
292	physicians are liable for any acts or omissions of
293	such graduate assistant physicians acting under their
294	supervision and control; authorizing third-party
295	payors to provide reimbursement for covered services
296	rendered by graduate assistant physicians; authorizing
297	the Board of Medicine and the Board of Osteopathic
298	Medicine, respectively, to adopt rules; creating s.
299	464.0121, F.S.; providing that temporary certificates
300	for practice in areas of critical need may be issued
301	to advanced practice registered nurses who meet
302	specified criteria; providing restrictions on the
303	issuance of temporary certificates; waiving licensure
304	fees for such applicants under certain circumstances;
305	amending s. 464.0123, F.S.; requiring certain
306	certified nurse midwives, as a condition precedent to
307	providing out-of-hospital intrapartum care, to
308	maintain a written policy for the transfer of patients
309	needing a higher acuity of care or emergency services;
310	requiring that such policy prescribe and require the
311	use of an emergency plan-of-care form; providing
312	requirements for the form; requiring such certified
313	nurse midwives to document specified information on
314	the form if a transfer of care is determined to be
315	necessary; requiring certified nurse midwives to
316	verbally provide the receiving provider with specified
317	information and make himself or herself immediately
318	available for consultation; requiring certified nurse
319	midwives to provide the patient's emergency plan-of-
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320	care form, as well as certain patient records, to the
321	receiving provider upon the patient's transfer;
322	requiring the Board of Nursing to adopt certain rules;
323	amending s. 464.019, F.S.; deleting the sunset date of
324	a certain annual report required of the Florida Center
325	for Nursing; amending s. 766.1115, F.S.; revising the
326	definition of the term "low-income" for purposes of
327	certain government contracts for health care services;
328	amending s. 1002.32, F.S.; requiring developmental
329	research (laboratory) schools (lab schools) to develop
330	programs for a specified purpose; requiring lab
331	schools to offer technical assistance to any school
332	district seeking to replicate the lab school's
333	programs; requiring lab schools, beginning on a
334	specified date, to annually report to the Legislature
335	on the development of such programs and their results;
336	amending s. 1009.8962, F.S.; revising the definition
337	of the term "institution" for purposes of the Linking
338	Industry to Nursing Education (LINE) Fund; amending
339	ss. 381.4018, 395.602, 458.313, 458.316, and 458.3165,
340	F.S.; conforming provisions to changes made by the
341	act; creating s. 456.4501, F.S.; enacting the
342	Interstate Medical Licensure Compact in this state;
343	providing purposes of the compact; providing that
344	state medical boards of member states retain
345	jurisdiction to impose adverse action against licenses
346	issued under the compact; defining terms; specifying
347	eligibility requirements for physicians seeking an
348	expedited license under the compact; providing
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349	requirements for designation of a state of principal
350	license for purposes of the compact; authorizing the
351	Interstate Medical Licensure Compact Commission to
352	develop certain rules; providing an application and
353	verification process for expedited licensure under the
354	compact; providing for expiration and termination of
355	expedited licenses; authorizing the Interstate
356	Commission to develop certain rules; providing
357	requirements for renewal of expedited licenses;
358	authorizing the Interstate Commission to develop
359	certain rules; providing for the establishment of a
360	database for coordinating licensure data amongst
361	member states; requiring and authorizing member boards
362	to report specified information to the database;
363	providing for confidentiality of such information;
364	providing construction; authorizing the Interstate
365	Commission to develop certain rules; authorizing
366	member states to conduct joint investigations and
367	share certain materials; providing for disciplinary
368	action of physicians licensed under the compact;
369	creating the Interstate Medical Licensure Compact
370	Commission; providing purpose and authority of the
371	commission; providing for membership and meetings of
372	the commission; providing public meeting and notice
373	requirements; authorizing closed meetings under
374	certain circumstances; providing public record
375	requirements; requiring the commission to establish an
376	executive committee; providing for membership, powers,
377	and duties of the committee; authorizing the
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378	commission to establish other committees; specifying
379	powers and duties of the commission; providing for
380	financing of the commission; providing for
381	organization and operation of the commission;
382	providing limited immunity from liability for
383	commissioners and other agents or employees of the
384	commission; authorizing the commission to adopt rules;
385	providing for rulemaking procedures, including public
386	notice and meeting requirements; providing for
387	judicial review of adopted rules; providing for
388	oversight and enforcement of the compact in member
389	states; requiring courts in member states to take
390	judicial notice of the compact and the commission
391	rules for purposes of certain proceedings; providing
392	that the commission is entitled to receive service of
393	process and has standing in certain proceedings;
394	rendering judgments or orders void as to the
395	commission, the compact, or commission rules under
396	certain circumstances; providing for enforcement of
397	the compact; specifying venue and civil remedies in
398	such proceedings; providing for attorney fees;
399	providing construction; specifying default procedures
400	for member states; providing for dispute resolution
401	between member states; providing for eligibility and
402	procedures for enactment of the compact; providing for
403	amendment to the compact; specifying procedures for
404	withdrawal from and subsequent reinstatement of the
405	compact; authorizing the Interstate Commission to
406	develop certain rules; providing for dissolution of
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		588-01852-24 20247016
	436	coverage to pay such claims or judgments; creating s.
	437	468.1335, F.S.; creating the Audiology and Speech-
	438	Language Pathology Interstate Compact; providing
	439	purposes and objectives; defining terms; specifying
	440	requirements for state participation in the compact
	441	and duties of member states; specifying that the
	442	compact does not affect an individual's ability to
	443	apply for, and a member state's ability to grant, a
	444	single-state license pursuant to the laws of that
	445	state; providing for recognition of compact privilege
	446	in member states; specifying criteria a licensee must
	447	meet for a compact privilege; providing for the
	448	expiration and renewal of the compact privilege;
	449	specifying that a licensee with a compact privilege in
	450	a remote state must adhere to the laws and rules of
	451	that state; authorizing member states to act on a
	452	licensee's compact privilege under certain
	453	circumstances; specifying the consequences and
	454	parameters of practice for a licensee whose compact
	455	privilege has been acted on or whose home state
	456	license is encumbered; specifying that a licensee may
	457	hold a home state license in only one member state at
	458	a time; specifying requirements and procedures for
	459	changing a home state license designation; providing
	460	for the recognition of the practice of audiology and
	461	speech-language pathology through telehealth in member
	462	states; specifying that licensees must adhere to the
	463	laws and rules of the remote state where they provide
	464	audiology or speech-language pathology through
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588-01852-24 20247016 407 the compact; providing severability and construction; 408 creating s. 456.4502, F.S.; providing that a formal 409 hearing before the Division of Administrative Hearings 410 must be held if there are any disputed issues of material fact when the licenses of certain physicians 411 412 and osteopathic physicians are suspended or revoked by 413 this state under the compact; requiring the Department 414 of Health to notify the Division of Administrative 415 Hearings of a petition for a formal hearing within a 416 specified timeframe; requiring the administrative law 417 judge to issue a recommended order; requiring the 418 Board of Medicine or the Board of Osteopathic 419 Medicine, as applicable, to determine and issue final 420 orders in certain cases; providing the department with 421 standing to seek judicial review of any final order of 422 the boards; creating s. 456.4504, F.S.; authorizing 423 the department to adopt rules to implement the 424 compact; creating ss. 458.3129 and 459.074, F.S.; 425 providing that an allopathic physician or an 426 osteopathic physician, respectively, licensed under 427 the compact is deemed to be licensed under ch. 458, 428 F.S., or ch. 459, F.S., as applicable; amending s. 429 768.28, F.S.; designating the state commissioners of 430 the Interstate Medical Licensure Compact Commission 431 and other members or employees of the commission as 432 state agents for the purpose of applying sovereign 433 immunity and waivers of sovereign immunity; requiring 434 the commission to pay certain claims or judgments; 435 authorizing the commission to maintain insurance

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465 telehealth; authorizing active duty military personnel	
466 and their spouses to keep their home state designation	
467 during active duty; specifying how such individuals	
468 may subsequently change their home state license	
designation; authorizing member states to take adverse	
470 actions against licensees and issue subpoenas for	
471 hearings and investigations under certain	
472 circumstances; providing requirements and procedures	
473 for such adverse action; authorizing member states to	
474 engage in joint investigations under certain	
475 circumstances; providing that a licensee's compact	
476 privilege must be deactivated in all member states for	
477 the duration of an encumbrance imposed by the	
478 licensee's home state; providing for notice to the	
479 data system and the licensee's home state of any	
480 adverse action taken against a licensee; establishing	
481 the Audiology and Speech-language Pathology Interstate	
482 Compact Commission; providing for jurisdiction and	
483 venue for court proceedings; providing for membership	
484 and powers of the commission; specifying powers and	
485 duties of the commission's executive committee;	
486 providing for the financing of the commission;	
487 providing specified individuals immunity from civil	
488 liability under certain circumstances; providing	
489 exceptions; requiring the commission to defend the	
490 specified individuals in civil actions under certain	
491 circumstances; requiring the commission to indemnify	
492 and hold harmless specified individuals for any	
493 settlement or judgment obtained in such actions under	
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	588-01852-24 20247016_
494	certain circumstances; providing for the development
495	of the data system, reporting procedures, and the
496	exchange of specified information between member
497	states; requiring the commission to notify member
498	states of any adverse action taken against a licensee
499	or applicant for licensure; authorizing member states
500	to designate as confidential information provided to
501	the data system; requiring the commission to remove
502	information from the data system under certain
503	circumstances; providing rulemaking procedures for the
504	commission; providing for member state enforcement of
505	the compact; authorizing the commission to receive
506	notice of process, and have standing to intervene, in
507	certain proceedings; rendering certain judgments and
508	orders void as to the commission, the compact, or
509	commission rules under certain circumstances;
510	providing for defaults and termination of compact
511	membership; providing procedures for the resolution of
512	certain disputes; providing for commission enforcement
513	of the compact; providing for remedies; providing for
514	implementation of, withdrawal from, and amendment to
515	the compact; providing construction and for
516	severability; specifying that the compact, commission
517	rules, and commission actions are binding on member
518	states; amending s. 456.073, F.S.; requiring the
519	Department of Health to report certain investigative
520	information to the commission's data system; amending
521	s. 456.076, F.S.; requiring that monitoring contracts
522	for certain impaired practitioners participating in
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i	588-01852-24 20247016_
523	treatment programs contain specified terms; amending
524	s. 468.1135, F.S.; requiring the Board of Speech-
525	Language Pathology and Audiology to appoint two of its
526	board members to serve as the state's delegates on the
527	compact commission; amending s. 468.1185, F.S.;
528	exempting audiologists and speech-language
529	pathologists from licensure requirements if they are
530	practicing in this state pursuant to a compact
531	privilege under the compact; amending s. 468.1295,
532	F.S.; authorizing the board to take adverse action
533	against the compact privilege of audiologists and
534	speech-language pathologists for specified prohibited
535	acts; amending s. 768.28, F.S.; designating the state
536	delegates and other members or employees of the
537	compact commission as state agents for the purpose of
538	applying sovereign immunity and waivers of sovereign
539	immunity; requiring the commission to pay certain
540	claims or judgments; authorizing the compact
541	commission to maintain insurance coverage to pay such
542	claims or judgments; creating s. 486.112, F.S.;
543	creating the Physical Therapy Licensure Compact;
544	providing a purpose and objectives of the compact;
545	defining terms; specifying requirements for state
546	participation in the compact; authorizing member
547	states to obtain biometric-based information from and
548	conduct criminal background checks on licensees
549	applying for a compact privilege; requiring member
550	states to grant the compact privilege to licensees if
551	they meet specified criteria; specifying criteria
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588-01852-24 20247016 552 licensees must meet to exercise the compact privilege 553 under the compact; providing for the expiration of the 554 compact privilege; requiring licensees practicing in a 555 remote state under the compact privilege to comply with the laws and rules of that state; subjecting 556 licensees to the regulatory authority of remote states 557 558 where they practice under the compact privilege; 559 providing for disciplinary action; specifying 560 circumstances under which licensees are ineligible for 561 a compact privilege; specifying conditions that a 562 licensee must meet to regain his or her compact privilege after an adverse action; specifying 563 locations active duty military personnel and their 564 565 spouses may use to designate their home state for 566 purposes of the compact; providing that only a home 567 state may impose adverse action against a license issued by that state; authorizing home states to take 568 569 adverse action based on investigative information of a 570 remote state, subject to certain requirements; 571 directing member states that use alternative programs 572 in lieu of discipline to require the licensee to agree 573 not to practice in other member states while 574 participating in the program, unless authorized by the 575 member state; authorizing member states to investigate 576 violations by licensees in other member states; 577 authorizing member states to take adverse action 578 against compact privileges issued in their respective 579 states; providing for joint investigations of licensees under the compact; establishing the Physical 580

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5	88-01852-24	20247016	5	88-01852-24	20247016
31	Therapy Compact Commission; providing for	the venue	610	providing for enforcement against	a defaulting state;
32	and jurisdiction for court proceedings by	y or against	611	providing construction; providing	for implementation
33	the commission; providing construction; p	providing for	612	and administration of the compact	and associated
34	commission membership, voting, and meeting	igs;	613	rules; providing that compact sta	tes that join after
35	authorizing the commission to convene clo	osed,	614	initial adoption of the commissio	n's rules are subject
36	nonpublic meetings under certain circumst	:ances;	615	to such rules; specifying procedu	res for compact
37	specifying duties and powers of the commi	ission;	616	states to withdraw from the compa	ct; providing
38	providing for membership and duties of th	ne executive	617	construction; providing for amend	ment of the compact;
39	board of the commission; providing for fi	inancing of	618	providing construction and severa	bility; amending s.
90	the commission; providing for qualified i	immunity,	619	456.073, F.S.; requiring the Depa	rtment of Health to
91	defense, and indemnification of the commi	Lssion;	620	report certain investigative info	rmation to the data
92	requiring the commission to develop and m	naintain a	621	system; amending s. 456.076, F.S.	; requiring
93	coordinated database and reporting system	n for certain	622	monitoring contracts for certain	impaired
94	information about licensees under the con	npact;	623	practitioners participating in tr	eatment programs to
95	requiring member states to submit specifi	Led	624	contain specified terms; amending	s. 486.023, F.S.;
96	information to the system; requiring that	: information	625	requiring the Board of Physical T	herapy Practice to
97	contained in the system be available only	/ to member	626	appoint an individual to serve as	the state's delegate
98	states; requiring the commission to promp	otly notify	627	on the Physical Therapy Compact C	ommission; amending
99	all member states of reported adverse act	tion taken	628	ss. 486.028, 486.031, 486.081, 48	6.102, and 486.107,
00	against licensees or applicants for licer	nsure;	629	F.S.; exempting physical therapis	ts and physical
01	authorizing member states to designate re	eported	630	therapist assistants from licensu	re requirements if
)2	information as exempt from public disclos	sure;	631	they are practicing in this state	pursuant to a
)3	providing for the removal of submitted in	nformation	632	compact privilege under the compa	ct; amending s.
)4	from the system under certain circumstanc	ces; providing	633	486.125, F.S.; authorizing the bo	ard to take adverse
)5	for commission rulemaking; providing cons	struction;	634	action against the compact privil	ege of physical
06	providing for state enforcement of the co	ompact;	635	therapists and physical therapist	assistants for
)7	providing for the default and termination	n of compact	636	specified prohibited acts; amendi	ng s. 768.28, F.S.;
8	membership; providing for appeals and cos	sts; providing	637	designating the state delegate an	d other members or
9	procedures for the resolution of certain	disputes;	638	employees of the commission as st	ate agents for the
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639	purpose of applying sovereign immunity and waivers of	668	area, an area having a special population, or a facility which
640	sovereign immunity; requiring the commission to pay	669	is designated by department rule as a health professional
641	certain claims or judgments; authorizing the	670	shortage area as defined by federal regulation and which has a
642	commission to maintain insurance coverage to pay such	671	shortage of dental health professionals who serve Medicaid
643	claims or judgments; amending ss. 486.025, 486.0715,	672	recipients and other low-income patients.
644	and 486.1065, F.S.; conforming cross-references;	673	(f)(e) "Public health program" means a county health
645	providing appropriations; providing effective dates.	674	department, the Children's Medical Services program, a federally
646		675	funded community health center, a federally funded migrant
647	Be It Enacted by the Legislature of the State of Florida:	676	health center, or other publicly funded or nonprofit health care
648		677	program designated by the department.
649	Section 1. Section 381.4019, Florida Statutes, is amended	678	(2) The department shall establish a dental student loan
650	to read:	679	repayment program to benefit Florida-licensed dentists and
651	381.4019 Dental Student Loan Repayment ProgramThe Dental	680	<u>dental hygienists</u> who <u>:</u>
652	Student Loan Repayment Program is established to support the	681	(a) Demonstrate, as required by department rule, active
653	state Medicaid program and promote access to dental care by	682	employment in a public health program or private practice that
654	supporting qualified dentists and dental hygienists who treat	683	serves Medicaid recipients and other low-income patients and is
655	medically underserved populations in dental health professional	684	located in a dental health professional shortage area or a
656	shortage areas or medically underserved areas.	685	medically underserved area; and
657	(1) As used in this section, the term:	686	(b) Volunteer 25 hours per year providing dental services
658	(a) "Dental health professional shortage area" means a	687	in a free clinic that is located in a dental health professional
659	geographic area designated as such by the Health Resources and	688	shortage area or a medically underserved area or through another
660	Services Administration of the United States Department of	689	volunteer program operated by the state pursuant to part IV of
661	Health and Human Services.	690	chapter 110. In order to meet the requirements of this
662	(b) "Department" means the Department of Health.	691	paragraph, the volunteer hours must be verifiable in a manner
663	(c) "Free clinic" means a provider that meets the	692	determined by the department.
664	description of a clinic specified in s. 766.1115(3)(d)14.	693	(3) The department shall award funds from the loan program
665	(d) "Loan program" means the Dental Student Loan Repayment	694	to repay the student loans of a dentist <u>or dental hygienist</u> who
666	Program.	695	meets the requirements of subsection (2).
667	(e)(d) "Medically underserved area" means a geographic	696	(a) An award shall be 20 percent of a dentist's or dental
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697	hygienist's principal loan amount at the time he or she applied		726	depai
698	for the program but may not exceed \$50,000 per year per eligible		727	381.4
699	dentist or \$7,500 per year per eligible dental hygienist.		728	
700	(b) Only loans to pay the costs of tuition, books, dental		729	progi
701	equipment and supplies, uniforms, and living expenses may be		730	
702	covered.		731	legis
703	(c) All repayments are contingent upon continued proof of		732	
704	eligibility and must be made directly to the holder of the loan.		733	fede
705	The state bears no responsibility for the collection of any		734	prog
706	interest charges or other remaining balances.		735	
707	(d) A dentist or dental hygienist may receive funds under		736	
708	the loan program for at least 1 year, up to a maximum of 5		737	trans
709	years.		738	and a
710	(c) The department shall limit the number of new dentists		739	
711	participating in the loan program to not more than 10 per fiscal		740	Medio
712	ycar.		741	
713	(4) A dentist <u>or dental hygienist</u> is <u>not</u> no longer eligible		742	qual:
714	to receive funds under the loan program if the dentist or dental		743	locat
715	hygienist:		744	estal
716	(a) Is no longer employed by a public health program $\underline{\mathrm{or}}$		745	Educa
717	private practice that meets the requirements of subsection (2)		746	of th
718	or does not verify, in a manner determined by the department,		747	educa
719	that he or she has volunteered his or her dental services for		748	a med
720	the required number of hours.		749	advar
721	(b) Ceases to participate in the Florida Medicaid program.		750	assis
722	(c) Has disciplinary action taken against his or her		751	
723	license by the Board of Dentistry for a violation of s. 466.028.		752	pract
724	(5) A dentist or dental hygienist who receives payment		753	this
725	under the program shall furnish information requested by the		754	
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	department for the purpose of the department's duties under s.
	381.4021.
	(6) The department shall adopt rules to administer the loa
	program.
	(7) (6) Implementation of the loan program is subject to
	legislative appropriation.
	(8) The Agency for Health Care Administration shall seek
	federal authority to use Title XIX matching funds for this
	program.
	(9) This section is repealed on July 1, 2034.
	Section 2. Section 1009.65, Florida Statutes, is
	transferred, renumbered as section 381.402, Florida Statutes,
	and amended to read:
	381.402 1009.65 Florida Reimbursement Assistance for
	Medical Education Reimbursement and Loan Repayment Program
	(1) To support the state Medicaid program and to encourage
	qualified medical professionals to practice in underserved
	locations where there are shortages of such personnel, there is
	established the Florida Reimbursement Assistance for Medical
	Education Reimbursement and Loan Repayment Program. The function
	of the program is to make payments that offset loans and
	educational expenses incurred by students for studies leading t
	a medical or nursing degree, medical or nursing licensure, or
	advanced practice registered nurse licensure or physician
	assistant licensure.
	(2) The following licensed or certified health care
	$\underline{practitioners}\ \underline{professionals}$ are eligible to participate in \underline{the}
	this program:
	(a) Medical doctors with primary care specialties $\underline{\cdot} au$
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755	(b) Doctors of osteopathic medicine with primary care
756	specialties.
757	(c) Advanced practice registered nurses registered to
758	engage in autonomous practice under s. 464.0123 and practicing
759	in a primary care specialty., physician assistants, licensed
760	practical nurses and registered nurses, and
761	(d) Advanced practice registered nurses with primary care
762	specialties such as certified nurse midwives.
763	(e) Physician assistants.
764	(f) Mental health professionals, including licensed
765	clinical social workers, licensed marriage and family
766	therapists, licensed mental health counselors, and licensed
767	psychologists.
768	(g) Licensed practical nurses and registered nurses.
769	
770	Primary care medical specialties for physicians include
771	obstetrics, gynecology, general and family practice, geriatrics,
772	internal medicine, pediatrics, psychiatry, and other specialties
773	which may be identified by the Department of Health.
774	(3) From the funds available, the Department of Health
775	shall make payments as follows:
776	(a) 1. For a 4-year period of continued proof of practice in
777	an area specified in paragraph (b), up to \$150,000 for
778	physicians, up to \$90,000 for advanced practice registered
779	nurses registered to engage in autonomous practice under s.
780	464.0123, up to \$75,000 for advanced practice registered nurses
781	and physician assistants, up to \$75,000 for mental health
782	professionals, and up to \$45,000 \$4,000 per year for licensed
783	practical nurses and registered nurses. Each practitioner is
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588-01852-24 2024701 784 eligible to receive an award for only one 4-year period of	6
784 oligible to receive an award for only one 4-year period of	
rou erigible co receive an award for only one 4-year period of	
785 continued proof of practice. At the end of each year that a	
786 practitioner participates in the program, the department shall	
787 award 25 percent of a practitioner's principal loan amount at	
788 the time he or she applied for the program, up to \$10,000 per	
789 year for advanced practice registered nurses and physician	
790 assistants, and up to \$20,000 per year for physicians. Penalti	es
791 for noncompliance are shall be the same as those in the Nation	al
792 Health Services Corps Loan Repayment Program. Educational	
793 expenses include costs for tuition, matriculation, registratio	n,
794 books, laboratory and other fees, other educational costs, and	
795 reasonable living expenses as determined by the Department of	
796 Health.	
797 (b) 2. All payments are contingent on continued proof of:	
798 <u>1.a.</u> Primary care practice in <u>a rural hospital as</u> an area	
799 defined in s. 395.602(2)(b) $_{ au}$ or an underserved area designated	
800 by the Department of Health, provided the practitioner accepts	
801 Medicaid reimbursement if eligible for such reimbursement; or	
802 b. For practitioners other than physicians and advanced	
803 practice registered nurses, practice in other settings,	
804 including, but not limited to, a nursing home facility as	
805 defined in s. 400.021, a home health agency as defined in s.	
806 400.462, or an intermediate care facility for the	
807 developmentally disabled as defined in s. 400.960. Any such	
808 setting must be located in, or serve residents or patients in,	
809 an underserved area designated by the Department of Health and	
810 must provide services to Medicaid patients.	
811 <u>2. Providing 25 hours annually of volunteer primary care</u>	
812 services in a free clinic as specified in s. 766.1115(3)(d)14.	
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or through another volunteer program operated by the state	842 Administration or a rural area as defined by the Federal Office
pursuant to part IV of chapter 110. In order to meet the	843 of Rural Health Policy.
requirements of this subparagraph, the volunteer hours must be	844 2. "Public health program" means a county health
verifiable in a manner determined by the department.	845 department, the Children's Medical Services program, a federall
(c) Correctional facilities, state hospitals, and other	846 funded community health center, a federally funded migrant
state institutions that employ medical personnel must shall be	847 health center, or any other publicly funded or nonprofit health
designated by the Department of Health as underserved locations.	848 care program designated by the department.
Locations with high incidences of infant mortality, high	849 (4) (2) The Department of Health may use funds appropriated
morbidity, or low Medicaid participation by health care	850 for the Medical Education Reimbursement and Loan Repayment
professionals may be designated as underserved.	851 program as matching funds for federal loan repayment programs
(b) Advanced practice registered nurses registered to	852 such as the National Health Service Corps State Loan Repayment
engage in autonomous practice under s. 464.0123 and practicing	853 Program.
in the primary care specialties of family medicine, general	(5) A health care practitioner who receives payment under
pediatrics, general internal medicine, or midwifery. From the	855 the program shall furnish information requested by the
funds available, the Department of Health shall make payments of	856 department for the purpose of the department's duties under s.
up to \$15,000 per year to advanced practice registered nurses	857 381.4021.
registered under s. 464.0123 who demonstrate, as required by	858 (6) (3) The Department of Health may adopt any rules
department rule, active employment providing primary care	859 necessary for the administration of the Medical Education
services in a public health program, an independent practice, or	860 Reimbursement and Loan Repayment program. The department may
a group practice that serves Medicaid recipients and other low-	861 also solicit technical advice regarding conduct of the program
income patients and that is located in a primary care health	862 from the Department of Education and Florida universities and
professional shortage area. Only loans to pay the costs of	863 Florida College System institutions. The Department of Health
tuition, books, medical equipment and supplies, uniforms, and	864 shall submit a budget request for an amount sufficient to fund
living expenses may be covered. For the purposes of this	865 medical education reimbursement, loan repayments, and program
paragraph:	866 administration.
1. "Primary care health professional shortage area" means a	867 (7) The Agency for Health Care Administration shall seek
geographic area, an area having a special population, or a	868 federal authority to use Title XIX matching funds for this
Facility with a score of at least 18, as designated and	869 program.
calculated by the Federal Health Resources and Services	870 (8) This section is repealed on July 1, 2034.
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DDING: Words stricken are deletions; words underlined are additions.	CODING: Words stricken are deletions; words underlined are additi

<pre>88-01852-24 20247016_ Section 3. Section 381.4021, Florida Statutes, is created or read: <u>381.4021 Student loan repayment programs reporting</u> (1) For the student loan repayment programs established in es. 381.4019 and 381.402, the department shall annually provide report, beginning July 1, 2024, to the Governor, the President of the Senate, and the Speaker of the House of Representatives which, at a minimum, details all of the following: (a) The number of applicants for loan repayment. (b) The number of loan payments made under each program. (c) The amounts for each loan payment made. (d) The type of practitioner to whom each loan payment was made. (e) The number of loan payments each practitioner has received under either program.</pre>
o read: <u>381.4021 Student loan repayment programs reporting</u> (1) For the student loan repayment programs established in as. 381.4019 and 381.402, the department shall annually provide report, beginning July 1, 2024, to the Governor, the President of the Senate, and the Speaker of the House of Representatives which, at a minimum, details all of the following: (a) The number of applicants for loan repayment. (b) The number of loan payments made under each program. (c) The amounts for each loan payment made. (d) The type of practitioner to whom each loan payment was hade. (e) The number of loan payments each practitioner has
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<pre>(c) The amounts for each loan payment made. (d) The type of practitioner to whom each loan payment was ade. (e) The number of loan payments each practitioner has</pre>
(d) The type of practitioner to whom each loan payment was ade. (e) The number of loan payments each practitioner has
(e) The number of loan payments each practitioner has
(e) The number of loan payments each practitioner has
eceived under either program.
(f) The practice setting in which each practitioner who
eceived a loan payment practices.
(2)(a) The department shall contract with an independent
hird party to develop and conduct a design study to evaluate
he impact of the student loan repayment programs established in
s. 381.4019 and 381.402, including, but not limited to, the
ffectiveness of the programs in recruiting and retaining health
are professionals in geographic and practice areas experiencing
hortages. The department shall begin collecting data for the
tudy by January 1, 2025, and shall submit the results of the
tudy to the Governor, the President of the Senate, and the
peaker of the House of Representatives by January 1, 2030.
(b) The department shall participate in a provider
etention and information system management multistate

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900	collaborative that collects data to measure outcomes of
901	education debt support-for-service programs.
902	(3) This section is repealed on July 1, 2034.
903	Section 4. Section 381.9855, Florida Statutes, is created
904	to read:
905	381.9855 Health Care Screening and Services Grant Program;
906	portal
907	(1) (a) The Department of Health shall implement a Health
908	Care Screening and Services Grant Program. The purpose of the
909	program is to expand access to no-cost health care screenings or
910	services for the general public facilitated by nonprofit
911	entities. The department shall do all of the following:
912	1. Publicize the availability of funds and enlist the aid
913	of county health departments for outreach to potential
914	applicants at the local level.
915	2. Establish an application process for submitting a grant
916	proposal and criteria an applicant must meet to be eligible.
917	3. Develop guidelines a grant recipient must follow for the
918	expenditure of grant funds and uniform data reporting
919	requirements for the purpose of evaluating the performance of
920	grant recipients.
921	(b) A nonprofit entity may apply for grant funds in order
922	to implement new health care screening or services programs that
923	the entity has not previously implemented.
924	(c) A nonprofit entity that has previously implemented a
925	specific health care screening or services program at one or
926	more specific locations may apply for grant funds in order to
927	provide the same or similar screenings or services at new
928	locations or through a mobile health clinic or mobile unit in
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929	order to expand the program's delivery capabilities.
930	(d) An entity that receives a grant under this section
931	must:
932	1. Follow Department of Health guidelines for reporting on
933	expenditure of grant funds and measures to evaluate the
934	effectiveness of the entity's health care screening or services
935	program.
936	2. Publicize to the general public and encourage the use of
937	the health care screening portal created under subsection (2).
938	(e) The Department of Health may adopt rules for the
939	implementation of this subsection.
940	(2) (a) The Department of Health shall create and maintain
941	an Internet-based portal to direct the general public to events,
942	organizations, and venues in this state from which health
943	screenings or services may be obtained at no cost or at a
944	reduced cost and for the purpose of directing licensed health
945	care practitioners to opportunities for volunteering their
946	services to conduct, administer, or facilitate such health
947	screenings or services. The department may contract for the
948	creation or maintenance of the portal with a third-party vendor.
949	(b) The portal must be easily accessible by the public, not
950	require a sign-up or login, and include the ability for a member
951	of the public to enter his or her address and obtain localized
952	and current data on opportunities for screenings and services
953	and volunteer opportunities for health care practitioners. The
954	portal must include, but need not be limited to, all statutorily
955	created screening programs that are funded and operational under
956	the department's authority. The department shall coordinate with
957	county health departments so that the portal includes
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958	information on such health screenings and services provided by
959	county health departments or by nonprofit entities in
960	partnership with county health departments.
961	(c) The department shall include a clear and conspicuous
962	link to the portal on the homepage of its website. The
963	department shall publicize the portal to, and encourage the use
964	of the portal by, the general public and shall enlist the aid of
965	county health departments for such outreach.
966	Section 5. Section 383.2163, Florida Statutes, is amended
967	to read:
968	383.2163 Telehealth minority maternity care program pilot
969	programs. By July 1, 2022, The department shall establish a
970	statewide telehealth minority maternity care pilot program that
971	in Duval County and Orange County which uses telehealth to
972	expand the capacity for positive maternal health outcomes in
973	racial and ethnic minority populations. The department shall
974	direct and assist the county health departments $\frac{1}{2}$ Duval County
975	and Orange County to implement the program programs.
976	(1) DEFINITIONSAs used in this section, the term:
977	(a) "Department" means the Department of Health.
978	(b) "Eligible pregnant woman" means a pregnant woman who is
979	receiving, or is eligible to receive, maternal or infant care
980	services from the department under chapter 381 or this chapter.
981	(c) "Health care practitioner" has the same meaning as in
982	s. 456.001.
983	(d) "Health professional shortage area" means a geographic
984	area designated as such by the Health Resources and Services
985	Administration of the United States Department of Health and
986	Human Services.
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any Indian tribe, band,	1	016	building model" means a distance health care education model
ommunity of Indians	1	017	that connects health care professionals, particularly
vided to Indians by the	1	018	specialists, with other health care professionals through
because of their status	1	019	simultaneous interactive videoconferencing for the purpose of
e village as defined in	1	020	facilitating case-based learning, disseminating best practices,
Claims Settlement Act,	1	021	and evaluating outcomes in the context of maternal health care.
tive date of this act.	1	022	(2) PURPOSE.—The purpose of the program pilot programs is
eath occurring during	1	023	to:
h is caused by pregnancy	1	024	(a) Expand the use of technology-enabled collaborative
	1	025	learning and capacity building models to improve maternal health
ion" means the population	1	026	outcomes for the following populations and demographics:
the United States	1	027	1. Ethnic and minority populations.
as an area with a	1	028	2. Health professional shortage areas.
es or a population group	1	029	3. Areas with significant racial and ethnic disparities in
ry of Health and Human	1	030	maternal health outcomes and high rates of adverse maternal
ervices.	1	031	health outcomes, including, but not limited to, maternal
s doulas, personnel from	1	.032	mortality and severe maternal morbidity.
s, childbirth educators,	1	033	4. Medically underserved populations.
rs, certified lactation	1	034	5. Indigenous populations.
ns, social workers, and	1	035	(b) Provide for the adoption of and use of telehealth
onals who assist women	1	036	services that allow for screening and treatment of common
riods.	1	.037	pregnancy-related complications, including, but not limited to,
period beginning on the	1	038	anxiety, depression, substance use disorder, hemorrhage,
	1	039	infection, amniotic fluid embolism, thrombotic pulmonary or
ans an unexpected outcome	1	040	other embolism, hypertensive disorders relating to pregnancy,
which results in	1	041	diabetes, cerebrovascular accidents, cardiomyopathy, and other
sequences to the woman's	1	042	cardiovascular conditions.
	1	043	(3) TELEHEALTH SERVICES AND EDUCATIONThe program pilot
ive learning and capacity	1	044	$\ensuremath{\ensuremath{programs}}$ shall adopt the use of telehealth or coordinate with
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ds underlined are additions.		c	CODING: Words stricken are deletions; words underlined are additions.

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987 (e) "Indigenous population" means 988 or nation or other organized group or co 989 recognized as eligible for services pro-United States Secretary of the Interior 990 991 as Indians, including any Alaskan nativ 43 U.S.C. s. 1602(c), the Alaska Native 992 as that definition existed on the effect 993 994 (f) "Maternal mortality" means a de

995 pregnancy or the postpartum period which is caused by pregnancy 996 or childbirth complications.

997 (g) "Medically underserved population" means the population 998 of an urban or rural area designated by the United States

999 Secretary of Health and Human Services as an area with a

1000 shortage of personal health care services or a population group 1001 designated by the United States Secretary of Health and Human 1002 Services as having a shortage of such services.

1003 (h) "Perinatal professionals" means doulas, personnel from 1004 Healthy Start and home visiting programs, childbirth educators, 1005 community health workers, peer supporters, certified lactation 1006 consultants, nutritionists and dietitians, social workers, and 1007 other licensed and nonlicensed professionals who assist women

1008 through their prenatal or postpartum periods

1009 (i) "Postpartum" means the 1-year period beginning on the 1010 last day of a woman's pregnancy.

1011 (j) "Severe maternal morbidity" means an unexpected outcome 1012 caused by a woman's labor and delivery which results in

1013 significant short-term or long-term consequences to the woman's 1014 health.

1015 (k) "Technology-enabled collaborative learning and capacity

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services.

such services.

water quality.

services and programs.

and postpartum periods.

perinatal health workers.

3. Nutrition counseling.

5. Lactation support.

7. Child care options.

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20247016 588-01852-24 20247016 prenatal home visiting programs to provide all of the following 1074 the following: services and education to eligible pregnant women up to the last 1075 1. A device to measure body weight, such as a scale. day of their postpartum periods, as applicable: 1076 2. A device to measure blood pressure which has a verbal (a) Referrals to Healthy Start's coordinated intake and 1077 reader to assist the pregnant woman in reading the device and to referral program to offer families prenatal home visiting 1078 ensure that the health care practitioner performing the wellness 1079 check through telehealth is able to hear the reading. (b) Services and education addressing social determinants 1080 3. A device to measure blood sugar levels with a verbal of health, including, but not limited to, all of the following: 1081 reader to assist the pregnant woman in reading the device and to 1082 1. Housing placement options. ensure that the health care practitioner performing the wellness 2. Transportation services or information on how to access 1083 check through telehealth is able to hear the reading. 1084 4. Any other device that the health care practitioner performing wellness checks through telehealth deems necessary. 1085 4. Access to healthy foods. 1086 (4) TRAINING.-The program pilot programs shall provide 1087 training to participating health care practitioners and other 6. Lead abatement and other efforts to improve air and 1088 perinatal professionals on all of the following: 1089 (a) Implicit and explicit biases, racism, and 1090 discrimination in the provision of maternity care and how to 8. Car seat installation and training. 1091 eliminate these barriers to accessing adequate and competent 9. Wellness and stress management programs. 1092 maternity care. 10. Coordination across safety net and social support 1093 (b) The use of remote patient monitoring tools for 1094 pregnancy-related complications. (c) Evidence-based health literacy and pregnancy, 1095 (c) How to screen for social determinants of health risks childbirth, and parenting education for women in the prenatal 1096 in the prenatal and postpartum periods, such as inadequate 1097 housing, lack of access to nutritional foods, environmental (d) For women during their pregnancies through the 1098 risks, transportation barriers, and lack of continuity of care. postpartum periods, connection to support from doulas and other 1099 (d) Best practices in screening for and, as needed, 1100 evaluating and treating maternal mental health conditions and (e) Tools for prenatal women to conduct key components of 1101 substance use disorders. maternal wellness checks, including, but not limited to, all of 1102 (e) Information collection, recording, and evaluation Page 37 of 234 Page 38 of 234 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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1103	activities to:		1132	
1104	1. Study the impact of the pilot program;		1133	t
1105	2. Ensure access to and the quality of care;		1134	
1106	3. Evaluate patient outcomes as a result of the pilot		1135	F
1107	program;		1136	
1108	4. Measure patient experience; and		1137	t
1109	5. Identify best practices for the future expansion of the		1138	
1110	pilot program.		1139	k
1111	(5) REPORTSBy October 31, 2025, and each October 31		1140	
1112	thereafter, the department shall submit a program report to the		1141	Ī
1113	Governor, the President of the Senate, and the Speaker of the		1142	t
1114	House of Representatives which includes, at a minimum, all of		1143	I
1115	the following for the previous fiscal year:		1144	t
1116	(a) The total number of clients served and the demographic		1145	2
1117	information for the population served, including ethnicity and		1146	
1118	race, age, education levels, and geographic location.		1147	C
1119	(b) The total number of screenings performed, by type.		1148	
1120	(c) The number of participants identified as having		1149	1
1121	experienced pregnancy-related complications, the number of		1150	F
1122	participants who received treatments for such complications, and		1151	
1123	the final outcome of the pregnancy for such participants.		1152	đ
1124	(d) The number of referrals made to the Healthy Start		1153	Ŧ
1125	program or other prenatal home visiting programs and the number		1154	ā
1126	of participants who subsequently received services from such		1155	j
1127	programs.		1156	ā
1128	(e) The number of referrals made to doulas and other		1157	S
1129	perinatal professionals and the number of participants who		1158	
1130	subsequently received services from doulas and other perinatal		1159	t
1131	professionals.		1160	
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1132	(f) The number and types of devices given to participants
1133	to conduct maternal wellness checks.
1134	(g) The average length of participation by program
1135	participants.
1136	(h) Composite results of a participant survey that measures
1137	the participants' experience with the program.
1138	(i) The total number of health care practitioners trained,
1139	by provider type and specialty.
1140	(j) The results of a survey of the health care
1141	practitioners trained under the program. The survey must address
1142	the quality and impact of the training provided, the health care
1143	practitioners' experiences using remote patient monitoring
1144	tools, the best practices provided in the training, and any
1145	suggestions for improvements.
1146	(k) Aggregate data on the maternal and infant health
1147	outcomes of program participants.
1148	(1) For the initial report, all available quantifiable data
1149	related to the telehealth minority maternity care pilot
1150	programs.
1151	(6) FUNDING The pilot programs shall be funded using funds
1152	appropriated by the Legislature for the Closing the Gap grant
1153	$\ensuremath{\ensuremath{program}}$ The department's Division of Community Health Promotion
1154	and Office of Minority Health and Health Equity shall $also$ work
1155	in partnership to apply for federal funds that are available to
1156	assist the department in accomplishing the program's purpose and
1157	successfully implementing the program pilot programs.
1158	(7)(6) RULESThe department may adopt rules to implement
1159	this section.
1160	Section 6. Present subsections (1) through (8), (9), and
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1161	(10) of section 383.302, Florida Statutes, are redesignated as
1162	subsections (2) through (9), (11), and (12), respectively, new
1163	subsections (1) and (10) are added to that section, and present
1164	subsection (4) of that section is amended, to read:
1165	383.302 Definitions of terms used in ss. 383.30-383.332As
1166	used in ss. 383.30-383.332, the term:
1167	(1) "Advanced birth center" means a licensed birth center
1168	designated as an advanced birth center which may perform trial
1169	of labor after cesarean deliveries for screened patients who
1170	qualify, planned low-risk cesarean deliveries, and anticipated
1171	vaginal deliveries for laboring patients from the beginning of
1172	the 37th week of gestation through the end of the 41st week of
1173	gestation.
1174	(5)(4) "Consultant" means a physician licensed pursuant to
1175	chapter 458 or chapter 459 who agrees to provide advice and
1176	services to a birth center and who either:
1177	(a) Is certified or eligible for certification by the
1178	American Board of Obstetrics and Gynecology or the American
1179	Osteopathic Board of Obstetrics and Gynecology; $_{\mathcal{T}}$ or
1180	(b) Has hospital obstetrical privileges.
1181	(10) "Medical director" means a person who holds an active
1182	unrestricted license as a physician under chapter 458 or chapter
1183	<u>459.</u>
1184	Section 7. Section 383.3081, Florida Statutes, is created
1185	to read:
1186	383.3081 Advanced birth center designation
1187	(1) To be designated as an advanced birth center, a birth
1188	center must, in addition to maintaining compliance with all of
1189	the requirements under ss. 383.30-383.332 applicable to birth
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1190	centers and advanced birth centers, meet all of the following
1191	criteria:
1192	(a) Be operated and staffed 24 hours per day, 7 days per
1193	week.
1194	(b) Employ two medical directors to oversee the activities
1195	of the center, one of whom must be a board-certified
1196	obstetrician and one of whom must be a board-certified
1197	anesthesiologist.
1198	(c) Have at least one properly equipped, dedicated surgical
1199	suite for the performance of cesarean deliveries.
1200	(d) Employ at least one registered nurse and ensure that at
1201	least one registered nurse is present in the center at all times
1202	and has the ability to stabilize and facilitate the transfer of
1203	patients and newborn infants when appropriate.
1204	(e) Enter into a written agreement with a blood bank for
1205	emergency blood bank services and have written protocols for the
1206	management of obstetrical hemorrhage which include provisions
1207	for emergency blood transfusions. If a patient admitted to an
1208	advanced birth center receives an emergency blood transfusion at
1209	the center, the patient must immediately thereafter be
1210	transferred to a hospital for further care.
1211	(f) Meet all standards adopted by rule for birth centers,
1212	unless specified otherwise, and advanced birth centers pursuant
1213	to s. 383.309.
1214	(g) Comply with the Florida Building Code and Florida Fire
1215	Prevention Code standards for ambulatory surgical centers.
1216	(h) Qualify for, enter into, and maintain a Medicaid
1217	provider agreement with the agency pursuant to s. 409.907 and
1218	provide services to Medicaid recipients according to the terms
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1219	of the provider agreement.	1248	repair, or demolition of birth centers. It is the intent of the
1220	(2) The agency shall establish by rule a process for	1249	Legislature to preempt that function to the Florida Building
1221	designating a birth center that meets the requirements of this	1250	Commission and the State Fire Marshal through adoption and
1222	section as an advanced birth center.	1251	maintenance of the Florida Building Code and the Florida Fire
1223	Section 8. Section 383.309, Florida Statutes, is amended to	1252	Prevention Code. However, the agency shall provide technical
1224	read:	1253	assistance to the commission and the State Fire Marshal in
1225	383.309 Minimum standards for birth centers and advanced	1254	updating the construction standards of the Florida Building Code
1226	birth centers; rules and enforcement	1255	and the Florida Fire Prevention Code which govern birth centers.
1227	(1) The agency shall adopt and enforce rules to administer	1256	In addition, the agency may enforce the special-occupancy
1228	ss. 383.30-383.332 and part II of chapter 408, which rules shall	1257	provisions of the Florida Building Code and the Florida Fire
1229	include, but are not limited to, reasonable and fair minimum	1258	Prevention Code which apply to birth centers in conducting any
1230	standards for ensuring that:	1259	inspection authorized under this chapter or part II of chapter
1231	(a) Sufficient numbers and qualified types of personnel and	1260	408.
1232	occupational disciplines are available at all times to provide	1261	Section 9. Section 383.313, Florida Statutes, is amended to
1233	necessary and adequate patient care and safety.	1262	read:
1234	(b) Infection control, housekeeping, sanitary conditions,	1263	383.313 Birth center performance of laboratory and surgical
1235	disaster plan, and medical record procedures that will	1264	services; use of anesthetic and chemical agents
1236	adequately protect patient care and provide safety are	1265	(1) LABORATORY SERVICESA birth center may collect
1237	established and implemented.	1266	specimens for those tests that are requested under protocol. A
1238	(c) Licensed facilities are established, organized, and	1267	birth center must obtain and continuously maintain certification
1239	operated consistent with established programmatic standards.	1268	by the Centers for Medicare and Medicaid Services under the
1240	(2) The standards adopted by rule for designating a birth	1269	federal Clinical Laboratory Improvement Amendments and the
1241	center as an advanced birth center must, at a minimum, be	1270	federal rules adopted thereunder in order to perform laboratory
1242	equivalent to the minimum standards adopted for ambulatory	1271	tests specified by rule of the agency, and which are appropriate
1243	surgical centers pursuant to s. 395.1055 and must include	1272	to meet the needs of the patient.
1244	standards for quality of care, blood transfusions, and sanitary	1273	(2) SURGICAL SERVICESExcept for advanced birth centers
1245	conditions for food handling and food service.	1274	authorized to provide surgical services under s. 383.3131, only
1246	(3) The agency may not establish any rule governing the	1275	those surgical procedures that are shall be limited to those
1247	design, construction, erection, alteration, modification,	1276	normally performed during uncomplicated childbirths, such as
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1277	episiotomies and repairs, may be performed at a birth center.
1278	and shall not include Operative obstetrics or caesarean sections
1279	may not be performed at a birth center.
1280	(3) ADMINISTRATION OF ANALGESIA AND ANESTHESIAGeneral and
1281	conduction anesthesia may not be administered at a birth center.
1282	Systemic analgesia may be administered, and local anesthesia for
1283	pudendal block and episiotomy repair may be performed if
1284	procedures are outlined by the clinical staff and performed by
1285	personnel who have the with statutory authority to do so.
1286	(4) INTRAPARTAL USE OF CHEMICAL AGENTSLabor may not be
1287	inhibited, stimulated, or augmented with chemical agents during
1288	the first or second stage of labor unless prescribed by
1289	personnel who have the with statutory authority to do so and
1290	unless in connection with and $\underline{before} \ \underline{prior \ to} \ \underline{connection}$
291	transport.
L292	Section 10. Section 383.3131, Florida Statutes, is created
1293	to read:
1294	383.3131 Advanced birth center performance of laboratory
1295	and surgical services; use of anesthetic and chemical agents
L296	(1) LABORATORY SERVICES An advanced birth center shall
1297	have a clinical laboratory on site. The clinical laboratory
1298	must, at a minimum, be capable of providing laboratory testing
1299	for hematology, metabolic screening, liver function, and
1300	coagulation studies. An advanced birth center may collect
1301	specimens for those tests that are requested under protocol. An
1302	advanced birth center may perform laboratory tests as defined by
1303	rule of the agency. Laboratories located in advanced birth
L304	centers must be appropriately certified by the Centers for
1305	Medicare and Medicaid Services under the federal Clinical
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1306	Laboratory Improvement Amendments and the federal rules adopted
1307	thereunder.
1308	(2) SURGICAL SERVICESIn addition to surgical procedures
1309	authorized under s. 383.313(2), surgical procedures for low-risk
1310	cesarean deliveries and surgical management of immediate
1311	complications may also be performed at an advanced birth center.
1312	Postpartum sterilization may be performed before discharge of
1313	the patient who has given birth during that admission.
1314	Circumcisions may be performed before discharge of the newborn
1315	infant.
1316	(3) ADMINISTRATION OF ANALGESIA AND ANESTHESIAGeneral,
1317	conduction, and local anesthesia may be administered at an
1318	advanced birth center if administered by personnel who have the
1319	statutory authority to do so. All general anesthesia must be
1320	administered by an anesthesiologist or a certified registered
1321	nurse anesthetist in accordance with s. 464.012. When general
1322	anesthesia is administered, a physician or a certified
1323	registered nurse anesthetist must be present in the advanced
1324	birth center during the anesthesia and postanesthesia recovery
1325	period until the patient is fully alert. Each advanced birth
1326	center shall comply with s. 395.0191(2)(b).
1327	(4) INTRAPARTAL USE OF CHEMICAL AGENTSLabor may be
1328	inhibited, stimulated, or augmented with chemical agents during
1329	the first or second stage of labor at an advanced birth center
1330	if prescribed by personnel who have the statutory authority to
1331	do so. Labor may be electively induced beginning at the 39th
1332	week of gestation for a patient with a documented Bishop score
1333	of 8 or greater.
1334	Section 11. Subsection (3) is added to section 383.315,
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588-01852-24 20247016 588-01852-24 20247016 Florida Statutes, to read: 1364 patients. 383.315 Agreements with consultants for advice or services; 1365 (4) A birth center licensed facility shall identify maintenance.-1366 neonatal-specific transportation services, including ground and (3) An advanced birth center shall employ or maintain an 1367 air ambulances; list their particular gualifications; and have agreement with an obstetrician who must be on call at all times 1368 the telephone numbers for access to these services clearly during which a patient is in active labor in the center to 1369 listed and immediately available. attend deliveries, available to respond to emergencies, and, 1370 (5) (4) The birth center shall assess and document Annual when necessary, available to perform cesarean deliveries. 1371 assessments of the transportation services and transfer Section 12. Section 383.316, Florida Statutes, is amended 1372 protocols annually shall be made and documented. to read: 1373 Section 13. Present subsections (2) and (3) of section 383.316 Transfer and transport of clients to hospitals .-1374 383.318, Florida Statutes, are redesignated as subsections (3) (1) If unforeseen complications arise during labor, 1375 and (4), respectively, a new subsection (2) is added to that delivery, or postpartum recovery, the client must shall be section, and subsection (1) of that section is amended, to read: 1376 transferred to a hospital. 1377 383.318 Postpartum care for birth center clients and (2) Each birth center licensed facility shall make 1378 infants.arrangements with a local ambulance service licensed under 1379 (1) Except at advanced birth centers that must adhere to chapter 401 for the transport of emergency patients to a the requirements of subsection (2), a mother and her infant must 1380 hospital. Such arrangements must shall be documented in the 1381 shall be dismissed from a the birth center within 24 hours after center's policy and procedures manual of the facility if the 1382 the birth of the infant, except in unusual circumstances as birth center does not own or operate a licensed ambulance. The 1383 defined by rule of the agency. If a mother or an infant is policy and procedures manual shall also must contain specific 1384 retained at the birth center for more than 24 hours after the protocols for the transfer of any patient to a licensed 1385 birth, a report must shall be filed with the agency within 48 hospital. 1386 hours after of the birth and must describe describing the (3) Each advanced birth center shall enter into a written 1387 circumstances and the reasons for the decision. transfer agreement with a local hospital licensed under chapter 1388 (2) (a) A mother and her infant must be dismissed from an 395 for the transfer and admission of emergency patients to the advanced birth center within 48 hours after a vaginal delivery 1389 hospital or a written agreement with an obstetrician who has 1390 of the infant or within 72 hours after a delivery by cesarean hospital privileges to provide coverage at all times and who has 1391 section, except in unusual circumstances as defined by rule of agreed to accept the transfer of the advanced birth center's 1392 the agency. Page 47 of 234 Page 48 of 234 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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1393	(b) If a mother or an infant is retained at the advanced
1394	birth center for more than the timeframes set forth in paragraph
1395	(a), a report must be filed with the agency within 48 hours
1396	after the scheduled discharge time and must describe the
1397	circumstances and the reasons for the decision.
1398	Section 14. Subsections (5), (31), and (36) of section
1399	394.455, Florida Statutes, are amended to read:
1400	394.455 DefinitionsAs used in this part, the term:
1401	(5) "Clinical psychologist" means a person licensed to
1402	practice psychology under chapter 490 a psychologist as defined
1403	in s. 490.003(7) with 3 years of postdoctoral experience in the
1404	practice of clinical psychology, inclusive of the experience
1405	$\frac{1}{1}$ required for licensure, or a psychologist employed by a facility
1406	operated by the United States Department of Veterans Affairs
1407	that qualifies as a receiving or treatment facility under this
1408	part.
1409	(31) "Mobile crisis response service" or "mobile response
1410	team" means a nonresidential behavioral health crisis service
1411	available 24 hours per day, 7 days per week which provides
1412	immediate intensive assessments and interventions, including
1413	screening for admission into a mental health receiving facility,
1414	an addictions receiving facility, or a detoxification facility,
1415	for the purpose of identifying appropriate treatment services.
1416	(36) "Psychiatric nurse" means an advanced practice
1417	registered nurse licensed under s. 464.012 who has a master's or
1418	doctoral degree in psychiatric nursing $\underline{\operatorname{and}}_{\overline{r}}$ holds a national
1419	advanced practice certification as a psychiatric mental health
1420	advanced practice nurse, and has $\underline{1 \ year} \ \underline{2 \ years}$ of post-master's
1421	clinical experience under the supervision of a physician.
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1422 Section 15. Paragraph (c) of subsection (5) of section
1423 394.457, Florida Statutes, is amended to read:
1424 394.457 Operation and administration
1425 (5) RULES
1426 (c) The department shall adopt rules establishing minimum
1427 standards for services provided by a mental health overlay
1428 program or a mobile crisis response service. <u>Minimum standards</u>
1429 for a mobile crisis response service must:
1430 1. Include the requirements of the child, adolescent, and
1431 young adult mobile response teams established under s.
1432 394.495(7) and ensure coverage of all counties by these
1433 specified teams; and
1434 2. Create a structure for general mobile response teams
1435 which focuses on emergency room diversion and the reduction of
1436 involuntary commitment under this chapter. The structure must
1437 require, but need not be limited to, the following:
1438 a. Triage and rapid crisis intervention within 60 minutes;
1439 b. Provision of and referral to evidence-based services
1440 that are responsive to the needs of the individual and the
1441 individual's family;
1442 c. Screening, assessment, early identification, and care
1443 coordination; and
1444 d. Follow-up at 90 and 180 days to gather outcome data on a
1445 mobile crisis response encounter to determine efficacy of the
1446 mobile crisis response service.
1447 Section 16. Subsections (1) and (3) of section 394.4598,
1448 Florida Statutes, are amended to read:
1449 394.4598 Guardian advocate
1450 (1) The administrator may petition the court for the
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588-01852-24 20247016 1451 appointment of a quardian advocate based upon the opinion of a 1452 psychiatrist or psychiatric nurse practicing within the 1453 framework of an established protocol with a psychiatrist that 1454 the patient is incompetent to consent to treatment. If the court 1455 finds that a patient is incompetent to consent to treatment and 1456 has not been adjudicated incapacitated and had a guardian with 1457 the authority to consent to mental health treatment appointed, 1458 the court must it shall appoint a quardian advocate. The patient 1459 has the right to have an attorney represent him or her at the 1460 hearing. If the person is indigent, the court must shall appoint 1461 the office of the public defender to represent him or her at the 1462 hearing. The patient has the right to testify, cross-examine 1463 witnesses, and present witnesses. The proceeding must shall be 1464 recorded, either electronically or stenographically, and 1465 testimony must shall be provided under oath. One of the 1466 professionals authorized to give an opinion in support of a 1467 petition for involuntary placement, as described in s. 394.4655 1468 or s. 394.467, must testify. A guardian advocate must meet the 1469 qualifications of a guardian contained in part IV of chapter 1470 744, except that a professional referred to in this part, an 1471 employee of the facility providing direct services to the 1472 patient under this part, a departmental employee, a facility 1473 administrator, or member of the Florida local advocacy council 1474 shall not be appointed. A person who is appointed as a guardian 1475 advocate must agree to the appointment. 1476 (3) A facility requesting appointment of a guardian 1477 advocate must, before prior to the appointment, provide the 1478 prospective guardian advocate with information about the duties 1479 and responsibilities of guardian advocates, including the Page 51 of 234 CODING: Words stricken are deletions; words underlined are additions.

588-01852-24 20247016 1480 information about the ethics of medical decisionmaking. Before 1481 asking a guardian advocate to give consent to treatment for a 1482 patient, the facility shall provide to the guardian advocate 1483 sufficient information so that the guardian advocate can decide 1484 whether to give express and informed consent to the treatment, 1485 including information that the treatment is essential to the 1486 care of the patient, and that the treatment does not present an 1487 unreasonable risk of serious, hazardous, or irreversible side 1488 effects. Before giving consent to treatment, the guardian 1489 advocate must meet and talk with the patient and the patient's 1490 physician or psychiatric nurse practicing within the framework of an established protocol with a psychiatrist in person, if at 1491 1492 all possible, and by telephone, if not. The decision of the 1493 guardian advocate may be reviewed by the court, upon petition of 1494 the patient's attorney, the patient's family, or the facility 1495 administrator. 1496 Section 17. Subsection (11) of section 394.4615, Florida 1497 Statutes, is amended to read: 1498 394.4615 Clinical records; confidentiality.-1499 (11) Patients must shall have reasonable access to their 1500 clinical records, unless such access is determined by the 1501 patient's physician or the patient's psychiatric nurse to be 1502 harmful to the patient. If the patient's right to inspect his or 1503 her clinical record is restricted by the facility, written 1504 notice of such restriction must shall be given to the patient 1505 and the patient's quardian, quardian advocate, attorney, and 1506 representative. In addition, the restriction must shall be 1507 recorded in the clinical record, together with the reasons for 1508 it. The restriction of a patient's right to inspect his or her Page 52 of 234

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1509	clinical record <u>expires</u> shall expire after 7 days but	may be	1538	restrictive manner, upon the written order of a physician $\underline{\text{or } a}$
1510	renewed, after review, for subsequent 7-day periods.		1539	psychiatric nurse practicing within the framework of an
1511	Section 18. Paragraph (f) of subsection (1) and s	subsection	1540	established protocol with a psychiatrist, if it is determined
1512	(5) of section 394.4625, Florida Statutes, are amended	d to read:	1541	that such treatment is necessary for the safety of the patient
1513	394.4625 Voluntary admissions		1542	or others.
1514	(1) AUTHORITY TO RECEIVE PATIENTS		1543	Section 19. Paragraph (f) of subsection (2) of section
1515	(f) Within 24 hours after admission of a volunta:	ry patient,	1544	394.463, Florida Statutes, is amended to read:
1516	the treating admitting physician or psychiatric nurse	practicing	1545	394.463 Involuntary examination
1517	within the framework of an established protocol with a	<u>1</u>	1546	(2) INVOLUNTARY EXAMINATION
1518	psychiatrist shall document in the patient's clinical	record	1547	(f) A patient <u>must</u> shall be examined by a physician or a
1519	that the patient is able to give express and informed	consent	1548	clinical psychologist, or by a psychiatric nurse performing
1520	for admission. If the patient is not able to give exp	ress and	1549	within the framework of an established protocol with a
1521	informed consent for admission, the facility <u>must</u> sha	l either	1550	psychiatrist at a facility without unnecessary delay to
1522	discharge the patient or transfer the patient to invol	untary	1551	determine if the criteria for involuntary services are met.
1523	status pursuant to subsection (5).		1552	Emergency treatment may be provided upon the order of a
1524	(5) TRANSFER TO INVOLUNTARY STATUSWhen a volunt	ary	1553	physician or a psychiatric nurse practicing within the framework
1525	patient, or an authorized person on the patient's beha	alf, makes	1554	of an established protocol with a psychiatrist if the physician
1526	a request for discharge, the request for discharge, un	less	1555	or psychiatric nurse determines that such treatment is necessary
1527	freely and voluntarily rescinded, must be communicated	l to a	1556	for the safety of the patient or others. The patient may not be
1528	physician, <u>a</u> clinical psychologist with at least 3 years	ars of	1557	released by the receiving facility or its contractor without the
1529	clinical experience, or <u>a</u> psychiatrist as quickly as p	possible,	1558	documented approval of a psychiatrist or a clinical psychologist
1530	but not later than 12 hours after the request is made	. If the	1559	with at least 3 years of clinical experience or, if the
1531	patient meets the criteria for involuntary placement,	the	1560	receiving facility is owned or operated by a hospital, health
1532	administrator of the facility must file with the court	a	1561	system, or nationally accredited community mental health center,
1533	petition for involuntary placement, within 2 court wo	cking days	1562	the release may also be approved by a psychiatric nurse
1534	after the request for discharge is made. If the petit:	lon is not	1563	performing within the framework of an established protocol with
1535	filed within 2 court working days, the patient $\underline{\text{must}}$ shows the second s	hall be	1564	a psychiatrist, or an attending emergency department physician
1536	discharged. Pending the filing of the petition, the pa	atient may	1565	with experience in the diagnosis and treatment of mental illness
1537	be held and emergency treatment rendered in the least		1566	after completion of an involuntary examination pursuant to this
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1567	subsection. A psychiatric nurse may not approve the release of a
1568	patient if the involuntary examination was initiated by a
1569	psychiatrist unless the release is approved by the initiating
1570	psychiatrist. The release may be approved through telehealth.
1571	Section 20. Paragraphs (a) and (b) of subsection (3),
1572	paragraph (b) of subsection (7), and paragraph (a) of subsection
1573	(8) of section 394.4655, Florida Statutes, are amended to read:
1574	394.4655 Involuntary outpatient services
1575	(3) INVOLUNTARY OUTPATIENT SERVICES
1576	(a)1. A patient who is being recommended for involuntary
1577	outpatient services by the administrator of the facility where
1578	the patient has been examined may be retained by the facility
1579	after adherence to the notice procedures provided in s.
1580	394.4599. The recommendation must be supported by the opinion of
1581	a psychiatrist and the second opinion of a clinical psychologist
1582	with at least 3 years of clinical experience, or another
1583	psychiatrist, or a psychiatric nurse practicing within the
1584	framework of an established protocol with a psychiatrist, both
1585	of whom have personally examined the patient within the
1586	preceding 72 hours, that the criteria for involuntary outpatient
1587	services are met. However, if the administrator certifies that a
1588	psychiatrist or <u>a</u> clinical psychologist with at least 3 years of
1589	clinical experience is not available to provide the second
1590	opinion, the second opinion may be provided by a licensed
1591	physician who has postgraduate training and experience in
1592	diagnosis and treatment of mental illness, a physician assistant
1593	who has at least 3 years' experience and is supervised by such
1594	licensed physician or a psychiatrist, a clinical social worker,
1595	a clinical psychologist with less than 3 years of clinical
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588-01852-24 20247016 1596 experience, or by a psychiatric nurse. Any second opinion 1597 authorized in this subparagraph may be conducted through a face-1598 to-face examination, in person or by electronic means. Such 1599 recommendation must be entered on an involuntary outpatient 1600 services certificate that authorizes the facility to retain the 1601 patient pending completion of a hearing. The certificate must be 1602 made a part of the patient's clinical record. 1603 2. If the patient has been stabilized and no longer meets 1604 the criteria for involuntary examination pursuant to s. 1605 394.463(1), the patient must be released from the facility while 1606 awaiting the hearing for involuntary outpatient services. Before 1607 filing a petition for involuntary outpatient services, the administrator of the facility or a designated department 1608 1609 representative must identify the service provider that will have 1610 primary responsibility for service provision under an order for 1611 involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in 1612 need of public financing for that treatment, in which case the 1613 1614 individual, if eligible, may be ordered to involuntary treatment 1615 pursuant to the existing psychiatric treatment relationship. 1616 3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's 1617 1618 guardian advocate, if appointed, for the court's consideration 1619 for inclusion in the involuntary outpatient services order that 1620 addresses the nature and extent of the mental illness and any 1621 co-occurring substance use disorder that necessitate involuntary 1622 outpatient services. The treatment plan must specify the likely 1623 level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient 1624

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588-01852-24 20247016 1625 services. Service providers may select and supervise other 1626 individuals to implement specific aspects of the treatment plan. 1627 The services in the plan must be deemed clinically appropriate 1628 by a physician, clinical psychologist, psychiatric nurse, mental 1629 health counselor, marriage and family therapist, or clinical 1630 social worker who consults with, or is employed or contracted 1631 by, the service provider. The service provider must certify to 1632 the court in the proposed plan whether sufficient services for 1633 improvement and stabilization are currently available and 1634 whether the service provider agrees to provide those services. 1635 If the service provider certifies that the services in the 1636 proposed treatment plan are not available, the petitioner may 1637 not file the petition. The service provider must notify the 1638 managing entity if the requested services are not available. The 1639 managing entity must document such efforts to obtain the 1640 requested services. 1641 (b) If a patient in involuntary inpatient placement meets 1642 the criteria for involuntary outpatient services, the 1643 administrator of the facility may, before the expiration of the 1644 period during which the facility is authorized to retain the 1645 patient, recommend involuntary outpatient services. The 1646 recommendation must be supported by the opinion of a 1647 psychiatrist and the second opinion of a clinical psychologist 1648 with at least 3 years of clinical experience, or another 1649 psychiatrist, or a psychiatric nurse practicing within the 1650 framework of an established protocol with a psychiatrist, both 1651 of whom have personally examined the patient within the 1652 preceding 72 hours, that the criteria for involuntary outpatient 1653 services are met. However, if the administrator certifies that a Page 57 of 234 CODING: Words stricken are deletions; words underlined are additions.

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1654	psychiatrist or <u>a</u> clinical psychologist with at least 3 years of
1655	clinical experience is not available to provide the second
1656	opinion, the second opinion may be provided by a licensed
1657	physician who has postgraduate training and experience in
1658	diagnosis and treatment of mental illness, a physician assistant
1659	who has at least 3 years' experience and is supervised by such
1660	licensed physician or a psychiatrist, a clinical social worker,
1661	a clinical psychologist with less than 3 years of clinical
1662	experience, or by a psychiatric nurse. Any second opinion
1663	authorized in this subparagraph may be conducted through a face-
1664	to-face examination, in person or by electronic means. Such
1665	recommendation must be entered on an involuntary outpatient
1666	services certificate, and the certificate must be made a part of
1667	the patient's clinical record.
1668	(7) HEARING ON INVOLUNTARY OUTPATIENT SERVICES
1669	(b)1. If the court concludes that the patient meets the
1670	criteria for involuntary outpatient services pursuant to
1671	subsection (2), the court $\underline{\text{must}}$ shall issue an order for
1672	involuntary outpatient services. The court order \underline{must} shall be
1673	for a period of up to 90 days. The order must specify the nature
1674	and extent of the patient's mental illness. The order of the
1675	court and the treatment plan must be made part of the patient's
1676	clinical record. The service provider shall discharge a patient
1677	from involuntary outpatient services when the order expires or
1678	any time the patient no longer meets the criteria for
1679	involuntary placement. Upon discharge, the service provider
1680	shall send a certificate of discharge to the court.
1681	2. The court may not order the department or the service
1682	provider to provide services if the program or service is not
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588-01852-24 20247016 1712 involuntary outpatient services order must shall remain in 1713 effect unless the service provider determines that the patient 1714 no longer meets the criteria for involuntary outpatient services 1715 or until the order expires. The service provider must determine 1716 whether modifications should be made to the existing treatment 1717 plan and must attempt to continue to engage the patient in 1718 treatment. For any material modification of the treatment plan 1719 to which the patient or the patient's guardian advocate, if 1720 applicable, agrees, the service provider shall send notice of 1721 the modification to the court. Any material modifications of the 1722 treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or 1723 1724 disapproved by the court consistent with subsection (3). 1725 (8) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT 1726 SERVICES.-1727 (a)1. If the person continues to meet the criteria for involuntary outpatient services, the service provider must 1728 1729 shall, at least 10 days before the expiration of the period 1730 during which the treatment is ordered for the person, file in 1731 the court that issued the order for involuntary outpatient 1732 services a petition for continued involuntary outpatient 1733 services. The court shall immediately schedule a hearing on the 1734 petition to be held within 15 days after the petition is filed. 1735 2. The existing involuntary outpatient services order 1736 remains in effect until disposition on the petition for 1737 continued involuntary outpatient services. 1738 3. A certificate must shall be attached to the petition 1739 which includes a statement from the person's physician or a 1740 clinical psychologist with at least 3 years of clinical Page 60 of 234

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available in the patient's local community, if there is no space

funding is not available for the program or service. The service

services are not available. The managing entity must document

such efforts to obtain the requested services. A copy of the

provider within 1 working day after it is received from the

existing data systems. After the order for involuntary services

is issued, the service provider and the patient may modify the

treatment plan. For any material modification of the treatment

plan to which the patient or, if one is appointed, the patient's

guardian advocate agrees, the service provider shall send notice

of the modification to the court. Any material modifications of

patient's guardian advocate, if applicable, must be approved or

established protocol with a psychiatrist, the patient has failed

psychiatric nurse, efforts were made to solicit compliance and

person may be brought to a receiving facility pursuant to s.

criteria for involuntary inpatient placement pursuant to s.

394.463. If, after examination, the patient does not meet the

394.467, the patient must be discharged from the facility. The

the patient may meet the criteria for involuntary examination, a

the treatment plan which are contested by the patient or the

3. If, in the clinical judgment of a physician or a

disapproved by the court consistent with subsection (3).

psychiatric nurse practicing within the framework of an

or has refused to comply with the treatment ordered by the

court, and, in the clinical judgment of the physician or

available in the program or service for the patient, or if

provider must notify the managing entity if the requested

order must be sent to the managing entity by the service

court. The order may be submitted electronically through

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1741	588-01852-24 20247016 experience justifying the request, a brief description of the		1770	588-01852-24 20247016 of clinical experience is not available to provide the second
1741	<u>experience</u> justifying the request, a brief description of the patient's treatment during the time he or she was receiving		1771	opinion, the second opinion may be provided by a licensed
1742	involuntary services, and an individualized plan of continued		1772	physician who has postgraduate training and experience in
1743	treatment.		1773	diagnosis and treatment of mental illness, a clinical
1744	4. The service provider shall develop the individualized		1774	psychologist with less than 3 years of clinical experience, or
1745	plan of continued treatment in consultation with the patient or		1775	$\frac{1}{2}$ a psychiatric nurse. Any opinion authorized in this
1740	the patient's quardian advocate, if applicable. When the		1776	subsection may be conducted through a face-to-face examination,
1747	petition has been filed, the clerk of the court shall provide		1777	in person, or by electronic means. Such recommendation must
1748	copies of the certificate and the individualized plan of		1778	shall be entered on a petition for involuntary inpatient
1749	continued services to the department, the patient, the patient's		1779	placement certificate that authorizes the facility to retain the
1751	quardian advocate, the state attorney, and the patient's private		1780	patient pending transfer to a treatment facility or completion
1752	counsel or the public defender.		1781	of a hearing.
1753	Section 21. Subsection (2) of section 394.467, Florida		1782	Section 22. Subsection (1) of section 394.4781, Florida
1754	Statutes, is amended to read:		1783	Statutes, is amended to read:
1755	394.467 Involuntary inpatient placement		1784	394.4781 Residential care for psychotic and emotionally
1756	(2) ADMISSION TO A TREATMENT FACILITYA patient may be		1785	disturbed children
1757	retained by a facility or involuntarily placed in a treatment		1786	(1) DEFINITIONSAs used in this section, the term:
1758	facility upon the recommendation of the administrator of the		1787	(b) (a) "Psychotic or severely emotionally disturbed child"
1759	facility where the patient has been examined and after adherence		1788	means a child so diagnosed by a psychiatrist or a clinical
1760	to the notice and hearing procedures provided in s. 394.4599.		1789	psychologist with at least 3 years of clinical experience, each
1761	The recommendation must be supported by the opinion of a		1790	of whom must have who has specialty training and experience with
1762	psychiatrist and the second opinion of a clinical psychologist		1791	children. Such a severely emotionally disturbed child or
1763	with at least 3 years of clinical experience, or another		1792	psychotic child shall be considered by this diagnosis to benefit
1764	psychiatrist, or a psychiatric nurse practicing within the		1793	by and require residential care as contemplated by this section.
1765	framework of an established protocol with a psychiatrist, both		1794	(a) (b) "Department" means the Department of Children and
1766	of whom have personally examined the patient within the		1795	Families.
1767	preceding 72 hours, that the criteria for involuntary inpatient		1796	Section 23. Subsection (2) of section 394.4785, Florida
1768	placement are met. However, if the administrator certifies that		1797	Statutes, is amended to read:
1769	a psychiatrist or <u>a</u> clinical psychologist with at least 3 years		1798	394.4785 Children and adolescents; admission and placement
		1		
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99	in mental facilities		1828	stabilize and redirect a client to the most appropriate and
00	(2) A person under the age of 14 who is admitted to any		1829	least restrictive community setting available, consistent with
)1	hospital licensed pursuant to chapter 395 may not be admitted to		1830	the client's needs. Crisis stabilization units may screen,
)2	a bed in a room or ward with an adult patient in a mental health		1831	assess, and admit for stabilization persons who present
)3	unit or share common areas with an adult patient in a mental		1832	themselves to the unit and persons who are brought to the unit
)4	health unit. However, a person 14 years of age or older may be		1833	under s. 394.463. Clients may be provided 24-hour observation,
)5	admitted to a bed in a room or ward in the mental health unit		1834	medication prescribed by a physician <u>,</u> or psychiatrist, <u>or</u>
06	with an adult if the admitting physician or psychiatric nurse		1835	psychiatric nurse performing within the framework of an
)7	documents in the case record that such placement is medically		1836	established protocol with a psychiatrist, and other appropriate
8	indicated or for reasons of safety. Such placement must shall be		1837	services. Crisis stabilization units shall provide services
9	reviewed by the attending physician or a designee or on-call		1838	regardless of the client's ability to pay and shall be limited
LO	physician each day and documented in the case record.		1839	in size to a maximum of 30 beds.
11	Section 24. Effective upon this act becoming a law, the		1840	Section 26. Paragraphs (i) and (j) are added to subsection
12	Agency for Health Care Administration shall seek federal		1841	(1) of section 395.1055, Florida Statutes, to read:
L3	approval for coverage and reimbursement authority for mobile		1842	395.1055 Rules and enforcement
L4	crisis response services pursuant to 42 U.S.C. s. 1396w-6. The		1843	(1) The agency shall adopt rules pursuant to ss. 120.536(1)
L 5	Department of Children and Families must coordinate with the		1844	and 120.54 to implement the provisions of this part, which shall
16	Agency for Health Care Administration to educate contracted		1845	include reasonable and fair minimum standards for ensuring that:
L7	providers of child, adolescent, and young adult mobile response		1846	(i) A hospital does not accept any payment from a medical
18	team services on the process to enroll as a Medicaid provider;		1847	school in exchange for, or directly or indirectly related to,
19	encourage and incentivize enrollment as a Medicaid provider; and		1848	allowing students from the medical school to obtain clinical
20	reduce barriers to maximizing federal reimbursement for		1849	hours or instruction at that hospital.
21	community-based mobile crisis response services.		1850	(j) All hospitals with an emergency department, including
22	Section 25. Paragraph (a) of subsection (1) of section		1851	hospital-based off-campus emergency departments, submit to the
23	394.875, Florida Statutes, is amended to read:		1852	agency for approval a plan for assisting patients to gain access
24	394.875 Crisis stabilization units, residential treatment		1853	to appropriate care settings when patients either present at the
25	facilities, and residential treatment centers for children and		1854	emergency department with nonemergent health care needs or
26	adolescents; authorized services; license required		1855	indicate, when receiving triage or treatment at the hospital,
27	(1)(a) The purpose of a crisis stabilization unit is to		1856	that they lack regular access to primary care, in order to
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57	divert such patients from presenting at the emergency department
58	for future nonemergent care. Effective July 1, 2025, such
59	emergency department diversion plan must be approved by the
60	agency before the hospital may receive initial licensure or
61	licensure renewal occurring after that date. A hospital with an
52	approved emergency department diversion plan must submit data to
53	the agency demonstrating the effectiveness of its plan on an
54	annual basis and must update the plan as necessary, or as
55	directed by the agency, before each licensure renewal. An
66	emergency department diversion plan must include at least one of
7	the following:
58	1. A partnership agreement with one or more nearby
9	federally qualified health centers or other primary care
0	settings. The goals of such partnership agreement must include,
1	but need not be limited to, identifying patients who present at
2	the emergency department for nonemergent care, care that would
3	best be provided in a primary care setting, or emergency care
4	that could potentially have been avoided through the regular
5	provision of primary care, and establishing a relationship
6	between the patient and the federally qualified health center or
7	other primary care setting so that the patient develops a
8	medical home at such setting for nonemergent and preventative
9	health care services.
30	2. The establishment, construction, and operation of a
1	hospital-owned urgent care center adjacent to the hospital
2	emergency department location or an agreement with an urgent
3	care center within 3 miles of the emergency department if
4	located in an urban area as defined in s. 189.041(1)(b) and
5	within 10 miles of the emergency department if located in a
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1886	rural community as defined in s. 288.0656(2). Under the
1887	hospital's emergency department diversion plan, and as
1888	appropriate for the patients' needs, the hospital shall seek to
1889	divert to the urgent care center those patients who present at
1890	the emergency department needing nonemergent health care
1891	services and subsequently assist the patient in obtaining
1892	primary care.
1893	
1894	For such patients who are enrolled in the Medicaid program and
1895	are members of a Medicaid managed care plan, the hospital's
1896	emergency department diversion plan must include outreach to the
1897	patient's Medicaid managed care plan and coordination with the
1898	managed care plan for establishing a relationship between the
1899	patient and a primary care setting as appropriate for the
1900	patient, which may include a federally qualified health center
1901	or other primary care setting with which the hospital has a
1902	partnership agreement. For such a Medicaid enrollee, the agency
1903	shall establish a process for the hospital to share updated
1904	contact information for the patient, if in the hospital's
1905	possession, with the patient's managed care plan.
1906	Section 27. Present subsections (5) and (6) of section
1907	408.051, Florida Statutes, are redesignated as subsections (6)
1908	and (7), respectively, and a new subsection (5) is added to that
1909	section, to read:
1910	408.051 Florida Electronic Health Records Exchange Act
1911	(5) HOSPITAL DATAA hospital as defined in s. 395.002(12)
1912	which maintains certified electronic health record technology
1913	must make available admit, transfer, and discharge data to the
1914	agency's Florida Health Information Exchange program for the
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1915	 purpose of supporting public health data registries and patient
1916	care coordination. The agency may adopt rules to implement this
1917	subsection.
1918	Section 28. Present subsection (8) of section 409.909,
1919	Florida Statutes, is redesignated as subsection (10), a new
1920	subsection (8) and subsection (9) are added to that section, and
1921	paragraph (a) of subsection (6) of that section is amended, to
1922	read:
1923	409.909 Statewide Medicaid Residency Program
1924	(6) The Slots for Doctors Program is established to address
1925	the physician workforce shortage by increasing the supply of
1926	highly trained physicians through the creation of new resident
1927	positions, which will increase access to care and improve health
1928	outcomes for Medicaid recipients.
1929	(a) <u>1.</u> Notwithstanding subsection (4), the agency shall
1930	annually allocate \$100,000 to hospitals and qualifying
1931	institutions for each newly created resident position that is
1932	first filled on or after June 1, 2023, and filled thereafter,
1933	and that is accredited by the Accreditation Council for Graduate
1934	Medical Education or the Osteopathic Postdoctoral Training
1935	Institution in an initial or established accredited training
1936	program which is in a physician specialty or subspecialty in a
1937	statewide supply-and-demand deficit.
1938	2. Notwithstanding the requirement that a new resident
1939	position be created to receive funding under this subsection,
1940	the agency may allocate \$100,000 to hospitals and qualifying
1941	institutions, pursuant to subparagraph 1., for up to 200
1942	resident positions that existed before July 1, 2023, if such
1943	resident position:
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1944	a. Is in a physician specialty or subspecialty experiencing
1945	a statewide supply-and-demand deficit;
1946	b. Has been unfilled for a period of 3 or more years;
1947	c. Is subsequently filled on or after June 1, 2024, and
1948	remains filled thereafter; and
1949	d. Is accredited by the Accreditation Council for Graduate
1950	Medical Education or the Osteopathic Postdoctoral Training
1951	Institution in an initial or established accredited training
1952	program.
1953	3. If applications for resident positions under this
1954	paragraph exceed the number of authorized resident positions or
1955	the available funding allocated, the agency shall prioritize
1956	applications for resident positions that are in a primary care
1957	specialty as specified in paragraph (2)(a).
1958	(8) If a hospital or qualifying institution receives state
1959	funds, including, but not limited to, intergovernmental
1960	transfers, under any of the programs established under this
1961	chapter, that hospital or qualifying institution must annually
1962	report to the agency data on each resident position funded.
1963	(a) Specific to funds allocated under this section, other
1964	than funds allocated pursuant to subsection (5), the data
1965	required to be reported under this subsection must include, but
1966	is not limited to, all of the following:
1967	1. The sponsoring institution for the resident position. A
1968	used in this section, the term "sponsoring institution" means a
1969	organization that oversees, supports, and administers one or
1970	more resident positions.
1971	2. The year the position was created and the current
1972	program year of the resident who is filling the position.
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1973	3. Whether the position is currently filled and whether
1974	there has been any period of time when it was not filled.
1975	4. The specialty or subspecialty for which the position is
1976	accredited and whether the position is a fellowship position.
1977	5. Each state funding source that was used to create the
1978	position or is being used to maintain the position, and the
1979	general purpose for which the funds were used.
1980	(b) Specific to funds allocated pursuant to subsection (5)
1981	on or after July 1, 2021, the data must include, but is not
1982	limited to, all of the following:
1983	1. The date on which the hospital or qualifying institution
1984	applied for funds under the program.
1985	2. The date on which the position funded by the program
1986	became accredited.
1987	3. The date on which the position was first filled and
1988	whether it has remained filled.
1989	4. The specialty of the position created.
1990	(c) Beginning on July 1, 2025, each hospital or qualifying
1991	institution shall annually produce detailed financial records no
1992	later than 30 days after the end of its fiscal year, detailing
1993	the manner in which state funds allocated under this section
1994	were expended. This requirement does not apply to funds
1995	allocated before July 1, 2025. The agency may also require that
1996	any hospital or qualifying institution submit to an audit of its
1997	financial records related to funds allocated under this section
1998	after July 1, 2025.
1999	(d) If a hospital or qualifying institution fails to
2000	produce records as required by this section, such hospital or
2001	gualifying institution is no longer eligible to participate in
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2002	any program established under this section until the hospital or
2003	qualifying institution has met the agency's requirements for
2004	producing the required records.
2005	(e) Upon completion of a residency, each hospital or
2006	gualifying institution must request that the resident fill out
2007	an exit survey on a form developed by the agency. The completed
2008	exit surveys must be provided to the agency annually. The exit
2009	survey must include, but need not be limited to, questions on
2010	all of the following:
2011	1. Whether the exiting resident has procured employment.
2012	2. Whether the exiting resident plans to leave the state
2013	and, if so, for which reasons.
2014	3. Where and in which specialty the exiting resident
2015	intends to practice.
2016	4. Whether the exiting resident envisions himself or
2017	herself working in the medical field as a long-term career.
2018	(9) The Graduate Medical Education Committee is created
2019	within the agency.
2020	(a) The committee shall be composed of the following
2021	members:
2022	1. Three deans, or their designees, from medical schools in
2023	this state, appointed by the chair of the Council of Florida
2024	Medical School Deans.
2025	2. Four members appointed by the Governor, one of whom is a
2026	representative of the Florida Medical Association or the Florida
2027	Osteopathic Medical Association who has supervised or is
2028	currently supervising residents, one of whom is a member of the
2029	Florida Hospital Association, one of whom is a member of the
2030	Safety Net Hospital Alliance, and one of whom is a physician
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2031	licensed under chapter 458 or chapter 459 practicing at a
2032	gualifying institution.
2033	3. Two members appointed by the Secretary of Health Care
2034	Administration, one of whom represents a statutory teaching
2035	hospital as defined in s. 408.07(46) and one of whom is a
2036	physician who has supervised or is currently supervising
2037	residents.
2038	4. Two members appointed by the State Surgeon General, one
2039	of whom must represent a teaching hospital as defined in s.
2040	408.07 and one of whom is a physician who has supervised or is
2041	currently supervising residents or interns.
2042	5. Two members, one appointed by the President of the
2043	Senate and one appointed by the Speaker of the House of the
2044	Representatives.
2045	(b)1. The members of the committee appointed under
2046	subparagraph (a)1. shall serve 4-year terms. When such members'
2047	terms expire, the chair of the Council of Florida Medical School
2048	Deans shall appoint new members as detailed in paragraph (a)1.
2049	from different medical schools on a rotating basis and may not
2050	reappoint a dean from a medical school that has been represented
2051	on the committee until all medical schools in the state have had
2052	an opportunity to be represented on the committee.
2053	2. The members of the committee appointed under
2054	subparagraphs (a)2., 3., and 4. shall serve 4-year terms, with
2055	the initial term being 3 years for members appointed under
2056	subparagraph (a)4. and 2 years for members appointed under
2057	subparagraph (a)3. The committee shall elect a chair to serve
2058	for a 1-year term.
2059	(c) Members shall serve without compensation but are
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2060	entitled to reimbursement for per diem and travel expenses
2061	pursuant to s. 112.061.
2062	(d) The committee shall convene its first meeting by July
2063	1, 2024, and shall meet as often as necessary to conduct its
2064	business, but at least twice annually, at the call of the chair.
2065	The committee may conduct its meetings though teleconference or
2066	other electronic means. A majority of the members of the
2067	committee constitutes a quorum, and a meeting may not be held
2068	with less than a quorum present. The affirmative vote of a
2069	majority of the members of the committee present is necessary
2070	for any official action by the committee.
2071	(e) Beginning on July 1, 2025, the committee shall submit
2072	an annual report to the Governor, the President of the Senate,
2073	and the Speaker of the House of Representatives which must, at a
2074	minimum, detail all of the following:
2075	1. The role of residents and medical faculty in the
2076	provision of health care.
2077	2. The relationship of graduate medical education to the
2078	state's physician workforce.
2079	3. The typical workload for residents and the role such
2080	workload plays in retaining physicians in the long-term
2081	workforce.
2082	4. The costs of training medical residents for hospitals
2083	and qualifying institutions.
2084	5. The availability and adequacy of all sources of revenue
2085	available to support graduate medical education.
2086	6. The use of state funds, including, but not limited to,
2087	intergovernmental transfers, for graduate medical education for
2088	each hospital or qualifying institution receiving such funds.
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2089	(f) The agency shall provide reasonable and necessary
2090	support staff and materials to assist the committee in the
091	performance of its duties. The agency shall also provide the
092	information obtained pursuant to subsection (8) to the committee
093	and assist the committee, as requested, in obtaining any other
094	information deemed necessary by the committee to produce its
095	report.
096	Section 29. Section 409.91256, Florida Statutes, is created
097	to read:
098	409.91256 Training, Education, and Clinicals in Health
099	(TEACH) Funding Program
100	(1) PURPOSE AND INTENTThe Training, Education, and
101	Clinicals in Health (TEACH) Funding Program is created to
102	provide a high-quality educational experience while supporting
103	participating federally qualified health centers, community
104	mental health centers, rural health clinics, and certified
105	community behavioral health clinics by offsetting administrative
106	costs and loss of revenue associated with training residents and
107	students to become licensed health care practitioners. Further,
108	it is the intent of the Legislature to use the program to
109	support the state Medicaid program and underserved populations
110	by expanding the available health care workforce.
111	(2) DEFINITIONSAs used in this section, the term:
112	(a) "Agency" means the Agency for Health Care
113	Administration.
114	(b) "Preceptor" means a Florida-licensed health care
115	practitioner who directs, teaches, supervises, and evaluates the
116	learning experience of a resident or student during a clinical
117	rotation.
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2118	(c) "Primary care specialty" means general internal
2119	medicine, family medicine, obstetrics and gynecology, general
2120	pediatrics, psychiatry, geriatric medicine, or any other
2121	specialty the agency identifies as primary care.
2122	(d) "Qualified facility" means a federally qualified health
2123	center, a community mental health center, rural health clinic,
2124	or a certified community behavioral health clinic.
2125	(3) APPLICATION FOR REIMBURSEMENT; AGREEMENTS;
2126	PARTICIPATION REQUIREMENTSThe agency shall develop an
2127	application process for qualified facilities to apply for funds
2128	to offset the administrative costs and loss of revenue
2129	associated with establishing, maintaining, or expanding a
2130	clinical training program. Upon approving an application, the
2131	agency shall enter into an agreement with the qualified facility
2132	which, at minimum, must require the qualified facility to do all
2133	of the following:
2134	(a) Agree to provide appropriate supervision or precepting
2135	for one or more of the following categories of residents or
2136	students:
2137	1. Allopathic or osteopathic residents pursuing a primary
2138	care specialty.
2139	2. Advanced practice registered nursing students pursuing a
2140	primary care specialty.
2141	3. Nursing students.
2142	4. Allopathic or osteopathic medical students.
2143	5. Dental students.
2144	6. Physician assistant students.
2145	7. Behavioral health students, including students studying
2146	psychology, clinical social work, marriage and family therapy,
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2147	or mental health counseling.
2148	(b) Meet and maintain all requirements to operate an
2149	accredited residency program if the qualified facility operates
2150	a residency program.
2151	(c) Obtain and maintain accreditation from an accreditation
2152	body approved by the agency if the qualified facility provides
2153	clinical rotations.
2154	(d) Ensure that clinical preceptors meet agency standards
2155	for precepting students, including the completion of any
2156	training required by the agency.
2157	(e) Submit quarterly reports to the agency by the first day
2158	of the second month following the end of a quarter to obtain
2159	reimbursement. At a minimum, the report must include all of the
2160	following:
2161	1. The type of residency or clinical rotation offered by
2162	the qualified facility, the number of residents or students
2163	participating in each type of clinical rotation or residency,
2164	and the number of hours worked by each resident or student each
2165	month.
2166	2. Evaluations by the residents and student participants of
2167	the clinical experience on an evaluation form developed by the
2168	agency.
2169	3. An itemized list of administrative costs associated with
2170	the operation of the clinical training program, including
2171	accreditation costs and other costs relating to the creation,
2172	implementation, and maintenance of the program.
2173	4. A calculation of lost revenue associated with operating
2174	the clinical training program.
2175	(4) TRAININGThe agency, in consultation with the
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2176	Department of Health, shall develop, or contract for the
2177	development of, training for preceptors and make such training
2178	available in either a live or electronic format. The agency
2179	shall also provide technical support for preceptors.
2180	(5) REIMBURSEMENTQualified facilities may be reimbursed
2181	under this section only to offset the administrative costs or
2182	lost revenue associated with training students, allopathic
2183	residents, or osteopathic residents who are enrolled in an
2184	accredited educational or residency program based in this state.
2185	(a) Subject to an appropriation, the agency may reimburse a
2186	qualified facility based on the number of clinical training
2187	hours reported under subparagraph (3)(e)1. The allowed
2188	reimbursement per student is as follows:
2189	1. A medical resident at a rate of \$50 per hour.
2190	2. A first-year medical student at a rate of \$27 per hour.
2191	3. A second-year medical student at a rate of \$27 per hour.
2192	4. A third-year medical student at a rate of \$29 per hour.
2193	5. A fourth-year medical student at a rate of \$29 per hour.
2194	6. A dental student at a rate of \$22 per hour.
2195	7. An advanced practice registered nursing student at a
2196	rate of \$22 per hour.
2197	8. A physician assistant student at a rate of \$22 per hour.
2198	9. A behavioral health student at a rate of \$15 per hour.
2199	(b) A qualified facility may not be reimbursed more than
2200	\$75,000 per fiscal year; however, if it operates a residency
2201	program, it may be reimbursed up to \$100,000 each fiscal year.
2202	(6) DATAA qualified facility that receives payment under
2203	the program shall furnish information requested by the agency
2204	for the purpose of the agency's duties under subsections (7) and
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2205	(8).
2206	(7) REPORTSBy December 1, 2025, and each December 1
2207	thereafter, the agency shall submit to the Governor, the
2208	President of the Senate, and the Speaker of the House of
2209	Representatives a report detailing the effects of the program
2210	for the prior fiscal year, including, but not limited to, all of
2211	the following:
2212	(a) The number of students trained in the program, by
2213	school, area of study, and clinical hours earned.
2214	(b) The number of students trained and the amount of
2215	program funds received by each participating qualified facility.
2216	(c) The number of program participants found to be employed
2217	by a participating qualified facility or in a federally
2218	designated health professional shortage area upon completion of
2219	their education and training.
2220	(d) Any other data the agency deems useful for determining
2221	the effectiveness of the program.
2222	(8) EVALUATIONThe agency shall contract with an
2223	independent third party to develop and conduct a design study to
2224	evaluate the impact of the TEACH funding program, including, but
2225	not limited to, the program's effectiveness in both of the
2226	following areas:
2227	(a) Enabling qualified facilities to provide clinical
2228	rotations and residency opportunities to students and medical
2229	school graduates, as applicable.
2230	(b) Enabling the recruitment and retention of health care
2231	professionals in geographic and practice areas experiencing
2232	shortages.
2233	
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2234	The agency shall begin collecting data for the study by January	
2235	1, 2025, and shall submit the results of the study to the	
2236	Governor, the President of the Senate, and the Speaker of the	
2237	House of Representatives by January 1, 2030.	
2238	(9) RULESThe agency may adopt rules to implement this	
2239	section.	
2240	(10) FEDERAL FUNDINGThe agency shall seek federal	
2241	approval to use Title XIX matching funds for the program.	
2242	(11) SUNSETThis section is repealed on July 1, 2034.	
2243	Section 30. Paragraph (e) of subsection (2) of section	
2244	409.967, Florida Statutes, is amended to read:	
2245	409.967 Managed care plan accountability	
2246	(2) The agency shall establish such contract requirements	
2247	as are necessary for the operation of the statewide managed care	
2248	program. In addition to any other provisions the agency may deem	
2249	necessary, the contract must require:	
2250	(e) Encounter data.—The agency shall maintain and operate a	
2251	Medicaid Encounter Data System to collect, process, store, and	
2252	report on covered services provided to all Medicaid recipients	
2253	enrolled in prepaid plans.	
2254	1. Each prepaid plan must comply with the agency's	
2255	reporting requirements for the Medicaid Encounter Data System.	
2256	Prepaid plans must submit encounter data electronically in a	
2257	format that complies with the Health Insurance Portability and	
2258	Accountability Act provisions for electronic claims and in	
2259	accordance with deadlines established by the agency. Prepaid	
2260	plans must certify that the data reported is accurate and	
2261	complete.	
2262	2. The agency is responsible for validating the data	
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2263	submitted by the plans. The agency shall develop methods and
2264	protocols for ongoing analysis of the encounter data that
2265	adjusts for differences in characteristics of prepaid plan
2266	enrollees to allow comparison of service utilization among plans
2267	and against expected levels of use. The analysis shall be used
2268	to identify possible cases of systemic underutilization or
2269	denials of claims and inappropriate service utilization such as
2270	higher-than-expected emergency department encounters. The
2271	analysis shall provide periodic feedback to the plans and enable
2272	the agency to establish corrective action plans when necessary.
2273	One of the focus areas for the analysis shall be the use of
2274	prescription drugs.
2275	3. The agency shall make encounter data available to those
2276	plans accepting enrollees who are assigned to them from other
2277	plans leaving a region.
2278	4. The agency shall annually produce a report entitled
2279	"Analysis of Potentially Preventable Health Care Events of
2280	Florida Medicaid Enrollees." The report must include, but need
2281	not be limited to, an analysis of the potentially preventable
2282	hospital emergency department visits, hospital admissions, and
2283	hospital readmissions that occurred during the previous state
2284	fiscal year which may have been prevented with better access to
2285	primary care, improved medication management, or better
2286	coordination of care, reported by age, eligibility group,
2287	managed care plan, and region, including conditions contributing
2288	to each potentially preventable event or category of potentially
2289	preventable events. The agency may include any other data or
2290	analysis parameters to augment the report which it deems
2291	pertinent to the analysis. The report must demonstrate trends
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2292	using applicable historical data. The agency shall submit the
2293	report to the Governor, the President of the Senate, and the
2294	Speaker of the House of Representatives by October 1, 2024, and
2295	each October 1 thereafter. The agency may contract with a third-
2296	party vendor to produce the report required under this
2297	subparagraph.
2298	Section 31. Subsection (4) of section 409.973, Florida
2299	Statutes, is amended to read:
2300	409.973 Benefits
2301	(4) PRIMARY CARE INITIATIVEEach plan operating in the
2302	managed medical assistance program shall establish a program to
2303	encourage enrollees to establish a relationship with their
2304	primary care provider. Each plan shall:
2305	(a) Provide information to each enrollee on the importance
2306	of and procedure for selecting a primary care provider, and
2307	thereafter automatically assign to a primary care provider any
2308	enrollee who fails to choose a primary care provider.
2309	(b) If the enrollee was not a Medicaid recipient before
2310	enrollment in the plan, assist the enrollee in scheduling an
2311	appointment with the primary care provider. If possible, the
2312	appointment should be made within 30 days after enrollment in
2313	the plan. If an appointment is not made within such 30-day
2314	period, the plan must continue assisting the enrollee to
2315	schedule an initial appointment.
2316	(c) Report to the agency the number of enrollees assigned
2317	to each primary care provider within the plan's network.
2318	(d) Report to the agency the number of enrollees who have
2319	not had an appointment with their primary care provider within
2320	their first year of enrollment.
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2321	(e) Report to the agency the number of emergency room			
2322	visits by enrollees who have not had at least one appointment			
2323	with their primary care provider.			
2324	(f) Coordinate with a hospital that contacts the plan under			
2325	the requirements of s. 395.1055(1)(j) for the purpose of			
2326	establishing the appropriate delivery of primary care services			
2327	for the plan's members who present at the hospital's emergency			
2328	department for nonemergent care or emergency care that could			
2329	potentially have been avoided through the regular provision of			
2330	primary care. The plan shall coordinate with such member and the			
2331	member's primary care provider for such purpose.			
2332	Section 32. The Agency for Health Care Administration shall			
2333	seek federal approval necessary to implement an acute hospital			
2334	care at home program in the state Medicaid program which is			
2335	substantially consistent with the parameters specified in 42			
2336	U.S.C. s. 1395cc-7(a)(2) and (3).			
2337	Section 33. Present subsections (3) through (8) of section			
2338	458.311, Florida Statutes, are redesignated as subsections (4)			
2339	through (9), respectively, a new subsection (3) is added to that			
2340	section, and paragraph (f) of subsection (1) and present			
2341	subsections (3) and (5) of that section are amended, to read:			
2342	458.311 Licensure by examination; requirements; fees			
2343	(1) Any person desiring to be licensed as a physician, who			
2344	does not hold a valid license in any state, shall apply to the			
2345	department on forms furnished by the department. The department			
2346	shall license each applicant who the board certifies:			
2347	(f) Meets one of the following medical education and			
2348	postgraduate training requirements:			
2349	1.a. Is a graduate of an allopathic medical school or			
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2350	allopathic college recognized and approved by an accrediting
2351	agency recognized by the United States Office of Education or is
2352	a graduate of an allopathic medical school or allopathic college
2353	within a territorial jurisdiction of the United States
2354	recognized by the accrediting agency of the governmental body of
2355	that jurisdiction;
2356	b. If the language of instruction of the medical school is
2357	other than English, has demonstrated competency in English
2358	through presentation of a satisfactory grade on the Test of
2359	Spoken English of the Educational Testing Service or a similar
2360	test approved by rule of the board; and
2361	c. Has completed an approved residency of at least 1 year.
2362	2.a. Is a graduate of an allopathic foreign medical school
2363	registered with the World Health Organization and certified
2364	pursuant to s. 458.314 as having met the standards required to
2365	accredit medical schools in the United States or reasonably
2366	comparable standards;
2367	b. If the language of instruction of the foreign medical
2368	school is other than English, has demonstrated competency in
2369	English through presentation of the Educational Commission for
2370	Foreign Medical Graduates English proficiency certificate or by
2371	a satisfactory grade on the Test of Spoken English of the
2372	Educational Testing Service or a similar test approved by rule
2373	of the board; and
2374	c. Has completed an approved residency of at least 1 year.
2375	3.a. Is a graduate of an allopathic foreign medical school
2376	which has not been certified pursuant to s. 458.314 $\underline{\text{and has not}}$
2377	been excluded from consideration under s. 458.314(8);
2378	b. Has had his or her medical credentials evaluated by the
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2379	Educational Commission for Foreign Medical Graduates, holds an
2380	active, valid certificate issued by that commission, and has
2381	passed the examination utilized by that commission; and
2382	c. Has completed an approved residency of at least 1 year;
2383	however, after October 1, 1992, the applicant shall have
2384	completed an approved residency or fellowship of at least 2
2385	years in one specialty area. However, to be acceptable, the
2386	fellowship experience and training must be counted toward
2387	regular or subspecialty certification by a board recognized and
2388	certified by the American Board of Medical Specialties.
2389	(3) Notwithstanding sub-subparagraphs (1)(f)2.c. and 3.c.,
2390	a graduate of a foreign medical school that has not been
2391	excluded from consideration under s. 458.314(8) is not required
2392	to complete an approved residency if he or she meets all of the
2393	following criteria:
2394	(a) Has an active, unencumbered license to practice
2395	medicine in a foreign country.
2396	(b) Has actively practiced medicine in the 4-year period
2397	preceding the date of the submission of a licensure application.
2398	(c) Has completed a residency or substantially similar
2399	postgraduate medical training in a country recognized by his or
2400	her licensing jurisdiction.
2401	(d) Has an offer for full-time employment as a physician
2402	from a health care provider that operates in this state.
2403	
2404	A physician licensed after meeting the requirements of this
2405	subsection must maintain his or her employment with the original
2406	employer under paragraph (d) or with another health care
2407	provider that operates in this state, at a location within this
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2408	state, for at least 2 consecutive years after licensure, in
2409	accordance with rules adopted by the board. Such physician must
2410	notify the board within 5 business days after any change of
2411	employer.
2412	(4)(3) Notwithstanding the provisions of subparagraph
2413	(1)(f)3., a graduate of a foreign medical school that has not
2414	been excluded from consideration under s. 458.314(8) need not
2415	present the certificate issued by the Educational Commission for
2416	Foreign Medical Graduates or pass the examination utilized by
2417	that commission if the graduate:
2418	(a) Has received a bachelor's degree from an accredited
2419	United States college or university.
2420	(b) Has studied at a medical school which is recognized by
2421	the World Health Organization.
2422	(c) Has completed all of the formal requirements of the
2423	foreign medical school, except the internship or social service
2424	requirements, and has passed part I of the National Board of
2425	Medical Examiners examination or the Educational Commission for
2426	Foreign Medical Graduates examination equivalent.
2427	(d) Has completed an academic year of supervised clinical
2428	training in a hospital affiliated with a medical school approved
2429	by the Council on Medical Education of the American Medical
2430	Association and upon completion has passed part II of the
2431	National Board of Medical Examiners examination or the
2432	Educational Commission for Foreign Medical Graduates examination
2433	equivalent.
2434	(6)(5) The board may not certify to the department for
2435	licensure any applicant who is under investigation in another
2436	jurisdiction for an offense which would constitute a violation
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243	of this chapter until such investigation is completed. Upon		2466	
243	completion of the investigation, the provisions of s. 458.331		2467	curriculum, reasonably comparable to that of similar accredited
243	shall apply. Furthermore, the department may not issue an		2468	institutions in the United States shall be considered fully
244	unrestricted license to any individual who has committed any act		2469	certified, for purposes of chapter 86-245, Laws of Florida.
244	or offense in any jurisdiction which would constitute the basis		2470	Section 36. Subsections (1) and (4) of section 458.3145,
244	for disciplining a physician pursuant to s. 458.331. When the		2471	Florida Statutes, are amended to read:
244	board finds that an individual has committed an act or offense		2472	458.3145 Medical faculty certificate
244	in any jurisdiction which would constitute the basis for		2473	(1) A medical faculty certificate may be issued without
244	disciplining a physician pursuant to s. 458.331, then the board		2474	examination to an individual who meets all of the following
244	5 may enter an order imposing one or more of the terms set forth		2475	criteria:
244	in subsection (9) (8).		2476	(a) Is a graduate of an accredited medical school or its
244	Section 34. Section 458.3124, Florida Statutes, is		2477	equivalent, or is a graduate of a foreign medical school listed
244	repealed.		2478	with the World Health Organization which has not been excluded
245	Section 35. Subsection (8) of section 458.314, Florida		2479	from consideration under s. 458.314(8).+
245	Statutes, is amended to read:		2480	(b) Holds a valid, current license to practice medicine in
245	458.314 Certification of foreign educational institutions		2481	another jurisdiction.+
245	(8) If a foreign medical school does not seek certification		2482	(c) Has completed the application form and remitted a
245	under this section, the board may, at its discretion, exclude		2483	nonrefundable application fee not to exceed \$500 $_{\cdot \dot{\tau}}$
245	the foreign medical school from consideration as an institution		2484	(d) Has completed an approved residency or fellowship of at
245	that provides medical education that is reasonably comparable to		2485	least 1 year or has received training that which has been
245	that of similar accredited institutions in the United States and		2486	determined by the board to be equivalent to the 1-year residency
245	that adequately prepares its students for the practice of		2487	requirement_+
245	medicine in this state. However, a license or medical faculty		2488	(e) Is at least 21 years of age. $\dot{\cdot}$
246	certificate issued to a physician under this chapter before July		2489	(f) Is of good moral character <u>.</u> ;
246	1, 2024, is not affected by this subsection Each institution		2490	(g) Has not committed any act in this or any other
246	which has been surveyed before October 1, 1986, by the		2491	jurisdiction which would constitute the basis for disciplining a
246	Commission to Evaluate Foreign Medical Schools or the Commission		2492	physician under s. 458.331 <u>.</u> +
246	on Foreign Medical Education of the Federation of State Medical		2493	(h) For any applicant who has graduated from medical school
246	Boards, Inc., and whose survey and supporting documentation		2494	after October 1, 1992, has completed, before entering medical
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2495	school, the equivalent of 2 academic years of preprofessional,			2524	critical need
2496	postsecondary education, as determined by rule of the board,			2525	(1) A physician or physician assistant who is licensed to
2497	which must include, at a minimum, courses in such fields as			2526	practice in any jurisdiction of the United States and $_{ au}$ whose
2498	anatomy, biology, and chemistry <u>.; and</u>			2527	license is currently valid, and who pays an application fee of
2499	(i) Has been offered and has accepted a full-time faculty			2528	$\frac{3000}{300}$ may be issued a temporary certificate for practice in areas
2500	appointment to teach in a program of medicine at any of the			2529	of critical need. A physician seeking such certificate must pay
2501	following institutions:			2530	an application fee of \$300.
2502	1. The University of Florida <u>.</u> +			2531	(2) A temporary certificate may be issued under this
2503	2. The University of Miami.+			2532	section to a physician or physician assistant who will:
2504	3. The University of South Florida.+			2533	(a) Will Practice in an area of critical need;
2505	4. The Florida State University <u>.</u> +			2534	(b) $Will$ Be employed by or practice in a county health
2506	5. The Florida International University. ;			2535	department; correctional facility; Department of Veterans'
2507	6. The University of Central Florida <u>.</u> +			2536	Affairs clinic; community health center funded by s. 329, s.
2508	7. The Mayo Clinic College of Medicine and Science in			2537	330, or s. 340 of the United States Public Health Services Act;
2509	Jacksonville, Florida <u>.</u> +			2538	or other agency or institution that is approved by the State
2510	8. The Florida Atlantic University <u>.</u> +			2539	Surgeon General and provides health care <u>services</u> to meet the
2511	9. The Johns Hopkins All Children's Hospital in St.			2540	needs of underserved populations in this state; or
2512	Petersburg, Florida <u>.</u> +			2541	(c) $\frac{1}{2}$ Practice for a limited time to address critical
2513	10. Nova Southeastern University .; or			2542	physician-specialty, demographic, or geographic needs for this
2514	11. Lake Erie College of Osteopathic Medicine.			2543	state's physician workforce as determined by the State Surgeon
2515	(4) In any year, the maximum number of extended medical			2544	General.
2516	faculty certificateholders as provided in subsection (2) may not			2545	(3) The board of Medicine may issue \underline{a} this temporary
2517	exceed 30 persons at each institution named in subparagraphs			2546	certificate under this section subject to with the following
2518	(1)(i)16., 8., and 9. and at the facility named in s. 1004.43			2547	restrictions:
2519	and may not exceed 10 persons at the institution named in			2548	(a) The State Surgeon General shall determine the areas of
2520	subparagraph (1) (i) 7.			2549	critical need. Such areas include, but are not limited to,
2521	Section 37. Section 458.315, Florida Statutes, is amended			2550	health professional shortage areas designated by the United
2522	to read:			2551	States Department of Health and Human Services.
2523	458.315 Temporary certificate for practice in areas of			2552	1. A recipient of a temporary certificate for practice in
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areas of critical need may use the certificate to work for any	2582 documentation confirming that the applicant has met any
approved entity in any area of critical need or as authorized by	2583 reasonable conditions of the board which may include, b
the State Surgeon General.	2584 not limited to, completing continuing education or unde
2. The recipient of a temporary certificate for practice in	2585 assessment of skills and training.
areas of critical need shall, within 30 days after accepting	2586 (c) Any certificate issued under this section is w
employment, notify the board of all approved institutions in	2587 so long as the State Surgeon General determines that th
which the licensee practices and of all approved institutions	2588 for which it was issued remains a critical need to the
where practice privileges have been denied, as applicable.	2589 The board of Medicine shall review each temporary
(b) The board may administer an abbreviated oral	2590 certificateholder <u>at least</u> not less than annually to as
examination to determine the physician's or physician	2591 that the certificateholder is complying with the minimu
assistant's competency, but a written regular examination is not	2592 requirements of the Medical Practice Act and its adopte
required. Within 60 days after receipt of an application for a	2593 as applicable to the certificateholder are being compli-
temporary certificate, the board shall review the application	2594 If it is determined that the certificateholder is not m
and issue the temporary certificate, notify the applicant of	2595 such minimum requirements are not being met, the board
denial, or notify the applicant that the board recommends	2596 shall revoke such certificate or shall impose restricti
additional assessment, training, education, or other	2597 conditions, or both, as a condition of continued practi
requirements as a condition of certification. If the applicant	2598 the certificate.
has not actively practiced during the <u>3-year period immediately</u>	(d) The board may not issue a temporary certificat
preceding the application prior 3 years and the board determines	2600 practice in an area of critical need to any physician o
that the applicant may lack clinical competency, possess	2601 physician assistant who is under investigation in any
diminished or inadequate skills, lack necessary medical	2602 jurisdiction in the United States for an act that would
knowledge, or exhibit patterns of deficits in clinical	2603 constitute a violation of this chapter until such time
decisionmaking, the board may:	2604 investigation is complete, at which time the provisions
1. Deny the application;	2605 458.331 <u>applies</u> apply .
2. Issue a temporary certificate having reasonable	2606 (4) The application fee and all licensure fees, in
restrictions that may include, but are not limited to, a	2607 neurological injury compensation assessments, are shall
requirement for the applicant to practice under the supervision	2608 waived for those persons obtaining a temporary certific
of a physician approved by the board; or	2609 practice in areas of critical need for the purpose of p
3. Issue a temporary certificate upon receipt of	2610 volunteer, uncompensated care for low-income residents.
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2611	applicant must submit an affidavit from the employing agency or	2640	months after he or she is granted a limited license under this
2612	institution stating that the physician or physician assistant	2641	subsection for practice, unless the board determines that a
2613	will not receive any compensation for any <u>health care services</u>	2642	shorter period of supervision will be sufficient to ensure that
2614	provided by the applicant service involving the practice of	2643	the applicant is qualified for licensure. Procedures for such
2615	medicine.	2644	supervision $\underline{\text{must}}$ shall be established by the board.
2616	Section 38. Section 458.317, Florida Statutes, is amended	2645	(c) The recipient of a limited license under this
2617	to read:	2646	subsection may practice only in the employ of public agencies or
2618	458.317 Limited licenses	2647	institutions or nonprofit agencies or institutions meeting the
2619	(1) PHYSICIANS LICENSED IN UNITED STATES JURISDICTIONS	2648	requirements of s. 501(c)(3) of the Internal Revenue Code, which
2620	(a) Any person desiring to obtain a limited license <u>under</u>	2649	agencies or institutions are located in the areas of critical
2621	$\underline{\text{this subsection}}$ shall submit to the board an application and fee	2650	medical need as determined by the board. Determination of
2622	not to exceed $\$300$ and demonstrate that he or she has been	2651	medically underserved areas shall be made by the board after
2623	licensed to practice medicine in any jurisdiction in the United	2652	consultation with the department $\frac{\partial f}{\partial t}$ Health and statewide medical
2624	States for at least 10 years and intends to practice only	2653	organizations; however, such determination shall include, but
2625	pursuant to the restrictions of a limited license granted	2654	not be limited to, health professional shortage areas designated
2626	pursuant to this $\underline{subsection} \ \underline{section}$. However, a physician who is	2655	by the United States Department of Health and Human Services. A
2627	not fully retired in all jurisdictions may use a limited license	2656	recipient of a limited license under this subsection may use the
2628	only for noncompensated practice. If the person applying for a	2657	license to work for any approved employer in any area of
2629	limited license submits a statement from the employing agency or	2658	critical need approved by the board.
2630	institution stating that he or she will not receive compensation	2659	(d) The recipient of a limited license shall, within 30
2631	for any service involving the practice of medicine, the	2660	days after accepting employment, notify the board of all
2632	application fee and all licensure fees shall be waived. However,	2661	approved institutions in which the licensee practices and of all
2633	any person who receives a waiver of fees for a limited license	2662	approved institutions where practice privileges have been
2634	shall pay such fees if the person receives compensation for the	2663	denied.
2635	practice of medicine.	2664	(e) This subsection does not limit Nothing herein limits in
2636	(b) If it has been more than 3 years since active practice	2665	any way any policy by the board, otherwise authorized by law, to
2637	was conducted by the applicant, the full-time director of the	2666	grant licenses to physicians duly licensed in other states under
2638	county health department or a licensed physician, approved by	2667	conditions less restrictive than the requirements of this
2639	the board, $\underline{\text{must}}\ \underline{\text{shall}}\ \underline{\text{supervise}}$ the applicant for a period of 6	2668	$\underline{subsection}$ section. Notwithstanding the other provisions of this
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2669	subsection section, the board may refuse to authorize a
2670	physician otherwise qualified to practice in the employ of any
2671	agency or institution otherwise qualified if the agency or
2672	institution has caused or permitted violations of the provisions
2673	of this chapter which it knew or should have known were
2674	occurring.
2675	(f) (2). The board shall notify the director of the full-time
2676	local county health department of any county in which a licensee
2677	intends to practice under the provisions of this subsection act.
2678	The director of the full-time county health department shall
2679	assist in the supervision of any licensee within the county and
2680	shall notify the board which issued the licensee his or her
2681	license if he or she becomes aware of any actions by the
2682	licensee which would be grounds for revocation of the limited
2683	license. The board shall establish procedures for such
2684	supervision.
2685	(g) (3) The board shall review the practice of each licensee
2686	biennially to verify compliance with the restrictions prescribed
2687	in this $\underline{subsection}$ section and other applicable provisions of
2688	this chapter.
2689	(h)(4) Any person holding an active license to practice
2690	medicine in $\underline{\text{this}}$ the state may convert that license to a limited
2691	license under this subsection for the purpose of providing
2692	volunteer, uncompensated care for low-income Floridians. The
2693	applicant must submit a statement from the employing agency or
2694	institution stating that he or she will not receive compensation
2695	for any service involving the practice of medicine. The
2696	application \underline{fee} and all licensure fees, including neurological
2697	injury compensation assessments, <u>are</u> shall be waived <u>for such</u>
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 $\textbf{CODING: Words } \underline{stricken} \text{ are deletions; words } \underline{underlined} \text{ are additions.}$

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2698	applicant.
2699	(2) GRADUATE ASSISTANT PHYSICIANS.—A graduate assistant
2700	physician is a medical school graduate who meets the
2701	requirements of this subsection and has obtained a limited
2702	license from the board for the purpose of practicing temporarily
2703	under the direct supervision of a physician who has a full,
2704	active, and unencumbered license issued under this chapter,
2705	pending the graduate's entrance into a residency under the
2706	National Resident Match Program.
2707	(a) Any person desiring to obtain a limited license as a
2708	graduate assistant physician must submit to the board an
2709	application and demonstrate that he or she meets all of the
2710	following criteria:
2711	1. Is a graduate of an allopathic medical school or
2712	allopathic college approved by an accrediting agency recognized
2713	by the United States Department of Education.
2714	2. Has successfully passed all parts of the United States
2715	Medical Licensing Examination.
2716	3. Has not received and accepted a residency match from the
2717	National Resident Match Program within the first year following
2718	graduation from medical school.
2719	(b) The board shall issue a graduate assistant physician
2720	limited license for a duration of 2 years to an applicant who
2721	meets the requirements of paragraph (a) and all of the following
2722	criteria:
2723	1. Is at least 21 years of age.
2724	2. Is of good moral character.
2725	3. Submits documentation that the applicant has agreed to
2726	enter into a written protocol drafted by a physician with a
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I.	588-01852-24 20247016
2727	full, active, and unencumbered license issued under this chapter
2728	upon the board's issuance of a limited license to the applicant
2729	and submits a copy of the protocol. The board shall establish by
2730	rule specific provisions that must be included in a physician-
2731	drafted protocol.
2732	4. Has not committed any act or offense in this or any
2733	other jurisdiction which would constitute the basis for
2734	disciplining a physician under s. 458.331.
2735	5. Has submitted to the department a set of fingerprints on
2736	a form and under procedures specified by the department.
2737	6. The board may not certify to the department for limited
2738	licensure under this subsection any applicant who is under
2739	investigation in another jurisdiction for an offense which would
2740	constitute a violation of this chapter or chapter 456 until such
2741	investigation is completed. Upon completion of the
2742	investigation, s. 458.331 applies. Furthermore, the department
2743	may not issue a limited license to any individual who has
2744	committed any act or offense in any jurisdiction which would
2745	constitute the basis for disciplining a physician under s.
2746	458.331. If the board finds that an individual has committed an
2747	act or offense in any jurisdiction which would constitute the
2748	basis for disciplining a physician under s. 458.331, the board
2749	may enter an order imposing one of the following terms:
2750	a. Refusal to certify to the department an application for
2751	a graduate assistant physician limited license; or
2752	b. Certification to the department of an application for a
2753	graduate assistant physician limited license with restrictions
2754	on the scope of practice of the licensee.
2755	(c) A graduate assistant physician limited licensee may
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2756	apply for a one-time renewal of his or her limited license by
2757	submitting a board-approved application, documentation of actual
2758	practice under the required protocol during the initial limited
2759	licensure period, and documentation of applications he or she
2760	has submitted for accredited graduate medical education training
2761	programs. The one-time renewal terminates after 1 year.
2762	(d) A limited licensed graduate assistant physician may
2763	provide health care services only under the direct supervision
2764	of a physician with a full, active, and unencumbered license
2765	issued under this chapter.
2766	(e) A physician must be approved by the board to supervise
2767	a limited licensed graduate assistant physician.
2768	(f) A physician may supervise no more than two graduate
2769	assistant physicians with limited licenses.
2770	(g) Supervision of limited licensed graduate assistant
2771	physicians requires the physical presence of the supervising
2772	physician at the location where the services are rendered.
2773	(h) A physician-drafted protocol must specify the duties
2774	and responsibilities of the limited licensed graduate assistant
2775	physician according to criteria adopted by board rule.
2776	(i) Each protocol that applies to a limited licensed
2777	graduate assistant physician and his or her supervising
2778	physician must ensure that:
2779	1. There is a process for the evaluation of the limited
2780	licensed graduate assistant physicians' performance; and
2781	2. The delegation of any medical task or procedure is
2782	within the supervising physician's scope of practice and
2783	appropriate for the graduate assistant physician's level of
2784	competency.
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2804(a) Any person desiring to obtain a limited license under2833board.2805this subsection must shall:2833board.28061.(a) Submit to the board a licensure application and fee2834(c)(3) The recipient of a2807required by this chapter. However, an osteopathic physician who2836subsection may practice only is2808is not fully retired in all jurisdictions may use a limited2837requirements of s. 501(c)(3) o2809license only for noncompensated practice. If the person applying2838agencies or institutions are l2810for a limited license submits a statement from the employing2839medical need or in medically u2811agency or institution stating that she or he will not receive2840jursuant to 42 U.S.C. s. 300e-2812monetary compensation for any service involving the practice of2841(d)(4) The board shall no2813osteopathic medicine, the application fee and all licensure fees2842local county health department	2802	459.0075 Limited licenses
2805this subsection must shall:2834(c) (3)The recipient of a28061.(a)Submit to the board a licensure application and fee2835subsection may practice only is2807required by this chapter. However, an osteopathic physician who2836institutions or nonprofit agen2808is not fully retired in all jurisdictions may use a limited2837requirements of s. 501(c) (3) o2809license only for noncompensated practice. If the person applying2838agencies or institutions are limited2810for a limited license submits a statement from the employing2839medical need or in medically u2811agency or institution stating that she or he will not receive2840jursuant to 42 U.S.C. s. 300e-2812monetary compensation for any service involving the practice of2841(d) (4)2813osteopathic medicine, the application fee and all licensure fees2842local county health department	2803	(1) PHYSICIANS LICENSED IN UNITED STATES JURISDICTIONS
28061.(a)Submit to the board a licensure application and fee2807required by this chapter. However, an osteopathic physician who2808is not fully retired in all jurisdictions may use a limited2809license only for noncompensated practice. If the person applying2810for a limited license submits a statement from the employing2811agency or institution stating that she or he will not receive2812monetary compensation for any service involving the practice of2813osteopathic medicine, the application fee and all licensure fees	2804	(a) Any person desiring to obtain a limited license under
2807required by this chapter. However, an osteopathic physician who is not fully retired in all jurisdictions may use a limited2836institutions or nonprofit agen requirements of s. 501(c)(3) o 28392809license only for noncompensated practice. If the person applying for a limited license submits a statement from the employing 2811 agency or institution stating that she or he will not receive 2812 monetary compensation for any service involving the practice of 28132836 osteopathic medicine, the application fee and all licensure fees	2805	this subsection must shall:
2808is not fully retired in all jurisdictions may use a limited2837requirements of s. 501(c) (3) o2809license only for noncompensated practice. If the person applying2838agencies or institutions are limited2810for a limited license submits a statement from the employing2839medical need or in medically u2811agency or institution stating that she or he will not receive2840pursuant to 42 U.S.C. s. 300e-2812monetary compensation for any service involving the practice of2841(d) (4)2813osteopathic medicine, the application fee and all licensure fees2842local county health department	2806	1.(a) Submit to the board a licensure application and fee
2809license only for noncompensated practice. If the person applying2838agencies or institutions are l2810for a limited license submits a statement from the employing2838agencies or institutions are l2811agency or institution stating that she or he will not receive2840pursuant to 42 U.S.C. s. 300e-2812monetary compensation for any service involving the practice of2841(d) (4)2813osteopathic medicine, the application fee and all licensure fees2842local county health department	2807	required by this chapter. However, an osteopathic physician who
2810for a limited license submits a statement from the employing2839medical need or in medically u2811agency or institution stating that she or he will not receive2840pursuant to 42 U.S.C. s. 300e-2812monetary compensation for any service involving the practice of2841(d) (4)2813osteopathic medicine, the application fee and all licensure fees2842local county health department	2808	is not fully retired in all jurisdictions may use a limited
2811agency or institution stating that she or he will not receive2840pursuant to 42 U.S.C. s. 300e-2812monetary compensation for any service involving the practice of2841(d) (4)2813osteopathic medicine, the application fee and all licensure fees2842local county health department	2809	license only for noncompensated practice. If the person applying
2812 monetary compensation for any service involving the practice of 2811 (d) (4) The board shall no 2813 osteopathic medicine, the application fee and all licensure fees 2842 local county health department	2810	for a limited license submits a statement from the employing
2813 osteopathic medicine, the application fee and all licensure fees 2842 local county health department	2811	agency or institution stating that she or he will not receive
	2812	monetary compensation for any service involving the practice of
Page 97 of 234 Page	2813	osteopathic medicine, the application fee and all licensure fees
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2843	intends to practice under the provisions of this <u>subsection</u>
2844	$\frac{1}{2}$ section. The director of the full-time county health department
2845	shall assist in the supervision of any licensee within $\underline{\text{the }}$ her
2846	$\overline{\text{or his}}$ county and shall notify the board if she or he becomes
2847	aware of any action by the licensee which would be a ground for
2848	revocation of the limited license. The board shall establish
2849	procedures for such supervision.
2850	(e)(5) The State board of Osteopathic Medicine shall review
2851	the practice of each licensee under this subsection section
2852	biennially to verify compliance with the restrictions prescribed
2853	in this <u>subsection</u> section and other provisions of this chapter.
2854	(f) (6) Any person holding an active license to practice
2855	osteopathic medicine in $\underline{\text{this}}$ the state may convert that license
2856	to a limited license $\underline{under \ this \ subsection}$ for the purpose of
2857	providing volunteer, uncompensated care for low-income
2858	Floridians. The applicant must submit a statement from the
2859	employing agency or institution stating that $\underline{she \ or}$ he \overline{or} she
2860	will not receive compensation for any service involving the
2861	practice of osteopathic medicine. The application \underline{fee} and all
2862	licensure fees, including neurological injury compensation
2863	assessments, are shall be waived for such applicant.
2864	(2) GRADUATE ASSISTANT PHYSICIANSA graduate assistant
2865	physician is a medical school graduate who meets the
2866	requirements of this subsection and has obtained a limited
2867	license from the board for the purpose of practicing temporarily
2868	under the direct supervision of a physician who has a full,
2869	active, and unencumbered license issued under this chapter,
2870	pending the graduate's entrance into a residency under the
2871	National Resident Match Program.
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2873	graduate assistant physician must submit to the board an
2874	application and demonstrate that she or he meets all of the
2875	following criteria:
2876	1. Is a graduate of a school or college of osteopathic
2877	medicine approved by an accrediting agency recognized by the
2878	United States Department of Education.
2879	2. Has successfully passed all parts of the examination
2880	conducted by the National Board of Osteopathic Medical Examiners
2881	or other examination approved by the board.
2882	3. Has not received and accepted a residency match from the
2883	National Residency Match Program within the first year following
2884	graduation from medical school.
2885	(b) The board shall issue a graduate assistant physician
2886	limited license for a duration of 2 years to an applicant who
2887	meets the requirements of paragraph (a) and all of the following
2888	criteria:
2889	1. Is at least 21 years of age.
2890	2. Is of good moral character.
2891	3. Submits documentation that the applicant has agreed to
2892	enter into a written protocol drafted by a physician with a
2893	full, active, and unencumbered license issued under this chapter
2894	upon the board's issuance of a limited license to the applicant,
2895	and submits a copy of the protocol. The board shall establish by
2896	rule specific provisions that must be included in a physician-
2897	drafted protocol.
2898	4. Has not committed any act or offense in this or any
2899	other jurisdiction which would constitute the basis for
2900	disciplining a physician under s. 459.015.
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2901	5. Has submitted to the department a set of fingerprints on
2902	a form and under procedures specified by the department.
2903	6. The board may not certify to the department for limited
2904	licensure under this subsection any applicant who is under
2905	investigation in another jurisdiction for an offense which would
2906	constitute a violation of this chapter or chapter 456 until such
2907	investigation is completed. Upon completion of the
2908	investigation, s. 459.015 applies. Furthermore, the department
2909	may not issue a limited license to any individual who has
2910	committed any act or offense in any jurisdiction which would
2911	constitute the basis for disciplining a physician under s.
2912	459.015. If the board finds that an individual has committed an
2913	act or offense in any jurisdiction which would constitute the
2914	basis for disciplining a physician under s. 459.015, the board
2915	may enter an order imposing one of the following terms:
2916	a. Refusal to certify to the department an application for
2917	a graduate assistant physician limited license; or
2918	b. Certification to the department of an application for a
2919	graduate assistant physician limited license with restrictions
2920	on the scope of practice of the licensee.
2921	(c) A graduate assistant physician limited licensee may
2922	apply for a one-time renewal of his or her limited licensed by
2923	submitting a board-approved application, documentation of actual
2924	practice under the required protocol during the initial limited
2925	licensure period, and documentation of applications he or she
2926	has submitted for accredited graduate medical education training
2927	programs. The one-time renewal terminates after 1 year.
2928	(d) A limited licensed graduate assistant physician may
2929	provide health care services only under the direct supervision
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2930	of a physician with a full, active, and unencumbered license
2931	issued under this chapter.
2932	(e) A physician must be approved by the board to supervise
2933	a limited licensed graduate assistant physician.
2934	(f) A physician may supervise no more than two graduate
2935	assistant physicians with limited licenses.
2936	(g) Supervision of limited licensed graduate assistant
2937	physicians requires the physical presence of the supervising
2938	physician at the location where the services are rendered.
2939	(h) A physician-drafted protocol must specify the duties
2940	and responsibilities of the limited licensed graduate assistant
2941	physician according to criteria adopted by board rule.
2942	(i) Each protocol that applies to a limited licensed
2943	graduate assistant physician and his or her supervising
2944	physician must ensure that:
2945	1. There is a process for the evaluation of the limited
2946	licensed graduate assistant physicians' performance; and
2947	2. The delegation of any medical task or procedure is
2948	within the supervising physician's scope of practice and
2949	appropriate for the graduate assistant physician's level of
2950	competency.
2951	(j) A limited licensed graduate assistant physician's
2952	prescriptive authority is governed by the physician-drafted
2953	protocol and criteria adopted by the board and may not exceed
2954	that of his or her supervising physician. Any prescriptions and
2955	orders issued by the graduate assistant physician must identify
2956	both the graduate assistant physician and the supervising
2957	physician.
2958	(k) A physician who supervises a graduate assistant
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588-01852-24 20247016 2959 physician is liable for any acts or omissions of the graduate 2960 assistant physician acting under the physician's supervision and 2961 control. Third-party payors may reimburse employers of graduate assistant physicians for covered services rendered by graduate 2962 2963 assistant physicians. 2964 (3) RULES.-The board may adopt rules to implement this 2965 section. 2966 Section 40. Section 459.0076, Florida Statutes, is amended 2967 to read: 2968 459.0076 Temporary certificate for practice in areas of 2969 critical need.-2970 (1) A physician or physician assistant who holds a valid 2971 license is licensed to practice in any jurisdiction of the 2972 United States, whose license is currently valid, and who pays an 2973 application fee of \$300 may be issued a temporary certificate 2974 for practice in areas of critical need. A physician seeking such 2975 certificate must pay an application fee of \$300. 2976 (2) A temporary certificate may be issued under this 2977 section to a physician or physician assistant who will: 2978 (a) Will Practice in an area of critical need; 2979 (b) Will Be employed by or practice in a county health 2980 department; correctional facility; Department of Veterans' 2981 Affairs clinic; community health center funded by s. 329, s. 2982 330, or s. 340 of the United States Public Health Services Act; 2983 or other agency or institution that is approved by the State 2984 Surgeon General and provides health care to meet the needs of 2985 underserved populations in this state; or 2986 (c) Will Practice for a limited time to address critical 2987 physician-specialty, demographic, or geographic needs for this Page 103 of 234 CODING: Words stricken are deletions; words underlined are additions.

588-01852-24 20247016 2988 state's physician workforce as determined by the State Surgeon 2989 General. 2990 (3) The board of Osteopathic Medicine may issue this 2991 temporary certificate subject to with the following 2992 restrictions: 2993 (a) The State Surgeon General shall determine the areas of 2994 critical need. Such areas include, but are not limited to, 2995 health professional shortage areas designated by the United 2996 States Department of Health and Human Services. 2997 1. A recipient of a temporary certificate for practice in 2998 areas of critical need may use the certificate to work for any approved entity in any area of critical need or as authorized by 2999 3000 the State Surgeon General. 3001 2. The recipient of a temporary certificate for practice in 3002 areas of critical need shall, within 30 days after accepting 3003 employment, notify the board of all approved institutions in 3004 which the licensee practices and of all approved institutions 3005 where practice privileges have been denied, as applicable. 3006 (b) The board may administer an abbreviated oral 3007 examination to determine the physician's or physician 3008 assistant's competency, but a written regular examination is not 3009 required. Within 60 days after receipt of an application for a 3010 temporary certificate, the board shall review the application 3011 and issue the temporary certificate, notify the applicant of 3012 denial, or notify the applicant that the board recommends 3013 additional assessment, training, education, or other 3014 requirements as a condition of certification. If the applicant 3015 has not actively practiced during the 3-year period immediately 3016 preceding the application prior 3 years and the board determines

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588-01852-24 20247016 3017 that the applicant may lack clinical competency, possess 3018 diminished or inadequate skills, lack necessary medical 3019 knowledge, or exhibit patterns of deficits in clinical 3020 decisionmaking, the board may: 3021 1. Deny the application; 3022 2. Issue a temporary certificate having reasonable 3023 restrictions that may include, but are not limited to, a 3024 requirement for the applicant to practice under the supervision 3025 of a physician approved by the board; or 3026 3. Issue a temporary certificate upon receipt of 3027 documentation confirming that the applicant has met any 3028 reasonable conditions of the board which may include, but are 3029 not limited to, completing continuing education or undergoing an 3030 assessment of skills and training. 3031 (c) Any certificate issued under this section is valid only 3032 so long as the State Surgeon General determines that the reason 3033 for which it was issued remains a critical need to the state. 3034 The board of Osteopathic Medicine shall review each temporary 3035 certificateholder at least not less than annually to ascertain 3036 that the certificateholder is complying with the minimum 3037 requirements of the Osteopathic Medical Practice Act and its 3038 adopted rules, as applicable to the certificateholder are being 3039 complied with. If it is determined that the certificateholder is 3040 not meeting such minimum requirements are not being met, the 3041 board must shall revoke such certificate or shall impose 3042 restrictions or conditions, or both, as a condition of continued 3043 practice under the certificate. 3044 (d) The board may not issue a temporary certificate for 3045 practice in an area of critical need to any physician or Page 105 of 234 CODING: Words stricken are deletions; words underlined are additions.

588-01852-24 20247016 3046 physician assistant who is under investigation in any 3047 jurisdiction in the United States for an act that would 3048 constitute a violation of this chapter until such time as the 3049 investigation is complete, at which time the provisions of s. 3050 459.015 applies apply. 3051 (4) The application fee and all licensure fees, including 3052 neurological injury compensation assessments, are shall be 3053 waived for those persons obtaining a temporary certificate to 3054 practice in areas of critical need for the purpose of providing 3055 volunteer, uncompensated care for low-income residents. The 3056 applicant must submit an affidavit from the employing agency or 3057 institution stating that the physician or physician assistant will not receive any compensation for any health care services 3058 3059 that he or she provides service involving the practice of 3060 medicine. 3061 Section 41. Section 464.0121, Florida Statutes, is created 3062 to read: 3063 464.0121 Temporary certificate for practice in areas of 3064 critical need.-3065 (1) An advanced practice registered nurse who is licensed 3066 to practice in any jurisdiction of the United States, whose 3067 license is currently valid, and who meets educational and 3068 training requirements established by the board may be issued a 3069 temporary certificate for practice in areas of critical need. 3070 (2) A temporary certificate may be issued under this section to an advanced practice registered nurse who will: 3071 3072 (a) Practice in an area of critical need; 3073 (b) Be employed by or practice in a county health department; correctional facility; Department of Veterans' 3074

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3075	Affairs clinic; community health center funded by s. 329, s.
3076	330, or s. 340 of the United States Public Health Services Act;
3077	or another agency or institution that is approved by the State
3078	Surgeon General and that provides health care services to meet
3079	the needs of underserved populations in this state; or
3080	(c) Practice for a limited time to address critical health
3081	care specialty, demographic, or geographic needs relating to
3082	this state's accessibility of health care services as determined
3083	by the State Surgeon General.
3084	(3) The board may issue a temporary certificate under this
3085	section subject to the following restrictions:
3086	(a) The State Surgeon General shall determine the areas of
3087	critical need. Such areas include, but are not limited to,
8088	health professional shortage areas designated by the United
8089	States Department of Health and Human Services.
3090	1. A recipient of a temporary certificate for practice in
3091	areas of critical need may use the certificate to work for any
8092	approved entity in any area of critical need or as authorized by
3093	the State Surgeon General.
8094	2. The recipient of a temporary certificate for practice in
8095	areas of critical need shall, within 30 days after accepting
3096	employment, notify the board of all approved institutions in
8097	which the licensee practices as part of his or her employment.
3098	(b) The board may administer an abbreviated oral
8099	examination to determine the advanced practice registered
3100	nurse's competency, but may not require a written regular
101	examination. Within 60 days after receipt of an application for
102	a temporary certificate, the board shall review the application
3103	and issue the temporary certificate, notify the applicant of
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3104	denial, or notify the applicant that the board recommends
3105	additional assessment, training, education, or other
3106	requirements as a condition of certification. If the applicant
3107	has not actively practiced during the 3-year period immediately
3108	preceding the application and the board determines that the
3109	applicant may lack clinical competency, possess diminished or
3110	inadequate skills, lack necessary medical knowledge, or exhibit
3111	patterns of deficits in clinical decisionmaking, the board may:
3112	1. Deny the application;
3113	2. Issue a temporary certificate imposing reasonable
3114	restrictions that may include, but are not limited to, a
3115	$\underline{requirement}$ that the applicant practice under the supervision of
3116	a physician approved by the board; or
3117	3. Issue a temporary certificate upon receipt of
3118	documentation confirming that the applicant has met any
3119	reasonable conditions of the board, which may include, but are
3120	not limited to, completing continuing education or undergoing an
3121	assessment of skills and training.
3122	(c) Any certificate issued under this section is valid only
3123	$\underline{\rm so}$ long as the State Surgeon General maintains the determination
3124	that the critical need that supported the issuance of the
3125	temporary certificate remains a critical need to the state. The
3126	board shall review each temporary certificateholder at least
3127	annually to ascertain that the certificateholder is complying
3128	with the minimum requirements of the Nurse Practice Act and its
3129	adopted rules, as applicable to the certificateholder. If it is
3130	determined that the certificateholder is not meeting such
3131	minimum requirements, the board must revoke such certificate or
3132	impose restrictions or conditions, or both, as a condition of
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20247016_ er the certificate. not issue a temporary certificate for critical need to any advanced practice s under investigation in any jurisdiction or an act that would constitute a until such time as the investigation is e s. 464.018 applies. fees, including neurological injury ts, are waived for those persons obtaining e to practice in areas of critical need viding volunteer, uncompensated care for The applicant must submit an affidavit ncy or institution stating that the stered nurse will not receive any ealth care services that he or she
not issue a temporary certificate for critical need to any advanced practice s under investigation in any jurisdiction or an act that would constitute a until such time as the investigation is e s. 464.018 applies. fees, including neurological injury ts, are waived for those persons obtaining e to practice in areas of critical need viding volunteer, uncompensated care for The applicant must submit an affidavit ncy or institution stating that the stered nurse will not receive any
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raph (b) of subsection (3) of section
utes, is amended to read:
us practice by an advanced practice
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provide out-of-hospital intrapartum care,
ife engaged in the autonomous practice of
aintain a written policy for the transfer
higher acuity of care or emergency
ust prescribe and require the use of an
form, which must be signed by the patient
trapartum care. At a minimum, the form
e following:

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3162	a. The name and address of the closest hospital that
3163	provides maternity and newborn services.
3164	b. Reasons for which transfer of care would be necessary,
3165	including the transfer-of-care conditions prescribed by board
3166	rule.
3167	c. Ambulances or other emergency medical services that
3168	would be used to transport the patient in the event of an
3169	emergency.
3170	2. If transfer of care is determined necessary by the
3171	certified nurse midwife or under the terms of the written
3172	policy, the certified nurse midwife must document all of the
3173	following information on the patient's emergency plan-of-care
3174	form:
3175	a. The name, date of birth, and condition of the patient.
3176	b. The gravidity and parity of the patient and the
3177	gestational age and condition of the fetus or newborn infant.
3178	c. The reasons that necessitated the transfer of care.
3179	d. A description of the situation, relevant clinical
3180	background, assessment, and recommendations.
3181	e. The planned mode of transporting the patient to the
3182	receiving facility.
3183	f. The expected time of arrival at the receiving facility.
3184	3. Before transferring the patient, or as soon as possible
3185	during or after an emergency transfer, the certified nurse
3186	midwife shall provide the receiving provider with a verbal
3187	summary of the information specified in subparagraph 2. and make
3188	himself or herself immediately available for consultation. Upon
3189	transfer of the patient to the receiving facility, the certified
3190	nurse midwife must provide the receiving provider with the
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588-01852-24 20247016 588-01852-24 20247016 patient's emergency plan-of-care form as soon as practicable. 3220 Nursing. 4. The certified nurse midwife shall provide the receiving 3221 (a) The Florida Center for Nursing shall evaluate programprovider, as soon as practicable, with the patient's prenatal 3222 specific data for each approved program and accredited program records, including patient history, prenatal laboratory results, 3223 conducted in the state, including, but not limited to: sonograms, prenatal care flow sheets, maternal fetal medical 3224 1. The number of programs and student slots available. reports, and labor flow charting and current notations. 3225 2. The number of student applications submitted, the number 5. The board shall adopt rules to prescribe transfer-of-3226 of qualified applicants, and the number of students accepted. care conditions, monitor for excessive transfers, conduct 3227 3. The number of program graduates. reviews of adverse maternal and neonatal outcomes, and monitor 3228 4. Program retention rates of students tracked from program the licensure of certified nurse midwives engaged in autonomous 3229 entry to graduation. practice must have a written patient transfer agreement with a 3230 5. Graduate passage rates on the National Council of State hospital and a written referral agreement with a physician 3231 Boards of Nursing Licensing Examination. licensed under chapter 458 or chapter 459 to engage in nurse 6. The number of graduates who become employed as practical 3232 midwifery. 3233 or professional nurses in the state. Section 43. Subsection (10) of section 464.019, Florida 3234 (b) The Florida Center for Nursing shall evaluate the Statutes, is amended to read: 3235 board's implementation of the: 464.019 Approval of nursing education programs.-3236 1. Program application approval process, including, but not (10) IMPLEMENTATION STUDY.-The Florida Center for Nursing limited to, the number of program applications submitted under 3237 shall study the administration of this section and submit 3238 subsection (1), the number of program applications approved and reports to the Governor, the President of the Senate, and the 3239 denied by the board under subsection (2), the number of denials Speaker of the House of Representatives annually by January 30_T of program applications reviewed under chapter 120, and a 3240 through January 30, 2025. The annual reports shall address the description of the outcomes of those reviews. 3241 previous academic year; provide data on the measures specified 3242 2. Accountability processes, including, but not limited to, in paragraphs (a) and (b), as such data becomes available; and 3243 the number of programs on probationary status, the number of include an evaluation of such data for purposes of determining 3244 approved programs for which the program director is required to whether this section is increasing the availability of nursing 3245 appear before the board under subsection (5), the number of education programs and the production of quality nurses. The 3246 approved programs terminated by the board, the number of department and each approved program or accredited program shall 3247 terminations reviewed under chapter 120, and a description of comply with requests for data from the Florida Center for the outcomes of those reviews. 3248 Page 111 of 234 Page 112 of 234 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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3249	(c) The Florida Center for Nursing shall complete an annual		3278	education for its students.
3250	assessment of compliance by programs with the accreditation		3279	(f) Each lab school shall develop programs that accelerate
3251	requirements of subsection (11), include in the assessment a		3280	the entry of enrolled lab school students into articulated
3252	determination of the accreditation process status for each		3281	health care programs at its affiliated university or at any
3253	program, and submit the assessment as part of the reports		3282	public or private postsecondary institution, with the approval
3254	required by this subsection.		3283	of the university president. Each lab school shall offer
3255	Section 44. Paragraph (e) of subsection (3) of section		3284	technical assistance to any Florida school district seeking to
3256	766.1115, Florida Statutes, is amended to read:		3285	replicate the lab school's programs and must annually, beginning
3257	766.1115 Health care providers; creation of agency		3286	December 1, 2025, report to the President of the Senate and the
3258	relationship with governmental contractors		3287	Speaker of the House of Representatives on the development of
3259	(3) DEFINITIONSAs used in this section, the term:		3288	such programs and their results.
3260	(e) "Low-income" means:		3289	Section 46. Paragraph (b) of subsection (3) of section
3261	1. A person who is Medicaid-eligible under Florida law;		3290	1009.8962, Florida Statutes, is amended to read:
3262	2. A person who is without health insurance and whose		3291	1009.8962 Linking Industry to Nursing Education (LINE)
3263	family income does not exceed $300 \ 200$ percent of the federal		3292	Fund
3264	poverty level as defined annually by the federal Office of		3293	(3) As used in this section, the term:
3265	Management and Budget; or		3294	(b) "Institution" means a school district career center
3266	3. Any client of the department who voluntarily chooses to		3295	under s. 1001.44 $\underline{i}_{\mathcal{T}}$ a charter technical career center under s.
3267	participate in a program offered or approved by the department		3296	1002.34 $_{\underline{i}\tau}$ a Florida College System institution $_{\underline{i}\tau}$ a state
3268	and meets the program eligibility guidelines of the department.		3297	university; - or an independent nonprofit college or university
3269	Section 45. Paragraph (f) is added to subsection (3) of		3298	located and chartered in this state and accredited by an agency
3270	section 1002.32, Florida Statutes, to read:		3299	or association that is recognized by the database created and
3271	1002.32 Developmental research (laboratory) schools		3300	maintained by the United States Department of Education to grant
3272	(3) MISSIONThe mission of a lab school shall be the		3301	baccalaureate degrees: $_{ au}$ or an independent school, college, or
3273	provision of a vehicle for the conduct of research,		3302	university with an accredited program as defined in s. 464.003
3274	demonstration, and evaluation regarding management, teaching,		3303	which is located in and chartered by the state and is licensed
3275	and learning. Programs to achieve the mission of a lab school		3304	by the Commission for Independent Education pursuant to s.
3276	shall embody the goals and standards established pursuant to ss.		3305	1005.31, which has a nursing education program that meets or
3277	1000.03(5) and 1001.23(1) and shall ensure an appropriate		3306	exceeds the following:
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588-01852-24 20247016 588-01852-24 20247016 3307 1. For a certified nursing assistant program, a completion 3336 3308 rate of at least 70 percent for the prior year. 3337 The department may adopt rules to implement this subsection, 3309 2. For a licensed practical nurse, associate of science in 3338 including rules that establish guidelines to implement the 3310 nursing, and bachelor of science in nursing program, a first-3339 federal Conrad 30 Waiver Program created under s. 214(1) of the time passage rate on the National Council of State Boards of 3340 Immigration and Nationality Act. 3312 Nursing Licensing Examination of at least 75 70 percent for the 3341 Section 48. Subsection (3) of section 395.602, Florida 3313 prior year based on a minimum of 10 testing participants. 3342 Statutes, is amended to read: Section 47. Paragraph (f) of subsection (3) of section 3343 395.602 Rural hospitals .-3315 381.4018, Florida Statutes, is amended to read: 3344 (3) USE OF FUNDS.-It is the intent of the Legislature that 3316 381.4018 Physician workforce assessment and development.-3345 funds as appropriated shall be utilized by the department for (3) GENERAL FUNCTIONS.-The department shall maximize the 3346 the purpose of increasing the number of primary care physicians, 3318 physician assistants, certified nurse midwives, nurse use of existing programs under the jurisdiction of the 3347 3319 department and other state agencies and coordinate governmental practitioners, and nurses in rural areas, either through the 3348 3320 and nongovernmental stakeholders and resources in order to 3349 Medical Education Reimbursement and Loan Repayment Program as develop a state strategic plan and assess the implementation of 3350 defined by s. 381.402 s. 1009.65 or through a federal loan 3322 such strategic plan. In developing the state strategic plan, the 3351 repayment program which requires state matching funds. The 3323 department shall: 3352 department may use funds appropriated for the Medical Education (f) Develop strategies to maximize federal and state 3353 Reimbursement and Loan Repayment Program as matching funds for 3325 programs that provide for the use of incentives to attract 3354 federal loan repayment programs for health care personnel, such 3326 physicians to this state or retain physicians within the state. 3355 as that authorized in Pub. L. No. 100-177, s. 203. If the Such strategies should explore and maximize federal-state 3356 department receives federal matching funds, the department shall partnerships that provide incentives for physicians to practice 3357 only implement the federal program. Reimbursement through either in federally designated shortage areas, in otherwise medically 3358 program shall be limited to: 3330 underserved areas, or in rural areas. Strategies shall also 3359 (a) Primary care physicians, physician assistants, consider the use of state programs, such as the Medical 3360 certified nurse midwives, nurse practitioners, and nurses 3332 Education Reimbursement and Loan Repayment Program pursuant to 3361 employed by or affiliated with rural hospitals, as defined in 3333 s. 381.402 s. 1009.65, which provide for education loan 3362 this act; and 3334 repayment or loan forgiveness and provide monetary incentives 3363 (b) Primary care physicians, physician assistants, 3335 for physicians to relocate to underserved areas of the state. 3364 certified nurse midwives, nurse practitioners, and nurses Page 115 of 234 Page 116 of 234 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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3365	employed by or affiliated with rural area health education	3394	score, as established by rule of the board, on the licensure
3366	centers, as defined in this section. These personnel shall	3395	examination of the Federation of State Medical Boards of the
3367	practice:	3396	United States, Inc. (FLEX), on the United States Medical
3368	1. In a county with a population density of no greater than	3397	Licensing Examination (USMLE), or on the examination of the
3369	100 persons per square mile; or	3398	National Board of Medical Examiners, or on a combination
3370	2. Within the boundaries of a hospital tax district which	3399	thereof, and on or after January 1, 2000, has obtained a passing
3371	encompasses a population of no greater than 100 persons per	3400	score on the United States Medical Licensing Examination
3372	square mile.	3401	(USMLE); and
3373		3402	(c) Has submitted evidence of the active licensed practice
3374	If the department administers a federal loan repayment program,	3403	of medicine in another jurisdiction, for at least 2 of the
3375	priority shall be given to obligating state and federal matching	3404	immediately preceding 4 years, or evidence of successful
3376	funds pursuant to paragraphs (a) and (b). The department may use	3405	completion of either a board-approved postgraduate training
3377	federal matching funds in other health workforce shortage areas	3406	program within 2 years preceding filing of an application or a
3378	and medically underserved areas in the state for loan repayment	3407	board-approved clinical competency examination within the year
3379	programs for primary care physicians, physician assistants,	3408	preceding the filing of an application for licensure. For
3380	certified nurse midwives, nurse practitioners, and nurses who	3409	purposes of this paragraph, the term "active licensed practice
3381	are employed by publicly financed health care programs that	3410	of medicine" means that practice of medicine by physicians,
3382	serve medically indigent persons.	3411	including those employed by any governmental entity in community
3383	Section 49. Subsection (1) of section 458.313, Florida	3412	or public health, as defined by this chapter, medical directors
3384	Statutes, is amended to read:	3413	under s. 641.495(11) who are practicing medicine, and those on
3385	458.313 Licensure by endorsement; requirements; fees	3414	the active teaching faculty of an accredited medical school.
3386	(1) The department shall issue a license by endorsement to	3415	Section 50. Subsection (1) of section 458.316, Florida
3387	any applicant who, upon applying to the department on forms	3416	Statutes, is amended to read:
3388	furnished by the department and remitting a fee set by the board	3417	458.316 Public health certificate
3389	not to exceed \$500, the board certifies:	3418	(1) Any person desiring to obtain a public health
3390	(a) Has met the qualifications for licensure in s.	3419	certificate shall submit an application fee not to exceed \$300
3391	458.311(1)(b)-(g) or in s. 458.311(1)(b)-(e) and (g) and (4)	3420	and shall demonstrate to the board that he or she is a graduate
3392	(3) ;	3421	of an accredited medical school and holds a master of public
3393	(b) <u>Before</u> Prior to January 1, 2000, has obtained a passing	3422	health degree or is board eligible or certified in public health
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3423	or preventive medicine, or is licensed to practice medicine	3452	
3424	without restriction in another jurisdiction in the United States	3453	
3425	and holds a master of public health degree or is board eligible	3454	
3426		3455	
3427	meet the requirements in s. $458.311(1)(a)-(g)$ and $(6)(5)$.	3450	
3428	Section 51. Section 458.3165, Florida Statutes, is amended	345	
3429	to read:	3458	8 Section 52. Section 456.4501, Florida Statutes, is created
3430	458.3165 Public psychiatry certificateThe board shall	3459	9 to read:
3431	issue a public psychiatry certificate to an individual who	3460	0 456.4501 Interstate Medical Licensure CompactThe
3432	remits an application fee not to exceed \$300, as set by the	3463	1 Interstate Medical Licensure Compact is hereby enacted into law
3433	board, who is a board-certified psychiatrist, who is licensed to	3462	and entered into by this state with all other jurisdictions
3434	practice medicine without restriction in another state, and who	3463	legally joining therein in the form substantially as follows:
3435	meets the requirements in s. 458.311(1)(a)-(g) and (6) (5). A	3464	4
3436	recipient of a public psychiatry certificate may use the	3465	5 <u>SECTION 1</u>
3437	certificate to work at any public mental health facility or	3460	6 <u>PURPOSE</u>
3438	program funded in part or entirely by state funds.	346	7
3439	(1) Such certificate shall:	3468	8 In order to strengthen access to health care, and in
3440	(a) Authorize the holder to practice only in a public	3469	9 recognition of the advances in the delivery of health care, the
3441	mental health facility or program funded in part or entirely by	3470	0 member states of the Interstate Medical Licensure Compact have
3442	state funds.	3473	allied in common purpose to develop a comprehensive process that
3443	(b) Be issued and renewable biennially if the State Surgeon	3472	2 complements the existing licensing and regulatory authority of
3444	General and the chair of the department of psychiatry at one of	3473	3 state medical boards and provides a streamlined process that
3445	the public medical schools or the chair of the department of	3474	allows physicians to become licensed in multiple states, thereby
3446	psychiatry at the accredited medical school at the University of	3475	5 enhancing the portability of a medical license and ensuring the
3447	Miami recommend in writing that the certificate be issued or	3476	6 safety of patients. The compact creates another pathway for
3448	renewed.	347	7 licensure and does not otherwise change a state's existing
3449	(c) Automatically expire if the holder's relationship with	3478	8 medical practice act. The compact also adopts the prevailing
3450	a public mental health facility or program expires.	3479	9 standard for licensure and affirms that the practice of medicine
3451	(d) Not be issued to a person who has been adjudged	3480	occurs where the patient is located at the time of the
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3481	physician-patient encounter and, therefore, requires the
3482	physician to be under the jurisdiction of the state medical
3483	board where the patient is located. State medical boards that
3484	participate in the compact retain the jurisdiction to impose an
3485	adverse action against a license to practice medicine in that
3486	state issued to a physician through the procedures in the
3487	compact.
3488	
3489	SECTION 2
3490	DEFINITIONS
3491	
3492	As used in the compact, the term:
3493	(1) "Bylaws" means those bylaws established by the
3494	Interstate Commission pursuant to Section 11 for its governance
3495	or for directing and controlling its actions and conduct.
3496	(2) "Commissioner" means the voting representative
3497	appointed by each member board pursuant to Section 11.
3498	(3) "Conviction" means a finding by a court that an
3499	individual is guilty of a criminal offense, through adjudication
3500	or entry of a plea of guilt or no contest to the charge by the
3501	offender. Evidence of an entry of a conviction of a criminal
3502	offense by the court shall be considered final for purposes of
3503	disciplinary action by a member board.
3504	(4) "Expedited license" means a full and unrestricted
3505	medical license granted by a member state to an eligible
3506	physician through the process set forth in the compact.
3507	(5) "Interstate Commission" means the Interstate Medical
3508	Licensure Compact Commission created pursuant to Section 11.
3509	(6) "License" means authorization by a state for a

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3510	physician to engage in the practice of medicine, which would be
3511	unlawful without the authorization.
3512	(7) "Medical practice act" means laws and regulations
3513	governing the practice of allopathic and osteopathic medicine
3514	within a member state.
3515	(8) "Member board" means a state agency in a member state
3516	which acts in the sovereign interests of the state by protecting
3517	the public through licensure, regulation, and education of
3518	physicians as directed by the state government.
3519	(9) "Member state" means a state that has enacted the
3520	compact.
3521	(10) "Offense" means a felony, high court misdemeanor, or
3522	crime of moral turpitude.
3523	(11) "Physician" means any person who:
3524	(a) Is a graduate of a medical school accredited by the
3525	Liaison Committee on Medical Education, the Commission on
3526	Osteopathic College Accreditation, or a medical school listed in
3527	the International Medical Education Directory or its equivalent;
3528	(b) Passed each component of the United States Medical
3529	Licensing Examination (USMLE) or the Comprehensive Osteopathic
3530	Medical Licensing Examination (COMLEX-USA) within three
3531	attempts, or any of its predecessor examinations accepted by a
3532	state medical board as an equivalent examination for licensure
3533	purposes;
3534	(c) Successfully completed graduate medical education
3535	approved by the Accreditation Council for Graduate Medical
3536	Education or the American Osteopathic Association;
3537	(d) Holds specialty certification or a time-unlimited
3538	specialty certificate recognized by the American Board of
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3539	Medical Specialties or the American Osteopathic Association's
3540	Bureau of Osteopathic Specialists; however, the specialty
3541	certification or a time-unlimited specialty certificate does not
3542	have to be maintained once a physician is initially determined
3543	to be eligible for expedited licensure through the compact;
3544	(e) Possesses a full and unrestricted license to engage in
3545	the practice of medicine issued by a member board;
3546	(f) Has never been convicted or received adjudication,
3547	deferred adjudication, community supervision, or deferred
3548	disposition for any offense by a court of appropriate
3549	jurisdiction;
3550	(g) Has never held a license authorizing the practice of
3551	medicine subjected to discipline by a licensing agency in any
3552	state, federal, or foreign jurisdiction, excluding any action
3553	related to nonpayment of fees related to a license;
3554	(h) Has never had a controlled substance license or permit
3555	suspended or revoked by a state or the United States Drug
3556	Enforcement Administration; and
3557	(i) Is not under active investigation by a licensing agency
3558	or law enforcement authority in any state, federal, or foreign
3559	jurisdiction.
3560	(12) "Practice of medicine" means the diagnosis, treatment,
3561	prevention, cure, or relieving of a human disease, ailment,
3562	defect, complaint, or other physical or mental condition by
3563	attendance, advice, device, diagnostic test, or other means, or
3564	offering, undertaking, attempting to do, or holding oneself out
3565	as able to do any of these acts.
3566	(13) "Rule" means a written statement by the Interstate
3567	Commission adopted pursuant to Section 12 of the compact which
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3568	is of general applicability; implements, interprets, or
3569	prescribes a policy or provision of the compact or an
3570	organizational, procedural, or practice requirement of the
3571	Interstate Commission; and has the force and effect of statutory
3572	law in a member state, if the rule is not inconsistent with the
3573	laws of the member state. The term includes the amendment,
3574	repeal, or suspension of an existing rule.
3575	(14) "State" means any state, commonwealth, district, or
3576	territory of the United States.
3577	(15) "State of principal license" means a member state
3578	where a physician holds a license to practice medicine and which
3579	has been designated as such by the physician for purposes of
3580	registration and participation in the compact.
3581	
3582	SECTION 3
3583	ELIGIBILITY
3584	
3585	(1) A physician must meet the eligibility requirements as
3586	provided in subsection (11) of Section 2 to receive an expedited
3587	license under the terms of the compact.
3588	(2) A physician who does not meet the requirements
3589	specified in subsection (11) of Section 2 may obtain a license
3590	to practice medicine in a member state if the individual
3591	complies with all laws and requirements, other than the compact,
3592	relating to the issuance of a license to practice medicine in
3593	that state.
3594	
3595	SECTION 4
3596	DESIGNATION OF STATE OF PRINCIPAL LICENSE
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3597	
3598	(1) A physician shall designate a member state as the state
3599	of principal license for purposes of registration for expedited
3600	licensure through the compact if the physician possesses a full
3601	and unrestricted license to practice medicine in that state and
3602	the state is:
3603	(a) The state of primary residence for the physician;
3604	(b) The state where at least 25 percent of the physician's
3605	practice of medicine occurs;
3606	(c) The location of the physician's employer; or
3607	(d) If no state qualifies under paragraph (a), paragraph
3608	(b), or paragraph (c), the state designated as the physician's
3609	state of residence for purpose of federal income tax.
3610	(2) A physician may redesignate a member state as state of
3611	principal license at any time, as long as the state meets one of
3612	the descriptions under subsection (1).
3613	(3) The Interstate Commission may develop rules to
3614	facilitate redesignation of another member state as the state of
3615	principal license.
3616	
3617	SECTION 5
3618	APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE
3619	
3620	(1) A physician seeking licensure through the compact must
3621	file an application for an expedited license with the member
3622	board of the state selected by the physician as the state of
3623	principal license.
3624	(2) Upon receipt of an application for an expedited
3625	license, the member board within the state selected as the state $\$
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3626	of principal license shall evaluate whether the physician is
3627	eligible for expedited licensure and issue a letter of
3628	qualification, verifying or denying the physician's eligibility,
3629	to the Interstate Commission.
3630	(a) Static qualifications, which include verification of
3631	medical education, graduate medical education, results of any
3632	medical or licensing examination, and other qualifications as
3633	determined by the Interstate Commission through rule, are not
3634	subject to additional primary source verification if already
3635	primary source-verified by the state of principal license.
3636	(b) The member board within the state selected as the state
3637	of principal license shall, in the course of verifying
3638	eligibility, perform a criminal background check of an
3639	applicant, including the use of the results of fingerprint or
3640	other biometric data checks compliant with the requirements of
3641	the Federal Bureau of Investigation, with the exception of
3642	federal employees who have a suitability determination in
3643	accordance with 5 C.F.R. s. 731.202.
3644	(c) Appeal on the determination of eligibility must be made
3645	to the member state where the application was filed and is
3646	subject to the law of that state.
3647	(3) Upon verification in subsection (2), physicians
3648	eligible for an expedited license must complete the registration
3649	process established by the Interstate Commission to receive a
3650	license in a member state selected pursuant to subsection (1).
3651	(4) After receiving verification of eligibility under
3652	subsection (2) and upon an applicant's completion of any
3653	registration process required under subsection (3), a member
3654	board shall issue an expedited license to the physician. This
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3655	license authorizes the physician to practice medicine in the
3656	issuing state consistent with the medical practice act and all
3657	applicable laws and regulations of the issuing member board and
3658	member state.
3659	(5) An expedited license is valid for a period consistent
3660	with the licensure period in the member state and in the same
3661	manner as required for other physicians holding a full and
3662	unrestricted license within the member state.
3663	(6) An expedited license obtained through the compact must
3664	be terminated if a physician fails to maintain a license in the
3665	state of principal license for a nondisciplinary reason, without
3666	redesignation of a new state of principal license.
3667	(7) The Interstate Commission may develop rules regarding
3668	the application process and the issuance of an expedited
3669	license.
3670	
3671	SECTION 6
3672	RENEWAL AND CONTINUED PARTICIPATION
3673	
3674	(1) A physician seeking to renew an expedited license
3675	granted in a member state shall complete a renewal process with
3676	the Interstate Commission if the physician:
3677	(a) Maintains a full and unrestricted license in a state of
3678	principal license;
3679	(b) Has not been convicted or received adjudication,
3680	deferred adjudication, community supervision, or deferred
3681	disposition for any offense by a court of appropriate
3682	jurisdiction;
3683	(c) Has not had a license authorizing the practice of
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3684	medicine subject to discipline by a licensing agency in any
3685	state, federal, or foreign jurisdiction, excluding any action
3686	related to nonpayment of fees related to a license; and
3687	(d) Has not had a controlled substance license or permit
3688	suspended or revoked by a state or the United States Drug
3689	Enforcement Administration.
3690	(2) Physicians shall comply with all continuing
3691	professional development or continuing medical education
3692	requirements for renewal of a license issued by a member state.
3693	(3) Physician information collected by the Interstate
3694	Commission during the renewal process must be distributed to all
3695	member boards.
3696	(4) The Interstate Commission may develop rules to address
3697	renewal of licenses obtained through the compact.
3698	
3699	SECTION 7
3700	COORDINATED INFORMATION SYSTEM
3701	
3702	(1) The Interstate Commission shall establish a database of
3703	all physicians licensed, or who have applied for licensure,
3704	under Section 5.
3705	(2) Notwithstanding any other provision of law, member
3706	boards shall report to the Interstate Commission any public
3707	action or complaints against a licensed physician who has
3708	applied or received an expedited license through the compact.
3709	(3) Member boards shall report to the Interstate Commission
3710	disciplinary or investigatory information determined as
3711	necessary and proper by rule of the Interstate Commission.
3712	(4) Member boards may report to the Interstate Commission
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3713	any nonpublic complaint, disciplinary, or investigatory
3714	information not required by subsection (3).
3715	(5) Member boards shall share complaint or disciplinary
3716	information about a physician upon request of another member
3717	board.
3718	(6) All information provided to the Interstate Commission
3719	or distributed by member boards shall be confidential, filed
3720	under seal, and used only for investigatory or disciplinary
3721	matters.
3722	(7) The Interstate Commission may develop rules for
3723	mandated or discretionary sharing of information by member
3724	boards.
3725	
3726	SECTION 8
3727	JOINT INVESTIGATIONS
3728	
3729	(1) Licensure and disciplinary records of physicians are
3730	deemed investigative.
3731	(2) In addition to the authority granted to a member board
3732	by its respective medical practice act or other applicable state
3733	law, a member board may participate with other member boards in
3734	joint investigations of physicians licensed by the member
3735	boards.
3736	(3) A subpoena issued by a member state is enforceable in
3737	other member states.
3738	(4) Member boards may share any investigative, litigation,
3739	or compliance materials in furtherance of any joint or
3740	individual investigation initiated under the compact.
3741	(5) Any member state may investigate actual or alleged
I	
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3742	$\underline{v}iolations$ of the statutes authorizing the practice of medicine
3743	in any other member state in which a physician holds a license
3744	to practice medicine.
3745	
3746	SECTION 9
3747	DISCIPLINARY ACTIONS
3748	
3749	(1) Any disciplinary action taken by any member board
3750	against a physician licensed through the compact is deemed
3751	unprofessional conduct which may be subject to discipline by
3752	other member boards, in addition to any violation of the medical
3753	practice act or regulations in that state.
3754	(2) If a license granted to a physician by the member board
3755	in the state of principal license is revoked, surrendered or
3756	relinguished in lieu of discipline, or suspended, then all
3757	licenses issued to the physician by member boards shall
3758	automatically be placed, without further action necessary by any
3759	member board, on the same status. If the member board in the
3760	state of principal license subsequently reinstates the
3761	physician's license, a license issued to the physician by any
3762	other member board must remain encumbered until that respective
3763	member board takes action to reinstate the license in a manner
3764	consistent with the medical practice act of that state.
3765	(3) If disciplinary action is taken against a physician by
3766	\underline{a} member board not in the state of principal license, any other
3767	$\underline{\mbox{member}}$ board may deem the action conclusive as to matter of law
3768	and fact decided, and:
3769	(a) Impose the same or lesser sanctions against the
3770	physician so long as such sanctions are consistent with the
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3771	medical practice act of that state; or
3772	(b) Pursue separate disciplinary action against the
3773	physician under its respective medical practice act, regardless
3774	of the action taken in other member states.
775	(4) If a license granted to a physician by a member board
776	is revoked, surrendered or relinquished in lieu of discipline,
777	or suspended, any license issued to the physician by any other
778	member board must be suspended, automatically and immediately
779	without further action necessary by the other member boards, for
780	90 days after entry of the order by the disciplining board, to
781	permit the member boards to investigate the basis for the action
782	under the medical practice act of that state. A member board may
783	terminate the automatic suspension of the license it issued
784	before the completion of the 90-day suspension period in a
785	manner consistent with the medical practice act of that state.
786	
787	SECTION 10
788	INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION
789	
790	(1) The member states hereby create the Interstate Medical
791	Licensure Compact Commission.
792	(2) The purpose of the Interstate Commission is the
793	administration of the compact, which is a discretionary state
794	function.
795	(3) The Interstate Commission is a body corporate and joint
796	agency of the member states and has all the responsibilities,
797	powers, and duties set forth in the compact, and such additional
798	powers as may be conferred upon it by a subsequent concurrent
799	action of the respective legislatures of the member states in
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3800	accordance with the terms of the compact.
3801	(4) The Interstate Commission shall consist of two voting
3802	representatives appointed by each member state, who shall serve
3803	as commissioners. In states where allopathic and osteopathic
3804	physicians are regulated by separate member boards, or if the
3805	licensing and disciplinary authority is split between multiple
3806	member boards within a member state, the member state shall
3807	appoint one representative from each member board. Each
3808	commissioner must be one of the following:
3809	(a) An allopathic or osteopathic physician appointed to a
3810	member board.
3811	(b) An executive director, an executive secretary, or a
3812	similar executive of a member board.
3813	(c) A member of the public appointed to a member board.
3814	(5) The Interstate Commission shall meet at least once each
3815	calendar year. A portion of this meeting must be a business
3816	meeting to address such matters as may properly come before the
3817	commission, including the election of officers. The chairperson
3818	may call additional meetings and shall call for a meeting upon
3819	the request of a majority of the member states.
3820	(6) The bylaws may provide for meetings of the Interstate
3821	Commission to be conducted by telecommunication or other
3822	electronic means.
3823	(7) Each commissioner participating at a meeting of the
3824	Interstate Commission is entitled to one vote. A majority of
3825	commissioners constitutes a quorum for the transaction of
3826	business, unless a larger quorum is required by the bylaws of
3827	the Interstate Commission. A commissioner may not delegate a
3828	vote to another commissioner. In the absence of its
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3829	588-01852-24 20247016_ commissioner, a member state may delegate voting authority for a
3830	
	specified meeting to another person from that state who must
3831	meet the qualification requirements specified in subsection (4).
3832	(8) The Interstate Commission shall provide public notice
3833	of all meetings, and all meetings must be open to the public.
3834	The Interstate Commission may close a meeting, in full or in
3835	portion, where it determines by a two-thirds vote of the
3836	commissioners present that an open meeting would be likely to:
3837	(a) Relate solely to the internal personnel practices and
3838	procedures of the Interstate Commission;
3839	(b) Discuss matters specifically exempted from disclosure
3840	by federal statute;
3841	(c) Discuss trade secrets or commercial or financial
3842	information that is privileged or confidential;
3843	(d) Involve accusing a person of a crime, or formally
3844	censuring a person;
3845	(e) Discuss information of a personal nature, the
3846	disclosure of which would constitute a clearly unwarranted
3847	invasion of personal privacy;
3848	(f) Discuss investigative records compiled for law
3849	enforcement purposes; or
3850	(g) Specifically relate to participation in a civil action
3851	or other legal proceeding.
3852	(9) The Interstate Commission shall keep minutes that fully
3853	describe all matters discussed in a meeting and provide a full
3854	and accurate summary of actions taken, including a record of any
3855	roll call votes.
3856	(10) The Interstate Commission shall make its information
3857	and official records, to the extent not otherwise designated in
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3858	the compact or by its rules, available to the public for
3859	inspection.
3860	(11) The Interstate Commission shall establish an executive
3861	committee, which shall include officers, members, and others as
3862	determined by the bylaws. The executive committee has the power
3863	to act on behalf of the Interstate Commission, with the
3864	exception of rulemaking, during periods when the Interstate
3865	Commission is not in session. When acting on behalf of the
3866	Interstate Commission, the executive committee shall oversee the
3867	administration of the compact, including enforcement and
3868	compliance with the compact and its bylaws and rules, and other
3869	duties as necessary.
3870	(12) The Interstate Commission may establish other
3871	committees for governance and administration of the compact.
3872	
3873	SECTION 11
3874	POWERS AND DUTIES OF THE INTERSTATE COMMISSION
3875	
3876	The Interstate Commission has all of the following powers
3877	and duties:
3878	(1) Overseeing and maintaining the administration of the
3879	compact.
3880	(2) Adopting rules, which shall be binding to the extent
3881	and in the manner provided for in the compact.
3882	(3) Issuing, upon the request of a member state or member
3883	board, advisory opinions concerning the meaning or
3884	interpretation of the compact and its bylaws, rules, and
3885	actions.
3886	(4) Enforcing compliance with the compact, the rules
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3887	adopted by the Interstate Commission, and the bylaws, using all
3888	necessary and proper means, including, but not limited to, the
3889	use of judicial process.
3890	(5) Establishing and appointing committees, including, but
3891	not limited to, an executive committee as required by Section
3892	11, which shall have the power to act on behalf of the
3893	Interstate Commission in carrying out its powers and duties.
3894	(6) Paying for or providing for the payment of the expenses
3895	related to the establishment, organization, and ongoing
3896	activities of the Interstate Commission.
3897	(7) Establishing and maintaining one or more offices.
3898	(8) Borrowing, accepting, hiring, or contracting for
3899	services of personnel.
3900	(9) Purchasing and maintaining insurance and bonds.
3901	(10) Employing an executive director, who shall have the
3902	power to employ, select, or appoint employees, agents, or
3903	consultants and to determine their qualifications, define their
3904	duties, and fix their compensation.
3905	(11) Establishing personnel policies and programs relating
3906	to conflicts of interest, rates of compensation, and
3907	qualifications of personnel.
3908	(12) Accepting donations and grants of money, equipment,
3909	supplies, materials, and services and receiving, using, and
3910	disposing of them in a manner consistent with the conflict-of-
3911	interest policies established by the Interstate Commission.
3912	(13) Leasing, purchasing, accepting contributions or
3913	donations of, or otherwise owning, holding, improving, or using
3914	any property, real, personal, or mixed.
3915	(14) Selling conveying, mortgaging, pledging, leasing,
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3916	exchanging, abandoning, or otherwise disposing of any property,
3917	real, personal, or mixed.
3918	(15) Establishing a budget and making expenditures.
3919	(16) Adopting a seal and bylaws governing the management
3920	and operation of the Interstate Commission.
3921	(17) Reporting annually to the legislatures and governors
3922	of the member states concerning the activities of the Interstate
3923	Commission during the preceding year. Such reports must also
3924	include reports of financial audits and any recommendations that
3925	may have been adopted by the Interstate Commission.
3926	(18) Coordinating education, training, and public awareness
3927	regarding the compact and its implementation and operation.
3928	(19) Maintaining records in accordance with the bylaws.
3929	(20) Seeking and obtaining trademarks, copyrights, and
3930	patents.
3931	(21) Performing any other functions necessary or
3932	appropriate to achieve the purposes of the compact.
3933	
3934	SECTION 12
3935	FINANCE POWERS
3936	
3937	(1) The Interstate Commission may levy on and collect an
3938	annual assessment from each member state to cover the cost of
3939	the operations and activities of the Interstate Commission and
3940	its staff. The total assessment, subject to appropriation, must
3941	be sufficient to cover the annual budget approved each year for
3942	which revenue is not provided by other sources. The aggregate
3943	annual assessment amount must be allocated upon a formula to be
3944	determined by the Interstate Commission, which shall adopt a
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3945	- rule binding upon all member states.
3946	(2) The Interstate Commission may not incur obligations of
3947	any kind before securing the funds adequate to meet the same.
3948	(3) The Interstate Commission may not pledge the credit of
3949	any of the member states, except by, and with the authority of,
3950	the member state.
3951	(4) The Interstate Commission is subject to an annual
3952	financial audit conducted by a certified or licensed public
3953	accountant, and the report of the audit must be included in the
3954	annual report of the Interstate Commission.
3955	
3956	SECTION 13
3957	ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION
3958	
3959	(1) The Interstate Commission shall, by a majority of
3960	commissioners present and voting, adopt bylaws to govern its
3961	conduct as may be necessary or appropriate to carry out the
3962	purposes of the compact within 12 months after the first
3963	Interstate Commission meeting.
3964	(2) The Interstate Commission shall elect or appoint
3965	annually from among its commissioners a chairperson, a vice
3966	chairperson, and a treasurer, each of whom shall have such
3967	authority and duties as may be specified in the bylaws. The
3968	chairperson, or in the chairperson's absence or disability, the
3969	vice chairperson, shall preside over all meetings of the
3970	Interstate Commission.
3971	(3) Officers selected pursuant to subsection (2) shall
3972	serve without remuneration from the Interstate Commission.
3973	(4) The officers and employees of the Interstate Commission
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3974	are immune from suit and liability, either personally or in
3975	their official capacity, for a claim for damage to or loss of
3976	property or personal injury or other civil liability caused or
3977	arising out of, or relating to, an actual or alleged act, error,
3978	or omission that occurred, or that such person had a reasonable
3979	basis for believing occurred, within the scope of Interstate
3980	Commission employment, duties, or responsibilities; provided
3981	that such person is not protected from suit or liability for
3982	damage, loss, injury, or liability caused by the intentional or
3983	willful and wanton misconduct of such person.
3984	(a) The liability of the executive director and employees
3985	of the Interstate Commission or representatives of the
3986	Interstate Commission, acting within the scope of such person's
3987	employment or duties for acts, errors, or omissions occurring
3988	within such person's state, may not exceed the limits of
3989	liability set forth under the constitution and laws of that
3990	state for state officials, employees, and agents. The Interstate
3991	Commission is considered to be an instrumentality of the states
3992	for the purposes of any such action. Nothing in this subsection
3993	may be construed to protect such person from suit or liability
3994	for damage, loss, injury, or liability caused by the intentional
3995	or willful and wanton misconduct of such person.
3996	(b) The Interstate Commission shall defend the executive
3997	director and its employees and, subject to the approval of the
3998	attorney general or other appropriate legal counsel of the
3999	member state represented by an Interstate Commission
4000	representative, shall defend such persons in any civil action
4001	seeking to impose liability arising out of an actual or alleged
4002	act, error, or omission that occurred within the scope of
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4003	Interstate Commission employment, duties, or responsibilities,
4004	or that the defendant had a reasonable basis for believing
4005	occurred within the scope of Interstate Commission employment,
4006	duties, or responsibilities, provided that the actual or alleged
4007	act, error, or omission did not result from intentional or
4008	willful and wanton misconduct on the part of such person.
4009	(c) To the extent not covered by the state involved, the
4010	member state, or the Interstate Commission, the representatives
4011	or employees of the Interstate Commission must be held harmless
4012	in the amount of a settlement or judgment, including attorney
4013	fees and costs, obtained against such persons arising out of an
4014	actual or alleged act, error, or omission that occurred within
4015	the scope of Interstate Commission employment, duties, or
1016	responsibilities, or that such persons had a reasonable basis
1017	for believing occurred within the scope of Interstate Commission
1018	employment, duties, or responsibilities, provided that the
1019	actual or alleged act, error, or omission did not result from
1020	intentional or willful and wanton misconduct on the part of such
1021	persons.
1022	
1023	SECTION 14
024	RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION
1025	
4026	(1) The Interstate Commission shall adopt reasonable rules
1027	in order to effectively and efficiently achieve the purposes of
1028	the compact. However, in the event the Interstate Commission
1029	exercises its rulemaking authority in a manner that is beyond
1030	the scope of the purposes of the compact, or the powers granted
1031	hereunder, then such an action by the Interstate Commission is
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4032	invalid and has no force or effect.
4033	(2) Rules deemed appropriate for the operations of the
4034	Interstate Commission must be made pursuant to a rulemaking
4035	process that substantially conforms to the "Model State
4036	Administrative Procedure Act" of 2010, and subsequent amendments
4037	thereto.
4038	(3) Not later than 30 days after a rule is adopted, any
4039	person may file a petition for judicial review of the rule in
4040	the United States District Court for the District of Columbia or
4041	the federal district where the Interstate Commission has its
4042	principal offices, provided that the filing of such a petition
4043	does not stay or otherwise prevent the rule from becoming
4044	effective unless the court finds that the petitioner has a
4045	substantial likelihood of success. The court must give deference
4046	to the actions of the Interstate Commission consistent with
4047	applicable law and may not find the rule to be unlawful if the
4048	rule represents a reasonable exercise of the authority granted
4049	to the Interstate Commission.
4050	
4051	SECTION 15
4052	OVERSIGHT OF INTERSTATE COMPACT
4053	
4054	(1) The executive, legislative, and judicial branches of
4055	state government in each member state shall enforce the compact
4056	and shall take all actions necessary and appropriate to
4057	effectuate the compact's purposes and intent. The compact and
4058	the rules adopted hereunder shall have standing as statutory law
4059	but do not override existing state authority to regulate the
4060	practice of medicine.
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4061	(2) All courts shall take judicial notice of the compact
4062	and the rules in any judicial or administrative proceeding in a
4063	member state pertaining to the subject matter of the compact
4064	which may affect the powers, responsibilities, or actions of the
4065	Interstate Commission.
4066	(3) The Interstate Commission is entitled to receive all
4067	service of process in any such proceeding and shall have
4068	standing to intervene in the proceeding for all purposes.
4069	Failure to provide service of process to the Interstate
4070	Commission shall render a judgment or order void as to the
4071	Interstate Commission, the compact, or adopted rules, as
4072	applicable.
4073	
4074	SECTION 16
4075	ENFORCEMENT OF INTERSTATE COMPACT
4076	
4077	(1) The Interstate Commission, in the reasonable exercise
4078	of its discretion, shall enforce the provisions and rules of the
4079	compact.
4080	(2) The Interstate Commission may, by majority vote of the
4081	commissioners, initiate legal action in the United States
4082	District Court for the District of Columbia, or, at the
4083	discretion of the Interstate Commission, in the federal district
4084	where the Interstate Commission has its principal offices, to
4085	enforce compliance with the compact and its adopted rules and
4086	bylaws against a member state in default. The relief sought may
4087	include both injunctive relief and damages. In the event
4088	judicial enforcement is necessary, the prevailing party must be
4089	awarded all costs of such litigation, including reasonable
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4090	attorney fees.
4091	(3) The remedies herein are not the exclusive remedies of
4092	the Interstate Commission. The Interstate Commission may avail
4092	itself of any other remedies available under state law or the
4094	regulation of a profession.
4094	regulación de a professión.
4095	SECTION 17
4090	DEFAULT PROCEDURES
4097	DEFAULT FROCEDORES
4099	(1) The grounds for default include, but are not limited
4100	to, failure of a member state to perform such obligations or
4101	responsibilities imposed upon it by the compact, or the rules
4102	and bylaws of the Interstate Commission adopted under the
4103	compact.
4104	(2) If the Interstate Commission determines that a member
4105	state has defaulted in the performance of its obligations or
4106	responsibilities under the compact, or the bylaws or adopted
4107	rules, the Interstate Commission shall:
4108	(a) Provide written notice to the defaulting state and
4109	other member states of the nature of the default, the means of
4110	curing the default, and any action taken by the Interstate
4111	Commission. The Interstate Commission shall specify the
4112	conditions by which the defaulting state must cure its default;
4113	and
4114	(b) Provide remedial training and specific technical
4115	assistance regarding the default.
4116	(3) If the defaulting state fails to cure the default, the
4117	defaulting state may be terminated from the compact upon an
4118	affirmative vote of a majority of the commissioners and all
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119	rights, privileges, and benefits conferred by the compact
120	terminate on the effective date of the termination. A cure of
120	the default does not relieve the offending state of obligations
121	
	or liabilities incurred during the period of the default.
123	(4) Termination of membership in the compact must be
124	imposed only after all other means of securing compliance have
125	been exhausted. Notice of intent to terminate must be given by
126	the Interstate Commission to the governor, the majority and
127	minority leaders of the defaulting state's legislature, and each
128	of the member states.
129	(5) The Interstate Commission shall establish rules and
130	procedures to address licenses and physicians that are
131	materially impacted by the termination of a member state, or the
132	withdrawal of a member state.
133	(6) The member state which has been terminated is
134	responsible for all dues, obligations, and liabilities incurred
135	through the effective date of termination, including
136	obligations, the performance of which extends beyond the
137	effective date of termination.
138	(7) The Interstate Commission shall not bear any costs
139	relating to any state that has been found to be in default or
140	which has been terminated from the compact, unless otherwise
141	mutually agreed upon in writing between the Interstate
142	Commission and the defaulting state.
143	(8) The defaulting state may appeal the action of the
144	Interstate Commission by petitioning the United States District
145	Court for the District of Columbia or the federal district where
146	the Interstate Commission has its principal offices. The
147	prevailing party must be awarded all costs of such litigation
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4148	including reasonable attorney fees.
4149	
4150	SECTION 18
4151	DISPUTE RESOLUTION
4152	
4153	(1) The Interstate Commission shall attempt, upon the
4154	request of a member state, to resolve disputes that are subject
4155	to the compact and that may arise among member states or member
4156	boards.
4157	(2) The Interstate Commission shall adopt rules providing
4158	for both mediation and binding dispute resolution as
4159	appropriate.
4160	
4161	SECTION 19
4162	MEMBER STATES, EFFECTIVE DATE, AND AMENDMENT
4163	
4164	(1) Any state is eligible to become a member state of the
4165	compact.
4166	(2) The compact becomes effective and binding upon
4167	legislative enactment of the compact into law by no less than
4168	seven states. Thereafter, it becomes effective and binding on a
4169	state upon enactment of the compact into law by that state.
4170	(3) The governors of nonmember states, or their designees,
4171	must be invited to participate in the activities of the
4172	Interstate Commission on a nonvoting basis before adoption of
4173	the compact by all states.
4174	(4) The Interstate Commission may propose amendments to the
4175	compact for enactment by the member states. No amendment becomes
4176	effective and binding upon the Interstate Commission and the
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1	588-01852-24 20247016
4177	member states unless and until it is enacted into law by
4178	unanimous consent of the member states.
4179	
4180	SECTION 20
4181	WITHDRAWAL
4182	
4183	(1) Once effective, the compact shall continue in force and
4184	remain binding upon each member state. However, a member state
4185	may withdraw from the compact by specifically repealing the
4186	statute which enacted the compact into law.
4187	(2) Withdrawal from the compact must be made by the
4188	enactment of a statute repealing the same, but the withdrawal
4189	shall not take effect until 1 year after the effective date of
4190	such statute and until written notice of the withdrawal has been
4191	given by the withdrawing state to the governor of each other
4192	member state.
4193	(3) The withdrawing state shall immediately notify the
4194	chairperson of the Interstate Commission in writing upon the
4195	introduction of legislation repealing the compact in the
4196	withdrawing state.
4197	(4) The Interstate Commission shall notify the other member
4198	states of the withdrawing state's intent to withdraw within 60
4199	days after receipt of notice provided under subsection (3).
4200	(5) The withdrawing state is responsible for all dues,
4201	obligations, and liabilities incurred through the effective date
4202	of withdrawal, including obligations, the performance of which
4203	extend beyond the effective date of withdrawal.
4204	(6) Reinstatement following withdrawal of a member state
4205	shall occur upon the withdrawing state reenacting the compact or
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4206	588-01852-24 20247016_ upon such later date as determined by the Interstate Commission.
4200	(7) The Interstate Commission may develop rules to address
4207	the impact of the withdrawal of a member state on licenses
4200	granted in other member states to physicians who designated the
4209	withdrawing member state as the state of principal license.
4210	withdrawing member state as the state of principal license.
4211	CECUTON 21
4212	SECTION 21
4213	DISSOLUTION
4214	(1) The compact shall discolute offerstive upon the data of
4215	(1) The compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the
4210	
4217	membership in the compact to one member state.
4210	(2) Upon the dissolution of the compact, the compact
4219	becomes null and void and shall be of no further force or
4220	effect, the business and affairs of the Interstate Commission
4221	must be concluded, and surplus funds of the Interstate Commission must be distributed in accordance with the bylaws.
4222	commission must be distributed in accordance with the bylaws.
4223	SECTION 22
4224	SEVERABILITY AND CONSTRUCTION
4225	SEVERABILITY AND CONSTRUCTION
4220	(1) The provisions of the compact are severable, and if any
4227	phrase, clause, sentence, or provision is deemed unenforceable,
4229	the remaining provisions of the compact remain enforceable.
4229	(2) The provisions of the compact must be liberally
4230	construed to effectuate its purposes.
4231	
4232	(3) The compact may be construed to prohibit the applicability of other interstate compacts to which the states
4233	······
4204	are members.
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588-01852-24 20247016 4235 4236 SECTION 23 4237 BINDING EFFECT OF COMPACT AND OTHER LAWS 4238 (1) Nothing herein prevents the enforcement of any other 4239 4240 law of a member state which is not inconsistent with the 4241 compact. 4242 (2) All laws in a member state in conflict with the compact 4243 are superseded to the extent of the conflict. 4244 (3) All lawful actions of the Interstate Commission, 4245 including all rules and bylaws adopted by the commission, are binding upon the member states. 4246 (4) All agreements between the Interstate Commission and 4247 4248 the member states are binding in accordance with their terms. 4249 (5) In the event any provision of the compact exceeds the 4250 constitutional limits imposed on the legislature of any member 4251 state, such provision is ineffective to the extent of the 4252 conflict with the constitutional provision in question in that 4253 member state. 4254 Section 53. Section 456.4502, Florida Statutes, is created 4255 to read: 4256 456.4502 Interstate Medical Licensure Compact; disciplinary 4257 proceedings.-A physician licensed pursuant to chapter 458, 4258 chapter 459, or s. 456.4501 whose license is suspended or 4259 revoked by this state pursuant to the Interstate Medical Licensure Compact as a result of disciplinary action taken 4260 4261 against the physician's license in another state must be granted 4262 a formal hearing before an administrative law judge from the Division of Administrative Hearings held pursuant to chapter 120 4263 Page 147 of 234 CODING: Words stricken are deletions; words underlined are additions.

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4264	if there are any disputed issues of material fact. In such
4265	proceedings:
4266	(1) Notwithstanding s. 120.569(2), the department shall
4267	notify the division within 45 days after receipt of a petition
4268	or request for a formal hearing.
4269	(2) The determination of whether the physician has violated
4270	the laws and rules regulating the practice of medicine or
4271	osteopathic medicine, as applicable, including a determination
4272	of the reasonable standard of care, is a conclusion of law that
4273	is to be determined by appropriate board and is not a finding of
4274	fact to be determined by an administrative law judge.
4275	(3) The administrative law judge shall issue a recommended
4276	order pursuant to chapter 120.
4277	(4) The Board of Medicine or the Board of Osteopathic
4278	Medicine, as applicable, shall determine and issue the final
4279	order in each disciplinary case. Such order shall constitute
4280	final agency action.
4281	(5) Any consent order or agreed-upon settlement is subject
4282	to the approval of the department.
4283	(6) The department shall have standing to seek judicial
4284	review of any final order of the board, pursuant to s. 120.68.
4285	Section 54. Section 456.4504, Florida Statutes, is created
4286	to read:
4287	456.4504 Interstate Medical Licensure Compact RulesThe
4288	department may adopt rules to implement the Interstate Medical
4289	Licensure Compact.
4290	Section 55. Section 458.3129, Florida Statutes, is created
4291	to read:
4292	458.3129 Interstate Medical Licensure Compact.—A physician
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4293	licensed to practice allopathic medicine under s. 456.4501 is
4294	deemed to also be licensed under this chapter.
4295	Section 56. Section 459.074, Florida Statutes, is created
4296	to read:
4297	459.074 Interstate Medical Licensure CompactA physician
4298	licensed to practice osteopathic medicine under s. 456.4501 is
4299	deemed to also be licensed under this chapter.
4300	Section 57. Paragraph (j) is added to subsection (10) of
4301	section 768.28, Florida Statutes, to read:
4302	768.28 Waiver of sovereign immunity in tort actions;
4303	recovery limits; civil liability for damages caused during a
4304	riot; limitation on attorney fees; statute of limitations;
4305	exclusions; indemnification; risk management programs
4306	(10)
4307	(j) For purposes of this section, the representative
4308	appointed from the Board of Medicine and the representative
4309	appointed from the Board of Osteopathic Medicine, when serving
4310	as commissioners of the Interstate Medical Licensure Compact
4311	Commission pursuant to s. 456.4501, and any administrator,
4312	officer, executive director, employee, or representative of the
4313	Interstate Medical Licensure Compact Commission, when acting
4314	within the scope of their employment, duties, or
4315	responsibilities in this state, are considered agents of the
4316	state. The commission shall pay any claims or judgments pursuant
4317	to this section and may maintain insurance coverage to pay any
4318	such claims or judgments.
4319	Section 58. Section 468.1335, Florida Statutes, is created
4320	to read:
4321	468.1335 Audiology and Speech-Language Pathology Interstate
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4322	Compact.—The Audiology and Speech-Language Pathology Interstate
4323	Compact is hereby enacted into law and entered into by this
4324	state with all other states legally joining therein in the form
4325	substantially as follows:
4326	
4327	ARTICLE I
4328	PURPOSE
4329	
4330	(1) The purpose of the compact is to facilitate the
4331	interstate practice of audiology and speech-language pathology
4332	with the goal of improving public access to audiology and
4333	speech-language pathology services.
4334	(2) The practice of audiology and speech-language pathology
4335	occurs in the state where the patient, client, or student is
4336	located at the time the services are provided.
4337	(3) The compact preserves the regulatory authority of
4338	states to protect the public health and safety through the
4339	current system of state licensure.
4340	(4) The compact is designed to achieve all of the following
4341	objectives:
4342	(a) Increase public access to audiology and speech-language
4343	pathology services by providing for the mutual recognition of
4344	other member state licenses.
4345	(b) Enhance the states' abilities to protect public health
4346	and safety.
4347	(c) Encourage the cooperation of member states in
4348	regulating multistate audiology and speech-language pathology
4349	practices.
4350	(d) Support spouses of relocating active duty military
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4351	personnel.
4352	(e) Enhance the exchange of licensure, investigative, and
1353	disciplinary information between member states.
354	(f) Allow a remote state to hold a licensee with compact
355	privilege in that state accountable to that state's practice
356	standards.
357	(g) Allow for the use of telehealth technology to
358	facilitate increased access to audiology and speech-language
359	pathology services.
360	
361	ARTICLE II
362	DEFINITIONS
363	
364	(1) As used in this section, the term:
365	(2) "Active duty military" means full-time duty status in
366	the active uniformed service of the United States, including
367	members of the National Guard and Reserve on active duty orders
368	pursuant to 10 U.S.C. chapters 1209 and 1211.
369	(3) "Adverse action" means any administrative, civil,
370	equitable, or criminal action permitted by a state's laws which
371	is imposed by a licensing board against a licensee, including
372	actions against an individual's license or privilege to
373	practice, such as revocation, suspension, probation, monitoring
374	of the licensee, or restriction on the licensee's practice.
375	(4) "Alternative program" means a nondisciplinary
376	monitoring process approved by an audiology licensing board or a
377	speech-language pathology licensing board to address impaired
378	licensees.
379	(5) "Audiologist" means an individual who is licensed by a
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4380	state to practice audiology.
4381	(6) "Audiology" means the care and services provided by a
4382	licensed audiologist as provided in the member state's rules and
4383	regulations.
4384	(7) "Audiology and Speech-Language Pathology Interstate
4385	Compact Commission" or "commission" means the national
4386	administrative body whose membership consists of all states that
4387	have enacted the compact.
4388	(8) "Audiology licensing board" means the agency of a state
4389	which is responsible for the licensing and regulation of
4390	audiologists.
4391	(9) "Compact privilege" means the authorization granted by
4392	a remote state to allow a licensee from another member state to
4393	practice as an audiologist or speech-language pathologist in the
4394	remote state under its rules and regulations. The practice of
4395	audiology or speech-language pathology occurs in the member
4396	state where the patient, client, or student is located at the
4397	time the services are provided.
4398	(10) "Current significant investigative information,"
4399	"investigative materials," "investigative records," or
4400	"investigative reports" means information that a licensing
4401	board, after an inquiry or investigation that includes
4402	notification and an opportunity for the audiologist or speech-
4403	language pathologist to respond, if required by state law, has
4404	reason to believe is not groundless and, if proved true, would
4405	indicate more than a minor infraction.
4406	(11) "Data system" means a repository of information
4407	relating to licensees, including, but not limited to, continuing
4408	education, examination, licensure, investigative, compact
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4409	privilege, and adverse action information.
4410	(12) "Encumbered license" means a license in which an
4411	adverse action restricts the practice of audiology or speech-
4412	language pathology by the licensee and the adverse action has
4413	been reported to the National Practitioner Data Bank.
4414	(13) "Executive committee" means a group of directors
4415	elected or appointed to act on behalf of, and within the powers
4416	granted to them by, the commission.
4417	(14) "Home state" means the member state that is the
4418	licensee's primary state of residence.
4419	(15) "Impaired licensee" means a licensee whose
4420	professional practice is adversely affected by substance abuse,
4421	addiction, or other health-related conditions.
4422	(16) "Licensee" means a person who is licensed by his or
4423	her home state to practice as an audiologist or speech-language
4424	pathologist.
4425	(17) "Licensing board" means the agency of a state which is
4426	responsible for the licensing and regulation of audiologists or
4427	speech-language pathologists.
4428	(18) "Member state" means a state that has enacted the
4429	compact.
4430	(19) "Privilege to practice" means the legal authorization
4431	to practice audiology or speech-language pathology in a remote
4432	state.
4433	(20) "Remote state" means a member state, other than the
4434	home state, where a licensee is exercising or seeking to
4435	exercise his or her compact privilege.
4436	(21) "Rule" means a regulation, principle, or directive
4437	adopted by the commission which has the force of law.
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4438	(22) "Single-state license" means an audiology or speech-
4439	language pathology license issued by a member state which
4440	authorizes practice only within the issuing state and does not
4441	include a privilege to practice in any other member state.
4442	(23) "Speech-language pathologist" means an individual who
4443	is licensed to practice speech-language pathology.
4444	(24) "Speech-language pathology" means the care and
4445	services provided by a licensed speech-language pathologist as
4446	provided in the member state's rules and regulations.
4447	(25) "Speech-language pathology licensing board" means the
4448	agency of a state which is responsible for the licensing and
4449	regulation of speech-language pathologists.
4450	(26) "State" means any state, commonwealth, district, or
4451	territory of the United States of America which regulates the
4452	practice of audiology and speech-language pathology.
4453	(27) "State practice laws" means a member state's laws,
4454	rules, and regulations that govern the practice of audiology or
4455	speech-language pathology, define the scope of audiology or
4456	speech-language pathology practice, and create the methods and
4457	grounds for imposing discipline.
4458	(28) "Telehealth" means the application of
4459	telecommunication technology to deliver audiology or speech-
4460	language pathology services at a distance for assessment,
4461	intervention, or consultation.
4462	
4463	ARTICLE III
4464	STATE PARTICIPATION
4465	
4466	(1) A license issued to an audiologist or speech-language
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4467	pathologist by a home state to a resident in that state must be
4468	recognized by each member state as authorizing an audiologist or
4469	speech-language pathologist to practice audiology or speech-
4470	language pathology, under a privilege to practice, in each
4471	member state.
4472	(2) A state must implement procedures for considering the
4473	criminal history records of applicants for initial privilege to
4474	practice. These procedures must include the submission of
4475	fingerprints or other biometric-based information by applicants
4476	for the purpose of obtaining an applicant's criminal history
4477	records from the Federal Bureau of Investigation and the agency
4478	responsible for retaining that state's criminal history records.
4479	(a) A member state must fully implement a criminal history
4480	records check procedure, within a timeframe established by rule,
4481	which requires the member state to receive an applicant's
1482	criminal history records from the Federal Bureau of
4483	Investigation and the agency responsible for retaining the
4484	member state's criminal history records and use such records in
4485	making licensure decisions.
1486	(b) Communication between a member state, the commission,
4487	and other member states regarding the verification of
4488	eligibility for licensure through the compact may not include
4489	any information received from the Federal Bureau of
4490	Investigation relating to a criminal history records check
4491	performed by a member state under Pub. L. No. 92-544.
4492	(3) Upon application for a privilege to practice, the
1493	licensing board in the issuing remote state must determine,
4494	through the data system, whether the applicant has ever held, or
4495	is the holder of, a license issued by any other state, whether
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4496	there are any encumbrances on any license or privilege to
4497	practice held by the applicant, and whether any adverse action
4498	has been taken against any license or privilege to practice held
4499	by the applicant.
4500	(4) Each member state must require an applicant to obtain
4501	or retain a license in his or her home state and meet the home
4502	state's qualifications for licensure or renewal of licensure and
4503	all other applicable state laws.
4504	(5) Each member state must require that an applicant meet
4505	all of the following criteria to receive the privilege to
4506	practice as an audiologist in the member state:
4507	(a) One of the following educational requirements:
4508	1. On or before December 31, 2007, has graduated with a
4509	master's degree or doctoral degree in audiology, or an
4510	equivalent degree, regardless of the name of such degree, from a
4511	program that is accredited by an accrediting agency recognized
4512	by the Council for Higher Education Accreditation, or its
4513	successor, or by the United States Department of Education and
4514	operated by a college or university accredited by a regional or
4515	national accrediting organization recognized by the board;
4516	2. On or after January 1, 2008, has graduated with a
4517	doctoral degree in audiology, or an equivalent degree,
4518	regardless of the name of such degree, from a program that is
4519	accredited by an accrediting agency recognized by the Council
4520	for Higher Education Accreditation, or its successor, or by the
4521	United States Department of Education and operated by a college
4522	or university accredited by a regional or national accrediting
4523	organization recognized by the board; or
4524	3. Has graduated from an audiology program that is housed
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4525	in an institution of higher education outside of the United
4526	States for which the degree program and institution have been
4527	approved by the authorized accrediting body in the applicable
4528	country and the degree program has been verified by an
4529	independent credentials review agency to be comparable to a
4530	state licensing board-approved program.
4531	(b) Has completed a supervised clinical practicum
4532	experience from an accredited educational institution or its
4533	cooperating programs as required by the commission.
4534	(c) Has successfully passed a national examination approved
4535	by the commission.
4536	(d) Holds an active, unencumbered license.
4537	(e) Has not been convicted or found guilty of, or entered a
4538	plea of guilty or nolo contendere to, regardless of
4539	adjudication, a felony in any jurisdiction which directly
4540	relates to the practice of his or her profession or the ability
4541	to practice his or her profession.
4542	(f) Has a valid United States social security number or a
4543	national provider identifier.
4544	(6) Each member state must require that an applicant meet
4545	all of the following criteria to receive the privilege to
4546	practice as a speech-language pathologist in the member state:
4547	(a) One of the following educational requirements:
4548	1. Has graduated with a master's degree from a speech-
4549	language pathology program that is accredited by an organization
4550	recognized by the United States Department of Education and
4551	operated by a college or university accredited by a regional or
4552	national accrediting organization recognized by the board; or
4553	2. Has graduated from a speech-language pathology program
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4554	that is housed in an institution of higher education outside of
4555	the United States for which the degree program and institution
4556	have been approved by the authorized accrediting body in the
4557	applicable country and the degree program has been verified by
4558	an independent credentials review agency to be comparable to a
4559	state licensing board-approved program.
4560	(b) Has completed a supervised clinical practicum
4561	experience from an educational institution or its cooperating
4562	programs as required by the commission.
4563	(c) Has completed a supervised postgraduate professional
4564	experience as required by the commission.
4565	(d) Has successfully passed a national examination approved
4566	by the commission.
4567	(e) Holds an active, unencumbered license.
4568	(f) Has not been convicted or found guilty of, or entered a
4569	plea of guilty or nolo contendere to, regardless of
4570	adjudication, a felony in any jurisdiction which directly
4571	relates to the practice of his or her profession or the ability
4572	to practice his or her profession.
4573	(g) Has a valid United States social security number or
4574	national provider identifier.
4575	(7) The privilege to practice is derived from the home
4576	state license.
4577	(8) An audiologist or speech-language pathologist
4578	practicing in a member state must comply with the state practice
4579	laws of the member state where the client is located at the time
4580	service is provided. The practice of audiology and speech-
4581	language pathology includes all audiology and speech-language
4582	pathology practices as defined by the state practice laws of the
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4583	588-01852-24 20247016
	member state where the client is located. The practice of
4584	audiology and speech-language pathology in a member state under
4585	a privilege to practice subjects an audiologist or speech-
4586	language pathologist to the jurisdiction of the licensing
4587	boards, courts, and laws of the member state where the client is
4588	located at the time service is provided.
4589	(9) Individuals not residing in a member state shall
4590	continue to be able to apply for a member state's single-state
4591	license as provided under the laws of each member state.
4592	However, the single-state license granted to these individuals
4593	may not be recognized as granting the privilege to practice
4594	audiology or speech-language pathology in any other member
4595	state. The compact does not affect the requirements established
4596	by a member state for the issuance of a single-state license.
4597	(10) Member states must comply with the bylaws and rules of
4598	the commission.
4599	
4600	ARTICLE IV
4601	COMPACT PRIVILEGE
4602	
4603	(1) To exercise compact privilege under the compact, the
4604	audiologist or speech-language pathologist must meet all of the
4605	following criteria:
4606	(a) Hold an active license in the home state.
4607	(b) Have no encumbrance on any state license.
4608	(c) Be eligible for compact privilege in any member state
4609	in accordance with Article III.
4610	(d) Not have any adverse action against any license or
4611	compact privilege within the 2 years preceding the date of
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4612	application.
4613	(e) Notify the commission that he or she is seeking compact
4614	privilege within a remote state or states.
4615	(f) Report to the commission any adverse action taken by
4616	any nonmember state within 30 days after the date the adverse
4617	action is taken.
4618	(2) For the purposes of compact privilege, an audiologist
4619	or speech-language pathologist may hold only one home state
4620	license at a time.
4621	(3) Except as provided in Article VI, if an audiologist or
4622	speech-language pathologist changes his or her primary state of
4623	residence by moving between two member states, the audiologist
4624	or speech-language pathologist must apply for licensure in the
4625	new home state, and the license issued by the prior home state
4626	shall be deactivated in accordance with applicable rules adopted
4627	by the commission.
4628	(4) The audiologist or speech-language pathologist may
4629	apply for licensure in advance of a change in his or her primary
4630	state of residence.
4631	(5) A license may not be issued by the new home state until
4632	the audiologist or speech-language pathologist provides
4633	satisfactory evidence of a change in his or her primary state of
4634	residence to the new home state and satisfies all applicable
4635	requirements to obtain a license from the new home state.
4636	(6) If an audiologist or speech-language pathologist
4637	changes his or her primary state of residence by moving from a
4638	member state to a nonmember state, the license issued by the
4639	prior home state shall convert to a single-state license, valid
4640	only in the former home state.
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4641 (7) Compact privilege is valid unt		4670		
4642 the home state license. The licensee mu	· · · · · · · · · · · · · · · · · · ·	4671		с.
4643 requirements of subsection (1) to maint		4672		-
4644 the remote state.		4673		
4645 (8) A licensee providing audiology	or speech-language	4674	<u> </u>	J
4646 pathology services in a remote state un		4675		-
4647 shall function within the laws and regu	lations of the remote	4676	6 privilege to practice as provided in the compact and rules	
4648 state		4677	adopted by the commission.	
4649 (9) A remote state may, in accorda	nce with due process and	4678	8	
4650 state law, remove a licensee's compact	privilege in the remote	4679	9 ARTICLE VI	
4651 state for a specific period of time, im	pose fines, or take any	4680	0 ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES	
4652 other necessary actions to protect the	health and safety of its	4681	1	
4653 residents.		4682	2 Active duty military personnel, or their spouses, as	
4654 (10) If a home state license is en	cumbered, the licensee	4683	3 applicable, shall designate a home state where the individual	
4655 <u>shall lose compact privilege in all rem</u>	ote states until both of	4684	4 has a current license in good standing. The individual may	
4656 the following occur:		4685	5 retain the home state designation during the period the	
4657 (a) The home state license is no l	onger encumbered.	4686	6 servicemember is on active duty. Subsequent to designating a	
4658 (b) Two years have lapsed from the	date of the adverse	4687	7 home state, the individual shall change his or her home state	
4659 <u>action.</u>		4688	8 only through application for licensure in the new state.	
4660 (11) Once an encumbered license in	the home state is	4689	3	
4661 <u>restored to good standing, the licensee</u>		4690	0 <u>ARTICLE VII</u>	
4662 <u>requirements of subsection (1) to obtai</u>	n compact privilege in	4691		
4663 <u>any remote state.</u>		4692		
4664 (12) Once the requirements of subs		4693		iW,
4665 met, the licensee must meet the requires		4694		
4666 to obtain compact privilege in a remote	state.	4695	· · · · · · · · · · · · · · · · · · ·	
4667		4696		<u>er</u>
4668 <u>ARTICLE V</u>		4697		
4669 <u>COMPACT PRIVILEGE TO PRACTI</u>	<u>CE TELEHEALTH</u>	4698	8 1 . Only the home state has the power to take adverse action 1 .	<u>.on</u>
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4699	against an audiologist's or a speech-language pathologist's
4700	license issued by the home state.
4701	2. For purposes of taking adverse action, the home state
4702	shall give the same priority and effect to reported conduct
4703	received from a member state as it would if the conduct had
4704	occurred within the home state. In so doing, the home state
4705	shall apply its own state laws to determine appropriate action.
4706	(b) Issue subpoenas for both hearings and investigations
4707	that require the attendance and testimony of witnesses as well
4708	as the production of evidence. Subpoenas issued by a licensing
4709	board in a member state for the attendance and testimony of
4710	witnesses or the production of evidence from another member
4711	state must be enforced in the latter state by any court of
4712	competent jurisdiction according to the practice and procedure
4713	of that court applicable to subpoenas issued in proceedings
4714	pending before it. The issuing authority shall pay any witness
4715	fees, travel expenses, mileage, and other fees required by the
4716	service statutes of the state in which the witnesses or evidence
4717	are located.
4718	(c) Complete any pending investigations of an audiologist
4719	or speech-language pathologist who changes his or her primary
4720	state of residence during the course of the investigations. The
4721	home state also has the authority to take appropriate actions
4722	and shall promptly report the conclusions of the investigations
4723	to the administrator of the data system. The administrator of
4724	the data system shall promptly notify the new home state of any
4725	adverse actions.
4726	(d) If otherwise allowed by state law, recover from the
4727	affected audiologist or speech-language pathologist the costs of
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4728	investigations and disposition of cases resulting from any
4729	adverse action taken against that audiologist or speech-language
4730	pathologist.
4731	(e) Take adverse action based on the factual findings of
4732	the remote state, provided that the member state follows the
4733	member state's own procedures for taking the adverse action.
4734	(2) (a) In addition to the authority granted to a member
4735	state by its respective audiology or speech-language pathology
4736	practice act or other applicable state law, any member state may
4737	participate with other member states in joint investigations of
4738	licensees.
4739	(b) Member states shall share any investigative,
4740	litigation, or compliance materials in furtherance of any joint
4741	or individual investigation initiated under the compact.
4742	(3) If adverse action is taken by the home state against an
4743	audiologist's or a speech language pathologist's license, the
4744	audiologist's or speech-language pathologist's privilege to
4745	practice in all other member states shall be deactivated until
4746	all encumbrances have been removed from the home state license.
4747	All home state disciplinary orders that impose adverse action
4748	against an audiologist's or a speech language pathologist's
4749	license must include a statement that the audiologist's or
4750	speech-language pathologist's privilege to practice is
4751	deactivated in all member states during the pendency of the
4752	order.
4753	(4) If a member state takes adverse action, it must
4754	promptly notify the administrator of the data system. The
4755	administrator of the data system shall promptly notify the home
4756	state of any adverse actions by remote states.
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4757	(5) The compact does not override a member state's decision
	(c) The compace does not override a member state s decision
4758	that participation in an alternative program may be used in lieu
4759	of adverse action.
4760	
4761	ARTICLE VIII
4762	ESTABLISHMENT OF THE AUDIOLOGY
4763	AND SPEECH-LANGUAGE PATHOLOGY INTERSTATE COMPACT COMMISSION
4764	
4765	(1) The member states hereby create and establish a joint
4766	public agency known as the Audiology and Speech-language
4767	Pathology Interstate Compact Commission.
4768	(a) The commission is an instrumentality of the compact
4769	states.
4770	(b) Venue is proper, and judicial proceedings by or against
4771	the commission must be brought solely and exclusively in a court
4772	of competent jurisdiction where the principal office of the
4773	commission is located. The commission may waive venue and
4774	jurisdictional defenses to the extent it adopts or consents to
4775	participate in alternative dispute resolution proceedings.
4776	(c) The compact does not waive sovereign immunity except to
4777	the extent sovereign immunity is waived in the member states.
4778	(2) (a) Each member state must have two delegates selected
4779	by that member state's licensing boards. The delegates must be
4780	current members of the licensing boards. One delegate must be an
4781	audiologist and one delegate must be a speech-language
4782	pathologist.
4783	(b) An additional five delegates, who are either public
4784	members or board administrators from licensing boards, must be
4785	chosen by the executive committee from a pool of nominees

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4786	provided by the commission at large.
4787	(c) A delegate may be removed or suspended from office as
4788	provided by the state law from which the delegate is appointed.
4789	(d) The member state board shall fill any vacancy occurring
4790	on the commission within 90 days after the vacancy occurs.
4791	(e) Each delegate is entitled to one vote with regard to
4792	the adoption of rules and creation of bylaws and shall otherwise
4793	have an opportunity to participate in the business and affairs
4794	of the commission.
4795	(f) A delegate shall vote in person or by other means as
4796	provided in the bylaws. The bylaws may provide for delegates'
4797	participation in meetings by telephone or other means of
4798	communication.
4799	(g) The commission shall meet at least once during each
4800	calendar year. Additional meetings must be held as provided in
4801	the bylaws and rules.
4802	(3) The commission has the following powers and duties:
4803	(a) Establish the commission's fiscal year.
4804	(b) Establish bylaws.
4805	(c) Establish a code of ethics.
4806	(d) Maintain its financial records in accordance with the
4807	bylaws.
4808	(e) Meet and take actions as are consistent with the
4809	compact and the bylaws.
4810	(f) Adopt uniform rules to facilitate and coordinate
4811	implementation and administration of the compact. The rules have
4812	the force and effect of law and are binding on all member
4813	states.
4814	(g) Bring and prosecute legal proceedings or actions in the
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blogy licensing board or a speech-language pathology nsing board to sue or be sued under applicable law is not cted. (h) Purchase and maintain insurance and bonds. (i) Borrow, accept, or contract for services of personnel, uding, but not limited to, employees of a member state. (j) Hire employees, elect or appoint officers, fix ensation, define duties, grant individuals appropriate
hsing board to sue or be sued under applicable law is not cted. (h) Purchase and maintain insurance and bonds. (i) Borrow, accept, or contract for services of personnel, uding, but not limited to, employees of a member state. (j) Hire employees, elect or appoint officers, fix ensation, define duties, grant individuals appropriate
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 (h) Purchase and maintain insurance and bonds. (i) Borrow, accept, or contract for services of personnel, uding, but not limited to, employees of a member state. (j) Hire employees, elect or appoint officers, fix ensation, define duties, grant individuals appropriate
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ensation, define duties, grant individuals appropriate
arity to carry out the nurneses of the compact and
Sitty to carry out the purposes of the compact, and
plish the commission's personnel policies and programs
ting to conflicts of interest, qualifications of personnel,
other related personnel matters.
(k) Accept any appropriate donations and grants of money,
oment, supplies, and materials and services, and receive,
and dispose of the same, provided that at all times the
ission must avoid any appearance of impropriety or conflict
nterest.
(1) Lease, purchase, accept appropriate gifts or donations
or otherwise own, hold, improve, or use any property, real,
onal, or mixed, provided that at all times the commission
l avoid any appearance of impropriety.
(m) Sell, convey, mortgage, pledge, lease, exchange,
don, or otherwise dispose of any property real, personal, or
<u>1.</u>
(n) Establish a budget and make expenditures.
(o) Borrow money.
(p) Appoint committees, including standing committees,

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4844	designated in the compact and the bylaws.
4845	(q) Provide and receive information from, and cooperate
4846	with, law enforcement agencies.
4847	(r) Establish and elect an executive committee.
4848	(s) Perform other functions as may be necessary or
4849	appropriate to achieve the purposes of the compact consistent
4850	with the state regulation of audiology and speech-language
4851	pathology licensure and practice.
4852	(4) The executive committee shall have the power to act on
4853	behalf of the commission according to the terms of the compact.
4854	(a) The executive committee must be composed of 10 members
4855	as follows:
4856	1. Seven voting members who are elected by the commission
4857	from the current membership of the commission.
4858	2. Two ex officio members, consisting of one nonvoting
4859	member from a recognized national audiology professional
4860	association and one nonvoting member from a recognized national
4861	speech-language pathology association.
4862	3. One ex officio, nonvoting member from the recognized
4863	membership organization of the audiology and speech-language
4864	pathology licensing boards.
4865	(b) The ex officio members must be selected by their
4866	respective organizations.
4867	(c) The commission may remove any member of the executive
4868	committee as provided in the bylaws.
4869	(d) The executive committee shall meet at least annually.
4870	(e) The executive committee has the following duties and
4871	responsibilities:
4872	1. Recommend to the entire commission changes to the rules
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r bylaws and changes to this compact legislation.
2. Ensure compact administration services are appropriately
rovided, contractual or otherwise.
3. Prepare and recommend the budget.
4. Maintain financial records on behalf of the commission.
5. Monitor compact compliance of member states and provide
ompliance reports to the commission.
6. Establish additional committees as necessary.
7. Other duties as provided by rule or bylaw.
(f) All meetings must be open to the public, and public
otice of meetings must be given in the same manner as required
nder the rulemaking provisions in Article X.
(g) If a meeting or any portion of a meeting is closed
nder this subsection, the commission's legal counsel or
esignee must certify that the meeting may be closed and must
eference each relevant exempting provision.
(h) The commission shall keep minutes that fully and
learly describe all matters discussed in a meeting and shall
rovide a full and accurate summary of actions taken, and the
easons therefore, including a description of the views
xpressed. All documents considered in connection with an action
ust be identified in minutes. All minutes and documents of a
losed meeting must remain under seal, subject to release by a
ajority vote of the commission or order of a court of competent
urisdiction.
(5) Relating to the financing of the commission, the
ommission:
(a) Shall pay, or provide for the payment of, the
easonable expenses of its establishment, organization, and
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4902	ongoing activities.
4903	(b) May accept any and all appropriate revenue sources,
4904	donations, and grants of money, equipment, supplies, materials,
4905	and services.
4906	(c) May not incur obligations of any kind before securing
4907	the funds adequate to meet the same and may not pledge the
4908	credit of any of the member states, except by and with the
4909	authority of the member state.
4910	(d) Shall keep accurate accounts of all receipts and
4911	disbursements of funds. The receipts and disbursements of funds
4912	of the commission are subject to the audit and accounting
4913	procedures established under its bylaws. However, all receipts
4914	and disbursements of funds handled by the commission must be
4915	audited yearly by a certified or licensed public accountant, and
4916	the report of the audit must be included in and become part of
4917	the annual report of the commission.
4918	(6) Relating to qualified immunity, defense, and
4919	indemnification:
4920	(a) The members, officers, executive director, employees,
4921	and representatives of the commission are immune from suit and
4922	liability, either personally or in their official capacity, for
4923	any claim for damage to or loss of property or personal injury
4924	or other civil liability caused by or arising out of any actual
4925	or alleged act, error, or omission that occurred, or that the
4926	person against whom the claim is made had a reasonable basis for
4927	believing occurred, within the scope of commission employment,
4928	duties, or responsibilities; provided that this paragraph may
4929	not be construed to protect any person from suit or liability
4930	for any damage, loss, injury, or liability caused by the
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4931	intentional or willful or wanton misconduct of that person.
4932	(b) The commission shall defend any member, officer,
4933	executive director, employee, or representative of the
4934	commission in any civil action seeking to impose liability
4935	arising out of any actual or alleged act, error, or omission
4936	that occurred within the scope of commission employment, duties,
4937	or responsibilities, or that the person against whom the claim
4938	is made had a reasonable basis for believing occurred within the
4939	scope of commission employment, duties, or responsibilities;
4940	provided that this paragraph may not be construed to prohibit
4941	that person from retaining his or her own counsel; and provided
4942	further that the actual or alleged act, error, or omission did
4943	not result from that person's intentional or willful or wanton
4944	misconduct.
4945	(c) The commission shall indemnify and hold harmless any
4946	member, officer, executive director, employee, or representative
4947	of the commission for the amount of any settlement or judgment
4948	obtained against that person arising out of any actual or
4949	alleged act, error, or omission that occurred within the scope
4950	of commission employment, duties, or responsibilities, or that
4951	the person had a reasonable basis for believing occurred within
4952	the scope of commission employment, duties, or responsibilities,
4953	provided that the actual or alleged act, error, or omission did
4954	not result from the intentional or willful or wanton misconduct
4955	of that person.
4956	
4957	ARTICLE IX
4958	DATA SYSTEM
4959	
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4960	(1) The commission shall provide for the development,
4961	maintenance, and use of a coordinated database and reporting
4962	system containing licensure, adverse action, and current
4963	significant investigative information on all licensed
4964	individuals in member states.
4965	(2) Notwithstanding any other law to the contrary, a member
4966	state shall submit a uniform data set to the data system on all
4967	individuals to whom the compact is applicable as required by the
4968	rules of the commission, including all of the following
4969	information:
4970	(a) Identifying information.
4971	(b) Licensure data.
4972	(c) Adverse actions against a license or compact privilege.
4973	(d) Nonconfidential information related to alternative
4974	program participation.
4975	(e) Any denial of application for licensure, and the reason
4976	for such denial.
4977	(f) Other information that may facilitate the
4978	administration of the compact, as determined by the rules of the
4979	commission.
4980	(3) Current significant investigative information
4981	pertaining to a licensee in a member state must be available
4982	only to other member states.
4983	(4) The commission shall promptly notify all member states
4984	of any adverse action taken against a licensee or an individual
4985	applying for a license. Adverse action information pertaining to
4986	a licensee or an individual applying for a license in any member
4987	state must be available to any other member state.
4988	(5) Member states contributing information to the data

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4989	system may designate information that may not be shared with the
4990	public without the express permission of the contributing state.
4991	(6) Any information submitted to the data system that is
4992	subsequently required to be expunged by the laws of the member
4993	state contributing the information must be removed from the data
4994	system.
4995	
4996	ARTICLE X
4997	RULEMAKING
4998	
4999	(1) The commission shall exercise its rulemaking powers
5000	pursuant to the criteria provided in this article and the rules
5001	adopted thereunder. Rules and amendments become binding as of
5002	the date specified in each rule or amendment.
5003	(2) If a majority of the legislatures of the member states
5004	rejects a rule by enactment of a statute or resolution in the
5005	same manner used to adopt the compact within 4 years after the
5006	date of adoption of the rule, the rule has no further force and
5007	effect in any member state.
5008	(3) Rules or amendments to the rules must be adopted at a
5009	regular or special meeting of the commission.
5010	(4) Before adoption of a final rule or rules by the
5011	commission, and at least 30 days before the meeting at which the
5012	rule shall be considered and voted upon, the commission shall
5013	file a notice of proposed rulemaking:
5014	(a) On the website of the commission or other publicly
5015	accessible platform; and
5016	(b) On the website of each member state audiology licensing
5017	board and speech-language pathology licensing board or other
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5018	publicly accessible platform or the publication where each state
5019	would otherwise publish proposed rules.
5020	(5) The notice of proposed rulemaking must include all of
5021	the following:
5022	(a) The proposed time, date, and location of the meeting in
5023	which the rule will be considered and voted upon.
5024	(b) The text of and reason for the proposed rule or
5025	amendment.
5026	(c) A request for comments on the proposed rule from any
5027	interested person.
5028	(d) The manner in which interested persons may submit
5029	notice to the commission of their intention to attend the public
5030	hearing and any written comments.
5031	(6) Before the adoption of a proposed rule, the commission
5032	shall allow persons to submit written data, facts, opinions, and
5033	arguments, which shall be made available to the public.
5034	(a) The commission shall grant an opportunity for a public
5035	hearing before it adopts a rule or amendment if a hearing is
5036	requested by:
5037	1. At least 25 persons;
5038	2. A state or federal governmental subdivision or agency;
5039	or
5040	3. An association having at least 25 members.
5041	(b) If a hearing is held on the proposed rule or amendment,
5042	the commission must publish the place, time, and date of the
5043	scheduled public hearing. If the hearing is held via electronic
5044	means, the commission must publish the mechanism for access to
5045	the electronic hearing.
5046	(c) All persons wishing to be heard at the hearing shall
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5047	notify the executive director of the commission or other
5048	designated member in writing of their desire to appear and
5049	testify at the hearing not less than 5 business days before the
5050	scheduled date of the hearing.
5051	(d) Hearings must be conducted in a manner providing each
5051	person who wishes to comment a fair and reasonable opportunity
5052	to comment orally or in writing.
5054	(e) All hearings must be recorded. A copy of the recording
5054	
5055	<pre>must be made available on request. (7) This article does not require a separate hearing on</pre>
5057	each rule. Rules may be grouped for the convenience of the
5058	commission at hearings required by this article.
5059	(8) Following the scheduled hearing date, or by the close
5060	of business on the scheduled hearing date if the hearing was not
5061	held, the commission shall consider all written and oral
5062	comments received.
5063	(9) If no written notice of intent to attend the public
5064	hearing by interested parties is received, the commission may
5065	proceed with adoption of the proposed rule without a public
5066	hearing.
5067	(10) The commission shall, by majority vote of all members,
5068	take final action on the proposed rule and shall determine the
5069	effective date of the rule, if any, based on the rulemaking
5070	record and the full text of the rule.
5071	(11) Upon determination that an emergency exists, the
5072	commission may consider and adopt an emergency rule without
5073	prior notice, opportunity for comment, or hearing, provided that
5074	the usual rulemaking procedures provided in the compact and in
5075	this article retroactively apply to the rule as soon as
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5076	reasonably possible, but in no event later than 90 days after
5077	the effective date of the rule. For purposes of this subsection,
5078	an emergency rule is one that must be adopted immediately in
5079	order to:
5080	(a) Meet an imminent threat to public health, safety, or
5081	welfare;
5082	(b) Prevent a loss of commission or member state funds; or
5083	(c) Meet a deadline for the promulgation of an
5084	administrative rule that is established by federal law or rule.
5085	(12) The commission or an authorized committee of the
5086	commission may direct revisions to a previously adopted rule or
5087	amendment for purposes of correcting typographical errors,
5088	errors in format, errors in consistency, or grammatical errors.
5089	Public notice of any revisions must be posted on the website of
5090	the commission. The revisions are subject to challenge by any
5091	person for a period of 30 days after posting. A revision may be
5092	challenged only on grounds that it results in a material change
5093	to a rule. A challenge must be made in writing and delivered to
5094	the chair of the commission before the end of the notice period.
5095	If no challenge is made, the revision takes effect without
5096	further action. If the revision is challenged, the revision may
5097	not take effect without the approval of the commission.
5098	
5099	ARTICLE XI
5100	DISPUTE RESOLUTION
5101	AND ENFORCEMENT
5102	
5103	(1) (a) Upon request by a member state, the commission shall
5104	attempt to resolve disputes related to the compact which arise
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	among member states and between member and nonmember states.
5106	(b) The commission shall adopt a rule providing for both
5107	mediation and binding dispute resolution for disputes as
5108	appropriate.
5109	(2) (a) The commission, in the reasonable exercise of its
5110	discretion, shall enforce the compact.
5111	(b) By majority vote, the commission may initiate legal
5112	action in the United States District Court for the District of
5113	Columbia or the federal district where the commission has its
5114	principal offices against a member state in default to enforce
5115	compliance with the compact and its adopted rules and bylaws.
5116	The relief sought may include both injunctive relief and
5117	damages. In the event judicial enforcement is necessary, the
5118	prevailing member must be awarded all costs of litigation,
5119	including reasonable attorney fees.
5120	(c) The remedies provided in this subsection are not the
5121	exclusive remedies of the commission. The commission may pursue
5122	any other remedies available under federal or state law.
5123	
5124	ARTICLE XII
5125	EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT
5126	
5127	(1) The compact becomes effective and binding on the date
5128	of legislative enactment of the compact by no fewer than 10
5129	member states. The provisions, which become effective at that
5130	time, shall be limited to the powers granted to the commission
5131	relating to assembly and the adoption of rules. Thereafter, the
5132	commission shall meet and exercise rulemaking powers as
5133	necessary to implement and administer the compact.
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5134	(2) Any state that joins the compact subsequent to the
5135	commission's initial adoption of the rules is subject to the
5136	rules as they exist on the date on which the compact becomes law
5137	in that state. Any rule that has been previously adopted by the
5138	commission has the full force and effect of law on the day the
5139	compact becomes law in that state.
5140	(3) A member state may withdraw from the compact by
5141	enacting a statute repealing the compact.
5142	(a) A member state's withdrawal does not take effect until
5143	6 months after enactment of the repealing statute.
5144	(b) Withdrawal does not affect the continuing requirement
5145	of the withdrawing state's audiology licensing board or speech-
5146	language pathology licensing board to comply with the
5147	investigative and adverse action reporting requirements of the
5148	compact before the effective date of withdrawal.
5149	(4) The compact does not invalidate or prevent any
5150	audiology or speech-language pathology licensure agreement or
5151	other cooperative arrangement between a member state and a
5152	nonmember state which does not conflict with the compact.
5153	(5) The compact may be amended by the member states. An
5154	amendment to the compact does not become effective and binding
5155	upon any member state until it is enacted into the laws of all
5156	member states.
5157	
5158	ARTICLE XIII
5159	CONSTRUCTION AND SEVERABILITY
5160	
5161	The compact must be liberally construed so as to effectuate
5162	$\underline{its}\ purposes.$ The provisions of the compact are severable and if
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5163	any phrase, clause, sentence, or provision of the compact is
5164	declared to be contrary to the constitution of any member state
5165	or of the United States or the applicability thereof to any
5166	government, agency, person, or circumstance is held invalid, the
5167	validity of the remainder of the compact and the applicability
5168	thereof to any government, agency, person, or circumstance is
5169	not be affected. If the compact is held contrary to the
5170	constitution of any member state, it shall remain in full force
5171	and effect as to the remaining member states and in full force
5172	and effect as to the member state affected as to all severable
5173	matters.
5174	
5175	ARTICLE XIV
5176	BINDING EFFECT OF COMPACT AND OTHER LAWS
5177	
5178	(1) This compact does not prevent the enforcement of any
5179	other law of a member state which is not inconsistent with the
5180	compact.
5181	(2) All laws of a member state in conflict with the compact
5182	are superseded to the extent of the conflict.
5183	(3) All lawful actions of the commission, including all
5184	rules and bylaws adopted by the commission, are binding upon the
5185	member states.
5186	(4) All agreements between the commission and the member
5187	states are binding in accordance with their terms.
5188	(5) In the event any provision of the compact exceeds the
5189	constitutional limits imposed on the legislature of any member
5190	state, the provision is ineffective to the extent of the
5191	conflict with the constitutional provision in question in that
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5192	member state.
5193	Section 59. Subsection (10) of section 456.073, Florida
5194	Statutes, is amended to read:
5195	456.073 Disciplinary proceedings.—Disciplinary proceedings
5196	for each board shall be within the jurisdiction of the
5197	department.
5198	(10) (a) The complaint and all information obtained pursuant
5199	to the investigation by the department are confidential and
5200	exempt from s. 119.07(1) until 10 days after probable cause has
5201	been found to exist by the probable cause panel or by the
5202	department, or until the regulated professional or subject of
5203	the investigation waives his or her privilege of
5204	confidentiality, whichever occurs first.
5205	(b) The department shall report any significant
5206	investigation information relating to a nurse holding a
5207	multistate license to the coordinated licensure information
5208	system pursuant to s. 464.0095; any investigative information
5209	relating to an audiologist or a speech-language pathologist
5210	holding a compact privilege under the Audiology and Speech-
5211	Language Pathology Interstate Compact to the data system
5212	pursuant to s. 468.1335; any significant investigatory
5213	information relating to a psychologist practicing under the
5214	Psychology Interjurisdictional Compact to the coordinated
5215	licensure information system pursuant to s. 490.0075; $_{ au}$ and any
5216	significant investigatory information relating to a health care
5217	practitioner practicing under the Professional Counselors
5218	Licensure Compact to the data system pursuant to s. 491.017, and
5219	any significant investigatory information relating to a
5220	psychologist practicing under the Psychology Interjurisdictional
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	5250	contract. In establishing the terms of monitoring, the
	5251	consultant may consider the recommendations of one or more
	5252	approved evaluators, treatment programs, or treatment providers.
	5253	A consultant may modify the terms of monitoring if the
	5254	consultant concludes, through the course of monitoring, that
	5255	extended, additional, or amended terms of monitoring are
	5256	required for the protection of the health, safety, and welfare
	5257	of the public. If the impaired practitioner is an audiologist or
	5258	a speech-language pathologist practicing under the Audiology and
	5259	Speech-Language Pathology Interstate Compact pursuant to s.
	5260	468.1335, a psychologist practicing under the Psychology
	5261	Interjurisdictional Compact pursuant to s. 490.0075, or a health
	5262	care practitioner practicing under the Professional Counselors
	5263	Licensure Compact pursuant to s. 491.017, the terms of the
	5264	monitoring contract must include the impaired practitioner's
	5265	withdrawal from all practice under the compact unless authorized
	5266	by a member state. If the impaired practitioner is a
	5267	psychologist practicing under the Psychology Interjurisdictional
	5268	Compact pursuant to s. 490.0075, the terms of the monitoring
	5269	contract must include the impaired practitioner's withdrawal
	5270	from all practice under the compact.
	5271	Section 61. Present subsections (4) , (5) , and (6) of
	5272	section 468.1135, Florida Statutes, are redesignated as
	5273	subsections (5), (6), and (7), respectively, and a new
	5274	subsection (4) is added to that section, to read:
	5275	468.1135 Board of Speech-Language Pathology and Audiology
	5276	(4) The board shall appoint two of its members to serve as
	5277	the state's delegates on the Speech-Language Pathology
	5278	Interstate Compact Commission, as required under s. 468.1335,
	1	

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5221 Compact to the coordinated licensure information system pursuant 5222 to s. 490.0075.

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5223 (c) Upon completion of the investigation and a 5224 recommendation by the department to find probable cause, and 5225 pursuant to a written request by the subject or the subject's attorney, the department shall provide the subject an 5226 5227 opportunity to inspect the investigative file or, at the 5228 subject's expense, forward to the subject a copy of the 5229 investigative file. Notwithstanding s. 456.057, the subject may 5230 inspect or receive a copy of any expert witness report or 5231 patient record connected with the investigation if the subject agrees in writing to maintain the confidentiality of any 5232 5233 information received under this subsection until 10 days after 5234 probable cause is found and to maintain the confidentiality of 5235 patient records pursuant to s. 456.057. The subject may file a 5236 written response to the information contained in the 5237 investigative file. Such response must be filed within 20 days 5238 of mailing by the department, unless an extension of time has 5239 been granted by the department. 5240 (d) This subsection does not prohibit the department from 5241 providing the complaint and any information obtained pursuant to 5242 the department's investigation such information to any law 5243 enforcement agency or to any other regulatory agency. 5244 Section 60. Subsection (5) of section 456.076, Florida 5245 Statutes, is amended to read: 5246 456.076 Impaired practitioner programs.-5247 (5) A consultant shall enter into a participant contract 5248 with an impaired practitioner and shall establish the terms of monitoring and shall include the terms in a participant 5249

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5279	one of whom must be an audiologist and one of whom must be a	5308	a report or records required by state or federal law, willfully
5280	speech-language pathologist.	5309	impeding or obstructing such filing, or inducing another person
5281	Section 62. Subsection (6) is added to section 468.1185,	5310	to impede or obstruct such filing. Such report or record shall
5282	Florida Statutes, to read:	5311	include only those reports or records which are signed in one's
5283	468.1185 Licensure	5312	capacity as a licensed speech-language pathologist or
5284	(6) A person licensed as an audiologist or a speech-	5313	audiologist.
5285	language pathologist in another state who is practicing under	5314	(e) Advertising goods or services in a manner which is
5286	the Audiology and Speech-Language Pathology Interstate Compact	5315	fraudulent, false, deceptive, or misleading in form or content.
5287	pursuant to s. 468.1335, and only within the scope provided	5316	(f) Being proven guilty of fraud or deceit or of
5288	therein, is exempt from the licensure requirements of this	5317	negligence, incompetency, or misconduct in the practice of
5289	section.	5318	speech-language pathology or audiology.
5290	Section 63. Subsections (1) and (2) of section 468.1295,	5319	(g) Violating a lawful order of the board or department
5291	Florida Statutes, are amended to read:	5320	previously entered in a disciplinary hearing, or failing to
5292	468.1295 Disciplinary proceedings	5321	comply with a lawfully issued subpoena of the board or
5293	(1) The following acts constitute grounds for denial of a	5322	department.
5294	license or disciplinary action, as specified in s. 456.072(2) or	5323	(h) Practicing with a revoked, suspended, inactive, or
5295	<u>s. 468.1335</u> :	5324	delinquent license.
5296	(a) Procuring, or attempting to procure, a license by	5325	(i) Using, or causing or promoting the use of, any
5297	bribery, by fraudulent misrepresentation, or through an error of	5326	advertising matter, promotional literature, testimonial,
5298	the department or the board.	5327	guarantee, warranty, label, brand, insignia, or other
5299	(b) Having a license revoked, suspended, or otherwise acted	5328	representation, however disseminated or published, which is
5300	against, including denial of licensure, by the licensing	5329	misleading, deceiving, or untruthful.
5301	authority of another state, territory, or country.	5330	(j) Showing or demonstrating or, in the event of sale,
5302	(c) Being convicted or found guilty of, or entering a plea	5331	delivery of a product unusable or impractical for the purpose
5303	of nolo contendere to, regardless of adjudication, a crime in	5332	represented or implied by such action.
5304	any jurisdiction which directly relates to the practice of	5333	(k) Failing to submit to the board on an annual basis, or
5305	speech-language pathology or audiology.	5334	such other basis as may be provided by rule, certification of
5306	(d) Making or filing a report or record which the licensee	5335	testing and calibration of such equipment as designated by the
5307	knows to be false, intentionally or negligently failing to file	5336	board and on the form approved by the board.
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5337	 (1) Aiding, assisting, procuring, employing, or advising 		5366	any other sense specially fabricated for an individual, when
5338	any licensee or business entity to practice speech-language		5367	such is not the case.
5339	pathology or audiology contrary to this part, chapter 456, or		5368	(s) Canvassing from house to house or by telephone, either
5340	any rule adopted pursuant thereto.		5369	in person or by an agent, for the purpose of selling a hearing
5341	(m) Misrepresenting the professional services available in		5370	aid, except that contacting persons who have evidenced an
5342	the fitting, sale, adjustment, service, or repair of a hearing		5371	interest in hearing aids, or have been referred as in need of
5343	aid, or using any other term or title which might connote the		5372	hearing aids, shall not be considered canvassing.
5344	availability of professional services when such use is not		5373	(t) Failing to notify the department in writing of a change
5345	accurate.		5374	in current mailing and place-of-practice address within 30 days
5346	(n) Representing, advertising, or implying that a hearing		5375	after such change.
5347	aid or its repair is guaranteed without providing full		5376	(u) Failing to provide all information as described in ss.
5348	disclosure of the identity of the guarantor; the nature, extent,		5377	468.1225(5)(b), 468.1245(1), and 468.1246.
5349	and duration of the guarantee; and the existence of conditions		5378	(v) Exercising influence on a client in such a manner as to
5350	or limitations imposed upon the guarantee.		5379	exploit the client for financial gain of the licensee or of a
5351	(o) Representing, directly or by implication, that a		5380	third party.
5352	hearing aid utilizing bone conduction has certain specified		5381	(w) Practicing or offering to practice beyond the scope
5353	features, such as the absence of anything in the ear or leading		5382	permitted by law or accepting and performing professional
5354	to the ear, or the like, without disclosing clearly and		5383	responsibilities the licensee or certificateholder knows, or has
5355	conspicuously that the instrument operates on the bone		5384	reason to know, the licensee or certificateholder is not
5356	conduction principle and that in many cases of hearing loss this		5385	competent to perform.
5357	type of instrument may not be suitable.		5386	(x) Aiding, assisting, procuring, or employing any
5358	(p) Stating or implying that the use of any hearing aid		5387	unlicensed person to practice speech-language pathology or
5359	will improve or preserve hearing or prevent or retard the		5388	audiology.
5360	progression of a hearing impairment or that it will have any		5389	(y) Delegating or contracting for the performance of
5361	similar or opposite effect.		5390	professional responsibilities by a person when the licensee
5362	(q) Making any statement regarding the cure of the cause of		5391	delegating or contracting for performance of such
5363	a hearing impairment by the use of a hearing aid.		5392	responsibilities knows, or has reason to know, such person is
5364	(r) Representing or implying that a hearing aid is or will		5393	not qualified by training, experience, and authorization to
5365	be "custom-made," "made to order," or "prescription-made," or in		5394	perform them.
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588-01852-24 20247016 5424 (2) (a) The board may enter an order denying licensure or 5425 imposing any of the penalties in s. 456.072(2) against any 5426 applicant for licensure or licensee who is found quilty of 5427 violating any provision of subsection (1) of this section or who 5428 is found quilty of violating any provision of s. 456.072(1). 5429 (b) The board may take adverse action against an 5430 audiologist's or a speech-language pathologist's compact 5431 privilege under the Audiology and Speech-Language Pathology 5432 Interstate Compact pursuant to s. 468.1335 and may impose any of 5433 the penalties in s. 456.072(2), if an audiologist or a speech-5434 language pathologist commits an act specified in subsection (1) 5435 or s. 456.072(1). 5436 Section 64. Paragraph (j) is added to subsection (10) of 5437 section 768.28, Florida Statutes, to read: 5438 768.28 Waiver of sovereign immunity in tort actions; 5439 recovery limits; civil liability for damages caused during a 5440 riot; limitation on attorney fees; statute of limitations; 5441 exclusions; indemnification; risk management programs.-5442 (10)5443 (j) For purposes of this section, the individuals appointed 5444 under s. 468.1135(4) as the state's delegates on the Audiology 5445 and Speech-Language Pathology Interstate Compact Commission, 5446 when serving in that capacity pursuant to s. 468.1335, and any 5447 administrator, officer, executive director, employee, or 5448 representative of the commission, when acting within the scope 5449 of his or her employment, duties, or responsibilities in this 5450 state, is considered an agent of the state. The commission shall 5451 pay any claims or judgments pursuant to this section and may 5452 maintain insurance coverage to pay any such claims or judgments.

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588-01852-24 20247016 5395 (z) Committing any act upon a patient or client which would 5396 constitute sexual battery or which would constitute sexual 5397 misconduct as defined pursuant to s. 468.1296. 5398 (aa) Being unable to practice the profession for which he or she is licensed or certified under this chapter with 5399 5400 reasonable skill or competence as a result of any mental or 5401 physical condition or by reason of illness, drunkenness, or use 5402 of drugs, narcotics, chemicals, or any other substance. In 5403 enforcing this paragraph, upon a finding by the State Surgeon General, his or her designee, or the board that probable cause 5404 5405 exists to believe that the licensee or certificateholder is 5406 unable to practice the profession because of the reasons stated 5407 in this paragraph, the department shall have the authority to 5408 compel a licensee or certificateholder to submit to a mental or 5409 physical examination by a physician, psychologist, clinical 5410 social worker, marriage and family therapist, or mental health 5411 counselor designated by the department or board. If the licensee 5412 or certificateholder refuses to comply with the department's 5413 order directing the examination, such order may be enforced by 5414 filing a petition for enforcement in the circuit court in the 5415 circuit in which the licensee or certificateholder resides or 5416 does business. The department shall be entitled to the summary 5417 procedure provided in s. 51.011. A licensee or certificateholder 5418 affected under this paragraph shall at reasonable intervals be 5419 afforded an opportunity to demonstrate that he or she can resume 5420 the competent practice for which he or she is licensed or 5421 certified with reasonable skill and safety to patients. 5422 (bb) Violating any provision of this chapter or chapter 5423 456, or any rules adopted pursuant thereto. Page 187 of 234 CODING: Words stricken are deletions; words underlined are additions.

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5453	Section 65. Section 486.112, Florida Statutes, is created
5454	to read:
5455	486.112 Physical Therapy Licensure CompactThe Physical
5456	Therapy Licensure Compact is hereby enacted into law and entered
5457	into by this state with all other jurisdictions legally joining
5458	therein in the form substantially as follows:
5459	
5460	ARTICLE I
5461	PURPOSE AND OBJECTIVES
5462	(1) The purpose of the compact is to facilitate interstate
5463	practice of physical therapy with the goal of improving public
5464	access to physical therapy services. The compact preserves the
5465	regulatory authority of member states to protect public health
5466	and safety through their current systems of state licensure. For
5467	purposes of state regulation under the compact, the practice of
5468	physical therapy is deemed to have occurred in the state where
5469	the patient is located at the time physical therapy is provided
5470	to the patient.
5471	(2) The compact is designed to achieve all of the following
5472	objectives:
5473	(a) Increase public access to physical therapy services by
5474	providing for the mutual recognition of other member state
5475	licenses.
5476	(b) Enhance the states' ability to protect the public's
5477	health and safety.
5478	(c) Encourage the cooperation of member states in
5479	regulating multistate physical therapy practice.
5480	(d) Support spouses of relocating military members.
5481	(e) Enhance the exchange of licensure, investigative, and
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5482	disciplinary information between member states.
5483	(f) Allow a remote state to hold a provider of services
5484	with a compact privilege in that state accountable to that
5485	state's practice standards.
5486	
5487	ARTICLE II
5488	DEFINITIONS
5489	As used in the compact, and except as otherwise provided,
5490	the term:
5491	(1) "Active duty military" means full-time duty status in
5492	the active uniformed service of the United States, including
5493	members of the National Guard and Reserve on active duty orders
5494	pursuant to 10 U.S.C. chapter 1209 or chapter 1211.
5495	(2) "Adverse action" means disciplinary action taken by a
5496	physical therapy licensing board based upon misconduct,
5497	unacceptable performance, or a combination of both.
5498	(3) "Alternative program" means a nondisciplinary
5499	monitoring or practice remediation process approved by a state's
5500	physical therapy licensing board. The term includes, but is not
5501	limited to, programs that address substance abuse issues.
5502	(4) "Compact privilege" means the authorization granted by
5503	a remote state to allow a licensee from another member state to
5504	practice as a physical therapist or physical therapist assistant
5505	in the remote state under its laws and rules.
5506	(5) "Continuing competence" means a requirement, as a
5507	condition of license renewal, to provide evidence of
5508	participation in, and completion of, educational and
5509	professional activities relevant to the practice of physical
5510	therapy.
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5511	(6) "Data system" means the coordinated database and		
5512	reporting system created by the Physical Therapy Compact		
5513	Commission for the exchange of information between member states		
5514	relating to licensees or applicants under the compact, including		
5515	identifying information, licensure data, investigative		
5516	information, adverse actions, nonconfidential information		
5517	related to alternative program participation, any denials of		
5518	applications for licensure, and other information as specified		
5519	by commission rule.		
5520	(7) "Encumbered license" means a license that a physical		
5521	therapy licensing board has limited in any way.		
5522	(8) "Executive board" means a group of directors elected or		
5523	appointed to act on behalf of, and within the powers granted to		
5524	them by, the commission.		
5525	(9) "Home state" means the member state that is the		
5526	licensee's primary state of residence.		
5527	(10) "Investigative information" means information,		
5528	records, and documents received or generated by a physical		
5529	therapy licensing board pursuant to an investigation.		
5530	(11) "Jurisprudence requirement" means the assessment of an		
5531	individual's knowledge of the laws and rules governing the		
5532	practice of physical therapy in a specific state.		
5533	(12) "Licensee" means an individual who currently holds an		
5534	authorization from a state to practice as a physical therapist		
5535	or physical therapist assistant.		
5536	(13) "Member state" means a state that has enacted the		
5537	compact.		
5538	(14) "Physical therapist" means an individual licensed by a		
5539	state to practice physical therapy.		
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5540	(15) "Physical therapist assistant" means an individual
5541	licensed by a state to assist a physical therapist in specified
5542	areas of physical therapy.
5543	(16) "Physical therapy" or "the practice of physical
5544	therapy" means the care and services provided by or under the
5545	direction and supervision of a licensed physical therapist.
5546	(17) "Physical Therapy Compact Commission" or "commission"
5547	means the national administrative body whose membership consists
5548	of all states that have enacted the compact.
5549	(18) "Physical therapy licensing board" means the agency of
5550	a state which is responsible for the licensing and regulation of
5551	physical therapists and physical therapist assistants.
5552	(19) "Remote state" means a member state other than the
5553	home state where a licensee is exercising or seeking to exercise
5554	the compact privilege.
5555	(20) "Rule" means a regulation, principle, or directive
5556	adopted by the commission which has the force of law.
5557	(21) "State" means any state, commonwealth, district, or
5558	territory of the United States of America which regulates the
5559	practice of physical therapy.
5560	
5561	ARTICLE III
5562	STATE PARTICIPATION IN THE COMPACT
5563	(1) To participate in the compact, a state must do all of
5564	the following:
5565	(a) Participate fully in the commission's data system,
5566	including using the commission's unique identifier, as defined
5567	by commission rule.
5568	(b) Have a mechanism in place for receiving and
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	investigating complaints about licensees.
5570	(c) Notify the commission, in accordance with the terms of
5571	the compact and rules, of any adverse action or the availability
5572	of investigative information regarding a licensee.
5573	(d) Fully implement a criminal background check
5574	requirement, within a timeframe established by commission rule,
5575	which uses results from the Federal Bureau of Investigation
5576	record search on criminal background checks to make licensure
5577	decisions in accordance with subsection (2).
5578	(e) Comply with the commission's rules.
5579	(f) Use a recognized national examination as a requirement
5580	for licensure pursuant to the commission's rules.
5581	(g) Have continuing competence requirements as a condition
5582	for license renewal.
5583	(2) Upon adoption of the compact, a member state has the
5584	authority to obtain biometric-based information from each
5585	licensee applying for a compact privilege and submit this
5586	information to the Federal Bureau of Investigation for a
5587	criminal background check in accordance with 28 U.S.C. s. 534
5588	and 34 U.S.C. s. 40316.
5589	(3) A member state must grant the compact privilege to a
5590	licensee holding a valid unencumbered license in another member
5591	state in accordance with the terms of the compact and rules.
5592	
5593	ARTICLE IV
5594	COMPACT PRIVILEGE
5595	(1) To exercise the compact privilege under the compact, a
5596	licensee must satisfy all of the following conditions:
5597	(a) Hold a license in the home state.
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5598	(b) Not have an encumbrance on any state license.
5599	(c) Be eligible for a compact privilege in all member
5600	states in accordance with subsections (4) , (7) , and (8) .
5601	(d) Not have had an adverse action against any license or
5602	compact privilege within the preceding 2 years.
5603	(e) Notify the commission that the licensee is seeking the
5604	compact privilege within a remote state.
5605	(f) Meet any jurisprudence requirements established by the
5606	remote state in which the licensee is seeking a compact
5607	privilege.
5608	(g) Report to the commission adverse action taken by any
5609	nonmember state within 30 days after the date the adverse actio
5610	<u>is taken.</u>
5611	(2) The compact privilege is valid until the expiration
5612	date of the home license. The licensee must continue to meet th
5613	requirements of subsection (1) to maintain the compact privileg
5614	in a remote state.
5615	(3) A licensee providing physical therapy in a remote state
5616	under the compact privilege must comply with the laws and rules
5617	of the remote state.
5618	(4) A licensee providing physical therapy in a remote stat
5619	is subject to that state's regulatory authority. A remote state
5620	may, in accordance with due process and that state's laws,
5621	remove a licensee's compact privilege in the remote state for a
5622	specific period of time, impose fines, and take any other
5623	necessary actions to protect the health and safety of its
5624	citizens. The licensee is not eligible for a compact privilege
5625	in any member state until the specific period of time for

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5627	(5) If a home state license is encumbered, the licensee
5628	loses the compact privilege in any remote state until the
5629	following conditions are met:
5630	(a) The home state license is no longer encumbered.
5631	(b) Two years have elapsed from the date of the adverse
5632	action.
5633	(6) Once an encumbered license in the home state is
5634	restored to good standing, the licensee must meet the
5635	requirements of subsection (1) to obtain a compact privilege in
5636	any remote state.
5637	(7) If a licensee's compact privilege in any remote state
5638	is removed, the licensee loses the compact privilege in all
5639	remote states until all of the following conditions are met:
5640	(a) The specific period of time for which the compact
5641	privilege was removed has ended.
5642	(b) All fines have been paid.
5643	(c) Two years have elapsed from the date of the adverse
5644	action.
5645	(8) Once the requirements of subsection (7) have been met,
5646	the licensee must meet the requirements of subsection (1) to
5647	obtain a compact privilege in a remote state.
5648	
5649	ARTICLE V
5650	ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES
5651	A licensee who is active duty military or is the spouse of
5652	an individual who is active duty military may choose any of the
5653	following locations to designate his or her home state:
5654	(1) Home of record.
5655	(2) Permanent change of station location.
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5656	(3) State of current residence, if it is different from the
5657	home of record or permanent change of station location.
5658	
5659	ARTICLE VI
5660	ADVERSE ACTIONS
5661	(1) A home state has exclusive power to impose adverse
5662	action against a license issued by the home state.
5663	(2) A home state may take adverse action based on the
5664	investigative information of a remote state, so long as the home
5665	state follows its own procedures for imposing adverse action.
5666	(3) The compact does not override a member state's decision
5667	that participation in an alternative program may be used in lieu
5668	of adverse action and that such participation remain nonpublic
5669	if required by the member state's laws. Member states must
5670	require licensees who enter any alternative programs in lieu of
5671	discipline to agree not to practice in any other member state
5672	during the term of the alternative program without prior
5673	authorization from such other member state.
5674	(4) A member state may investigate actual or alleged
5675	violations of the laws and rules for the practice of physical
5676	therapy committed in any other member state by a physical
5677	therapist or physical therapist assistant practicing under the
5678	compact who holds a license or compact privilege in such other
5679	member state.
5680	(5) A remote state may do any of the following:
5681	(a) Take adverse actions as set forth in subsection (4) of
5682	article IV against a licensee's compact privilege in the state.
5683	(b) Issue subpoenas for both hearings and investigations
5684	which require the attendance and testimony of witnesses and the

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5685	production of evidence. Subpoenas issued by a physical therapy
5686	licensing board in a member state for the attendance and
5687	testimony of witnesses or for the production of evidence from
5688	another member state must be enforced in the latter state by any
5689	court of competent jurisdiction, according to the practice and
5690	procedure of that court applicable to subpoenas issued in
5691	proceedings pending before it. The issuing authority shall pay
5692	any witness fees, travel expenses, mileage, and other fees
5693	required by the service laws of the state where the witnesses or
5694	evidence is located.
5695	(c) If otherwise permitted by state law, recover from the
5696	licensee the costs of investigations and disposition of cases
5697	resulting from any adverse action taken against that licensee.
5698	(6) (a) In addition to the authority granted to a member
5699	state by its respective physical therapy practice act or other
5700	applicable state law, a member state may participate with other
5701	member states in joint investigations of licensees.
5702	(b) Member states shall share any investigative,
5703	litigation, or compliance materials in furtherance of any joint
5704	or individual investigation initiated under the compact.
5705	
5706	ARTICLE VII
5707	ESTABLISHMENT OF THE PHYSICAL THERAPY COMPACT COMMISSION
5708	(1) COMMISSION CREATEDThe member states hereby create and
5709	establish a joint public agency known as the Physical Therapy
5710	Compact Commission:
5711	(a) The commission is an instrumentality of the member
5712	states.
5713	(b) Venue is proper, and judicial proceedings by or against
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5714	the commission may be brought solely and exclusively in a court
5715	of competent jurisdiction where the principal office of the
5716	commission is located. The commission may waive venue and
5717	jurisdictional defenses to the extent it adopts or consents to
5718	participate in alternative dispute resolution proceedings.
5719	(c) The compact may not be construed to be a waiver of
5720	sovereign immunity.
5721	(2) MEMBERSHIP, VOTING, AND MEETINGS
5722	(a) Each member state has and is limited to one delegate
5723	selected by that member state's physical therapy licensing board
5724	to serve on the commission. The delegate must be a current
5725	member of the physical therapy licensing board who is a physical
5726	therapist, a physical therapist assistant, a public member, or
5727	the board administrator.
5728	(b) A delegate may be removed or suspended from office as
5729	provided by the law of the state from which the delegate is
5730	appointed. Any vacancy occurring on the commission must be
5731	filled by the physical therapy licensing board of the member
5732	state for which the vacancy exists.
5733	(c) Each delegate is entitled to one vote with regard to
5734	the adoption of rules and bylaws and shall otherwise have an
5735	opportunity to participate in the business and affairs of the
5736	commission.
5737	(d) A delegate shall vote in person or by such other means
5738	as provided in the bylaws. The bylaws may provide for delegates'
5739	participation in meetings by telephone or other means of
5740	communication.
5741	(e) The commission shall meet at least once during each
5742	calendar year. Additional meetings may be held as set forth in
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5743	the bylaws.
5744	(f) All meetings must be open to the public, and public
5745	notice of meetings must be given in the same manner as required
5746	under the rulemaking provisions in article IX.
5747	(g) The commission or the executive board or other
5748	committees of the commission may convene in a closed, nonpublic
5749	meeting if the commission or executive board or other committees
5750	of the commission must discuss any of the following:
5751	1. Noncompliance of a member state with its obligations
5752	under the compact.
5753	2. The employment, compensation, or discipline of, or other
5754	matters, practices, or procedures related to, specific employees
5755	or other matters related to the commission's internal personnel
5756	practices and procedures.
5757	3. Current, threatened, or reasonably anticipated
5758	litigation against the commission, executive board, or other
5759	committees of the commission.
5760	4. Negotiation of contracts for the purchase, lease, or
5761	sale of goods, services, or real estate.
5762	5. An accusation of any person of a crime or a formal
5763	censure of any person.
5764	6. Information disclosing trade secrets or commercial or
5765	financial information that is privileged or confidential.
5766	7. Information of a personal nature where disclosure would
5767	constitute a clearly unwarranted invasion of personal privacy.
5768	8. Investigatory records compiled for law enforcement
5769	purposes.
5770	9. Information related to any investigative reports
5771	prepared by or on behalf of or for use of the commission or
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5772 <u>othe</u>	r committee charged with responsibility for investigation or
5773 <u>dete</u>	rmination of compliance issues pursuant to the compact.
5774	10. Matters specifically exempted from disclosure by
5775 <u>fede</u>	ral or member state statute.
5776	(h) If a meeting, or portion of a meeting, is closed
5777 <u>purs</u>	uant to this subsection, the commission's legal counsel or
5778 <u>desi</u>	gnee must certify that the meeting may be closed and must
5779 <u>refe</u>	rence each relevant exempting provision.
5780	(i) The commission shall keep minutes that fully and
5781 <u>clea</u>	rly describe all matters discussed in a meeting and shall
5782 <u>prov</u>	ide a full and accurate summary of actions taken and the
5783 <u>reas</u>	ons therefor, including a description of the views
5784 <u>expr</u>	essed. All documents considered in connection with an action
5785 <u>must</u>	be identified in the minutes. All minutes and documents of
5786 <u>a cl</u>	osed meeting must remain under seal, subject to release only
5787 <u>by a</u>	majority vote of the commission or order of a court of
5788 <u>comp</u>	etent jurisdiction.
5789	(3) DUTIESThe commission shall do all of the following:
5790	(a) Establish the fiscal year of the commission.
5791	(b) Establish bylaws.
5792	(c) Maintain its financial records in accordance with the
5793 <u>byla</u>	WS.
5794	(d) Meet and take such actions as are consistent with the
5795 <u>prov</u>	isions of the compact and the bylaws.
5796	(4) POWERSThe commission may do any of the following:
5797	(a) Adopt uniform rules to facilitate and coordinate
5798 <u>impl</u>	ementation and administration of the compact. The rules have
5799 <u>the</u>	force and effect of law and are binding in all member
5800 <u>stat</u>	es.
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5803 5804 5805 5806	(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state physical therapy licensing board to sue or be sued under applicable law is not affected. (c) Purchase and maintain insurance and bonds. (d) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.
5803 5804 5805 5806	physical therapy licensing board to sue or be sued under applicable law is not affected. (c) Purchase and maintain insurance and bonds. (d) Borrow, accept, or contract for services of personnel,
5804 5805 5806	applicable law is not affected. (c) Purchase and maintain insurance and bonds. (d) Borrow, accept, or contract for services of personnel,
5805 5806	(c) Purchase and maintain insurance and bonds. (d) Borrow, accept, or contract for services of personnel,
5806	(d) Borrow, accept, or contract for services of personnel,
5807	including, but not limited to, employees of a member state.
5808	(e) Hire employees and elect or appoint officers; fix the
5809	compensation of, define the duties of, and grant appropriate
5810	authority to such individuals to carry out the purposes of the
5811	compact; and establish the commission's personnel policies and
5812	programs relating to conflicts of interest, qualifications of
5813	personnel, and other related personnel matters.
5814	(f) Accept any appropriate donations and grants of money,
5815	equipment, supplies, materials, and services and receive, use,
5816	and dispose of the same, provided that at all times the
5817	commission avoids any appearance of impropriety or conflict of
5818	interest.
5819	(g) Lease, purchase, accept appropriate gifts or donations
5820	of, or otherwise own, hold, improve, or use any property, real,
5821	personal, or mixed, provided that at all times the commission
5822	avoids any appearance of impropriety or conflict of interest.
5823	(h) Sell, convey, mortgage, pledge, lease, exchange,
5824	abandon, or otherwise dispose of any property, real, personal,
5825	or mixed.
5826	(i) Establish a budget and make expenditures.
5827	(j) Borrow money.
5828	(k) Appoint committees, including standing committees
5829	composed of members, state regulators, state legislators or

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5830	their representatives, and consumer representatives, and such
5831	$\underline{\mbox{other}}$ interested persons as may be designated in the compact and
5832	the bylaws.
5833	(1) Provide information to, receive information from, and
5834	cooperate with law enforcement agencies.
5835	(m) Establish and elect an executive board.
5836	(n) Perform such other functions as may be necessary or
5837	appropriate to achieve the purposes of the compact consistent
5838	with the state regulation of physical therapy licensure and
5839	practice.
5840	(5) THE EXECUTIVE BOARD
5841	(a) The executive board may act on behalf of the commission
5842	according to the terms of the compact.
5843	(b) The executive board shall be composed of the following
5844	nine members:
5845	1. Seven voting members who are elected by the commission
5846	from the current membership of the commission.
5847	2. One ex-officio, nonvoting member from the recognized
5848	national physical therapy professional association.
5849	3. One ex-officio, nonvoting member from the recognized
5850	membership organization of the physical therapy licensing
5851	boards.
5852	(c) The ex-officio members shall be selected by their
5853	respective organizations.
5854	(d) The commission may remove any member of the executive
5855	board as provided in its bylaws.
5856	(e) The executive board shall meet at least annually.
5857	(f) The executive board shall do all of the following:
5858	1. Recommend to the entire commission changes to the rules
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5859	or bylaws, compact legislation, fees paid by compact member
5860	states, such as annual dues, and any commission compact fee
5861	charged to licensees for the compact privilege.
5862	2. Ensure compact administration services are appropriately
5863	provided, contractually or otherwise.
5864	3. Prepare and recommend the budget.
5865	4. Maintain financial records on behalf of the commission.
5866	5. Monitor compact compliance of member states and provide
5867	compliance reports to the commission.
5868	6. Establish additional committees as necessary.
5869	7. Perform other duties as provided in the rules or bylaws.
5870	(6) FINANCING OF THE COMMISSION
5871	(a) The commission shall pay, or provide for the payment
5872	of, the reasonable expenses of its establishment, organization,
5873	and ongoing activities.
5874	
5875	(b) The commission may accept any appropriate revenue
5876	sources, donations, and grants of money, equipment, supplies,
5876	materials, and services.
5878	(c) The commission may levy and collect an annual
	assessment from each member state or impose fees on other
5879	parties to cover the cost of the operations and activities of
5880	the commission and its staff. Such assessments and fees must
5881	total to an amount sufficient to cover the commission's annual
5882	budget as approved each year for which revenue is not provided
5883	by other sources. The aggregate annual assessment amount must be
5884	allocated based upon a formula to be determined by the
5885	commission, which shall adopt a rule binding upon all member
5886	states.
5887	(d) The commission may not incur obligations of any kind
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5888	before securing the funds adequate to meet such obligations; nor			
5889	may the commission pledge the credit of any of the member			
5890	states, except by and with the authority of the member state.			
5891	(e) The commission shall keep accurate accounts of all			
5892	receipts and disbursements. The receipts and disbursements of			
5893	the commission are subject to the audit and accounting			
5894	procedures established under its bylaws. However, all receipts			
5895	and disbursements of funds handled by the commission must be			
5896	audited yearly by a certified or licensed public accountant, and			
5897	the report of the audit must be included in and become part of			
5898	the annual report of the commission.			
5899	(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION			
5900	(a) The members, officers, executive director, employees,			
5901	and representatives of the commission are immune from suit and			
5902	liability, whether personally or in their official capacity, for			
5903	any claim for damage to or loss of property or personal injury			
5904	or other civil liability caused by or arising out of any actual			
5905	or alleged act, error, or omission that occurred, or that the			
5906	person against whom the claim is made had a reasonable basis for			
5907	believing occurred, within the scope of commission employment,			
5908	duties, or responsibilities. However, this paragraph may not be			
5909	construed to protect any such person from suit or liability for			
5910	any damage, loss, injury, or liability caused by the			
5911	intentional, willful, or wanton misconduct of that person.			
5912	(b) The commission shall defend any member, officer,			
5913	executive director, employee, or representative of the			
5914	commission in any civil action seeking to impose liability			
5915	arising out of any actual or alleged act, error, or omission			
5916	that occurred within the scope of commission employment, duties,			

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5917	or responsibilities, or that the person against whom the claim			
5918	is made had a reasonable basis for believing occurred within the			
5919	<u>is made had a reasonable basis for believing occurred within the</u> scope of commission employment, duties, or responsibilities.			
5920				
	However, this subsection may not be construed to prohibit any			
5921	member, officer, executive director, employee, or representative			
5922	of the commission from retaining his or her own counsel or to			
5923	require the commission to defend such person if the actual or			
5924	alleged act, error, or omission resulted from that person's			
5925	intentional, willful, or wanton misconduct.			
5926	(c) The commission shall indemnify and hold harmless any			
5927	member, officer, executive director, employee, or representative			
5928	of the commission for the amount of any settlement or judgment			
5929	obtained against that person arising out of any actual or			
5930	alleged act, error, or omission that occurred within the scope			
5931	of commission employment, duties, or responsibilities, or that			
5932	such person had a reasonable basis for believing occurred within			
5933	the scope of commission employment, duties, or responsibilities,			
5934	provided that the actual or alleged act, error, or omission did			
5935	not result from the intentional, willful, or wanton misconduct			
5936	of that person.			
5937				
5938	ARTICLE VIII			
5939	DATA SYSTEM			
5940	(1) The commission shall provide for the development,			
5941	maintenance, and use of a coordinated database and reporting			
5942	system containing licensure, adverse action, and investigative			
5943	information on all licensees in member states.			
5944	(2) Notwithstanding any other provision of state law to the			
5945	contrary, a member state shall submit a uniform data set to the			
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5946	data system on all individuals to whom the compact is applicable			
5947	as required by the rules of the commission, which data set must			
5948	include all of the following:			
5949	(a) Identifying information.			
5950	(b) Licensure data.			
5951	(c) Investigative information.			
5952	(d) Adverse actions against a license or compact privilege.			
5953	(e) Nonconfidential information related to alternative			
5954	program participation.			
5955	(f) Any denial of application for licensure and the reason			
5956	for such denial.			
5957	(g) Other information that may facilitate the			
5958	administration of the compact, as determined by the rules of the			
5959	commission.			
5960	(3) Investigative information in the system pertaining to a			
5961	licensee in any member state must be available only to other			
5962	member states.			
5963	(4) The commission shall promptly notify all member states			
5964	of any adverse action taken against a licensee or an individual			
5965	applying for a license in a member state. Adverse action			
5966	information pertaining to a licensee in any member state must be			
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5973	state contributing the information must be removed from the data			
5974	system.			
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5975				
5976	ARTICLE IX			
5977	RULEMAKING			
5978	(1) The commission shall exercise its rulemaking powers			
5979	pursuant to the criteria set forth in this article and the rules			
5980	adopted thereunder. Rules and amendments become binding as of			
5981	the date specified in each rule or amendment.			
5982	(2) If a majority of the legislatures of the member states			
5983	rejects a rule by enactment of a statute or resolution in the			
5984	same manner used to adopt the compact within 4 years after the			
5985	date of adoption of the rule, such rule does not have further			
5986	force and effect in any member state.			
5987	(3) Rules or amendments to the rules must be adopted at a			
5988	regular or special meeting of the commission.			
5989	(4) Before adoption of a final rule by the commission, and			
5990	at least 30 days before the meeting at which the rule will be			
5991	considered and voted upon, the commission must file a notice of			
5992	proposed rulemaking on all of the following:			
5993	(a) The website of the commission or another publicly			
5994	accessible platform.			
5995	(b) The website of each member state physical therapy			
5996	licensing board or another publicly accessible platform or the			
5997	publication in which each state would otherwise publish proposed			
5998	rules.			
5999	(5) The notice of proposed rulemaking must include all of			
6000	the following:			
6001	(a) The proposed date, time, and location of the meeting in			
6002	which the rule or amendment will be considered and voted upon.			
6003	(b) The text of the proposed rule or amendment and the			
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6004	reason for the proposed rule.			
6005	(c) A request for comments on the proposed rule or			
6006	amendment from any interested person.			
6007	(d) The manner in which interested persons may submit			
6008	notice to the commission of their intention to attend the public			
6009	hearing and any written comments.			
6010	(6) Before adoption of a proposed rule or amendment, the			
6011	commission must allow persons to submit written data, facts,			
6012	opinions, and arguments, which must be made available to the			
6013	public.			
6014	(7) The commission must grant an opportunity for a public			
6015	hearing before it adopts a rule or an amendment if a hearing is			
6016	requested by any of the following:			
6017	(a) At least 25 persons.			
6018	(b) A state or federal governmental subdivision or agency.			
6019	(c) An association having at least 25 members.			
6020	(8) If a scheduled public hearing is held on the proposed			
6021	rule or amendment, the commission must publish the date, time,			
6022	and location of the hearing. If the hearing is held through			
6023	electronic means, the commission must publish the mechanism for			
6024	access to the electronic hearing.			
6025	(a) All persons wishing to be heard at the hearing must			
6026	notify the executive director of the commission or another			
6027	designated member in writing of their desire to appear and			
6028	testify at the hearing at least 5 business days before the			
6029	scheduled date of the hearing.			
6030	(b) Hearings must be conducted in a manner providing each			
6031	person who wishes to comment a fair and reasonable opportunity			
6032	to comment orally or in writing.			
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6033	(c) All hearings must be recorded. A copy of the recording			
6034	must be made available on request.			
6035	(d) This article may not be construed to require a separate			
6036	hearing on each rule. Rules may be grouped for the convenience			
6037	of the commission at hearings required by this section.			
6038	(9) Following the scheduled hearing date, or by the close			
6039	of business on the scheduled hearing date if the hearing was not			
6040	held, the commission shall consider all written and oral			
6041	comments received.			
6042	(10) If no written notice of intent to attend the public			
6043	hearing by interested parties is received, the commission may			
6044	proceed with adoption of the proposed rule without a public			
6045	hearing.			
6046	(11) The commission shall, by majority vote of all members,			
6047	take final action on the proposed rule and shall determine the			
5048	effective date of the rule, if any, based on the rulemaking			
6049	record and the full text of the rule.			
6050	(12) Upon determination that an emergency exists, the			
6051	commission may consider and adopt an emergency rule without			
6052	prior notice, opportunity for comment, or hearing, provided that			
6053	the usual rulemaking procedures provided in the compact and in			
5054	this article are retroactively applied to the rule as soon as			
6055	reasonably possible, in no event later than 90 days after the			
6056	effective date of the rule. For the purposes of this subsection,			
6057	an emergency rule is one that must be adopted immediately in			
6058	order to do any of the following:			
6059	(a) Meet an imminent threat to public health, safety, or			
6060	welfare.			
6061	(b) Prevent a loss of commission or member state funds.			

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6062	(c) Meet a deadline for the adoption of an administrative			
6063	rule established by federal law or rule.			
6064	(d) Protect public health and safety.			
6065	(13) The commission or an authorized committee of the			
6066	commission may direct revisions to a previously adopted rule or			
6067	amendment for purposes of correcting typographical errors,			
6068	errors in format, errors in consistency, or grammatical errors.			
6069	Public notice of any revisions must be posted on the website of			
6070	the commission. The revision is subject to challenge by any			
6071	person for a period of 30 days after posting. The revision may			
6072	be challenged only on grounds that the revision results in a			
6073	material change to a rule. A challenge must be made in writing			
6074	and delivered to the chair of the commission before the end of			
6075	the notice period. If a challenge is not made, the revision			
6076	takes effect without further action. If the revision is			
6077	challenged, the revision may not take effect without the			
6078	approval of the commission.			
6079				
6080	ARTICLE X			
6081	OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT			
6082	(1) OVERSIGHT			
6083	(a) The executive, legislative, and judicial branches of			
6084	state government in each member state shall enforce the compact			
6085	and take all actions necessary and appropriate to carry out the			
6086	compact's purposes and intent. The provisions of the compact and			
6087	the rules adopted pursuant thereto shall have standing as			
6088	statutory law.			
6089	(b) All courts shall take judicial notice of the compact			
6090	and the rules in any judicial or administrative proceeding in a			
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6091	member state pertaining to the subject matter of the compact			
6092	which may affect the powers, responsibilities, or actions of the			
6093	commission.			
6094	(c) The commission is entitled to receive service of			
6095	process in any such proceeding and has standing to intervene in			
6096	such a proceeding for all purposes. Failure to provide service			
6097	of process to the commission renders a judgment or an order void			
6098	as to the commission, the compact, or the adopted rules.			
6099	(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION			
6100	(a) If the commission determines that a member state has			
6101	defaulted in the performance of its obligations or			
6102	responsibilities under the compact or the adopted rules, the			
6103	commission must do all of the following:			
6104	1. Provide written notice to the defaulting state and other			
6105	member states of the nature of the default, the proposed means			
6106	of curing the default, and any other action to be taken by the			
6107	commission.			
6108	2. Provide remedial training and specific technical			
6109	assistance regarding the default.			
6110	(b) If a state in default fails to cure the default, the			
6111	defaulting state may be terminated from the compact upon an			
6112	affirmative vote of a majority of the member states, and all			
6113	rights, privileges, and benefits conferred by the compact may be			
6114	terminated on the effective date of termination. A cure of the			
6115	default does not relieve the offending state of obligations or			
6116	liabilities incurred during the period of default.			
6117	(c) Termination of membership in the compact may be imposed			
6118	only after all other means of securing compliance have been			
6119	exhausted. The commission shall give notice of intent to suspend			
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6120	or terminate a defaulting member state to the governor and			
6121	majority and minority leaders of the defaulting state's			
6122	legislature and to each of the member states.			
6123	(d) A state that has been terminated from the compact is			
6124	responsible for all assessments, obligations, and liabilities			
6125	incurred through the effective date of termination, including			
6126	obligations that extend beyond the effective date of			
6127	termination.			
6128	(e) The commission does not bear any costs related to a			
6129	state that is found to be in default or that has been terminated			
6130	from the compact, unless agreed upon in writing between the			
6131	commission and the defaulting state.			
6132	(f) The defaulting state may appeal the action of the			
6133	commission by petitioning the U.S. District Court for the			
6134	District of Columbia or the federal district where the			
6135	commission has its principal offices. The prevailing member			
6136	shall be awarded all costs of such litigation, including			
6137	reasonable attorney fees.			
6138	(3) DISPUTE RESOLUTION			
6139	(a) Upon request by a member state, the commission must			
6140	attempt to resolve disputes related to the compact which arise			
6141	among member states and between member and nonmember states.			
6142	(b) The commission shall adopt a rule providing for both			
6143	mediation and binding dispute resolution for disputes as			
6144	appropriate.			
6145	(4) ENFORCEMENT			
6146	(a) The commission, in the reasonable exercise of its			
6147	discretion, shall enforce the compact and the commission's			
6148	<u>rules.</u>			
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6149	(b) By majority vote, the commission may initiate legal			
6150	action in the United States District Court for the District of			
6151	Columbia or the federal district where the commission has its			
6152	principal offices against a member state in default to enforce			
6153	compliance with the provisions of the compact and its adopted			
6154	rules and bylaws. The relief sought may include both injunctive			
6155	relief and damages. In the event judicial enforcement is			
6156	necessary, the prevailing member shall be awarded all costs of			
6157	such litigation, including reasonable attorney fees.			
6158	(c) The remedies under this article are not the exclusive			
6159	remedies of the commission. The commission may pursue any other			
6160	remedies available under federal or state law.			
6161				
6162	ARTICLE XI			
6163	DATE OF IMPLEMENTATION OF THE PHYSICAL THERAPY COMPACT AND			
6164	ASSOCIATED RULES; WITHDRAWAL; AND AMENDMENTS			
6165	(1) The compact becomes effective on the date that the			
6166	compact statute is enacted into law in the tenth member state.			
6167	The provisions that become effective at that time are limited to			
6168	the powers granted to the commission relating to assembly and			
6169	the adoption of rules. Thereafter, the commission shall meet and			
6170	exercise rulemaking powers necessary for the implementation and			
6171	administration of the compact.			
6172	(2) Any state that joins the compact subsequent to the			
6173	commission's initial adoption of the rules is subject to the			
6174	rules as they exist on the date that the compact becomes law in			
6175	that state. Any rule that has been previously adopted by the			
6176	commission has the full force and effect of law on the day the			
6177	compact becomes law in that state.			
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6178	(3) Any member state may withdraw from the compact by			
6179				
6180				
6181				
6182	(b) Withdrawal does not affect the continuing requirement			
6183	of the withdrawing state's physical therapy licensing board to			
6184				
6185	requirements of this act before the effective date of			
6186	withdrawal.			
6187	(4) The compact may not be construed to invalidate or			
6188	prevent any physical therapy licensure agreement or other			
6189				
6190	state which does not conflict with the provisions of the			
6191	compact.			
6192	(5) The compact may be amended by the member states. An			
6193	amendment to the compact does not become effective and binding			
6194	upon any member state until it is enacted into the laws of all			
6195	member states.			
6196				
6197	ARTICLE XII			
6198	CONSTRUCTION AND SEVERABILITY			
6199	The compact must be liberally construed so as to carry out			
6200	the purposes thereof. The provisions of the compact are			
6201	severable, and if any phrase, clause, sentence, or provision of			
6202	the compact is declared to be contrary to the constitution of			
6203	any member state or of the United States or the applicability			
6204	thereof to any government, agency, person, or circumstance is			
6205	held invalid, the validity of the remainder of the compact and			
6206	the applicability thereof to any government, agency, person, or			
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6207	circumstance is not affected thereby. If the compact is held	6236	Professional Counselors Licensure Compact to the data system
6208	contrary to the constitution of any member state, the compact	6237	pursuant to s. 491.017, and any significant investigatory
6209	remains in full force and effect as to the remaining member	6238	information relating to a psychologist practicing under the
6210	states and in full force and effect as to the member state	6239	Psychology Interjurisdictional Compact to the coordinated
6211	affected as to all severable matters.	6240	licensure information system pursuant to s. 490.0075.
6212	Section 66. Subsection (10) of section 456.073, Florida	6241	(c) Upon completion of the investigation and a
6213	Statutes, is amended to read:	6242	recommendation by the department to find probable cause, and
6214	456.073 Disciplinary proceedings.—Disciplinary proceedings	6243	pursuant to a written request by the subject or the subject's
6215	for each board shall be within the jurisdiction of the	6244	attorney, the department shall provide the subject an
6216	department.	6245	opportunity to inspect the investigative file or, at the
6217	(10) (a) The complaint and all information obtained pursuant	6246	subject's expense, forward to the subject a copy of the
6218	to the investigation by the department are confidential and	6247	investigative file. Notwithstanding s. 456.057, the subject may
6219	exempt from s. 119.07(1) until 10 days after probable cause has	6248	inspect or receive a copy of any expert witness report or
6220	been found to exist by the probable cause panel or by the	6249	patient record connected with the investigation if the subject
6221	department, or until the regulated professional or subject of	6250	agrees in writing to maintain the confidentiality of any
6222	the investigation waives his or her privilege of	6251	information received under this subsection until 10 days after
6223	confidentiality, whichever occurs first.	6252	probable cause is found and to maintain the confidentiality of
6224	(b) The department shall report any significant	6253	patient records pursuant to s. 456.057. The subject may file a
6225	investigation information relating to a nurse holding a	6254	written response to the information contained in the
6226	multistate license to the coordinated licensure information	6255	investigative file. Such response must be filed within 20 days
6227	system pursuant to s. 464.0095; any investigative information	6256	of mailing by the department, unless an extension of time has
6228	relating to a physical therapist or physical therapist assistant	6257	been granted by the department.
6229	holding a compact privilege under the Physical Therapy Licensure	6258	(d) This subsection does not prohibit the department from
6230	Compact to the data system pursuant to s. 486.112; any	6259	providing the complaint and any information obtained pursuant to
6231	significant investigatory information relating to a psychologist	6260	the department's investigation such information to any law
6232	practicing under the Psychology Interjurisdictional Compact to	6261	enforcement agency or to any other regulatory agency.
6233	the coordinated licensure information system pursuant to s.	6262	Section 67. Subsection (5) of section 456.076, Florida
6234	490.0075; - and any significant investigatory information	6263	Statutes, is amended to read:
6235	relating to a health care practitioner practicing under the	6264	456.076 Impaired practitioner programs
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588-01852-24 20247016 6265 (5) A consultant shall enter into a participant contract 6266 with an impaired practitioner and shall establish the terms of 6267 monitoring and shall include the terms in a participant 6268 contract. In establishing the terms of monitoring, the consultant may consider the recommendations of one or more 6269 6270 approved evaluators, treatment programs, or treatment providers. 6271 A consultant may modify the terms of monitoring if the 6272 consultant concludes, through the course of monitoring, that 6273 extended, additional, or amended terms of monitoring are 6274 required for the protection of the health, safety, and welfare 6275 of the public. If the impaired practitioner is a physical therapist or physical therapist assistant practicing under the 6276 Physical Therapy Licensure Compact pursuant to s. 486.112, a 6277 6278 psychologist practicing under the Psychology Interjurisdictional 6279 Compact pursuant to s. 490.0075, or a health care practitioner 6280 practicing under the Professional Counselors Licensure Compact 6281 pursuant to s. 491.017, the terms of the monitoring contract 6282 must include the impaired practitioner's withdrawal from all 6283 practice under the compact unless authorized by a member state. 6284 If the impaired practitioner is a psychologist practicing under 6285 the Psychology Interjurisdictional Compact pursuant to s. 6286 490.0075, the terms of the monitoring contract must include the 6287 impaired practitioner's withdrawal from all practice under the 6288 compact. 62.89 Section 68. Subsection (5) is added to section 486.023, 6290 Florida Statutes, to read: 6291 486.023 Board of Physical Therapy Practice .-62.92 (5) The board shall appoint an individual to serve as the 6293 state's delegate on the Physical Therapy Compact Commission, as

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6294	required under s. 486.112.
6295	Section 69. Section 486.028, Florida Statutes, is amended
6296	to read:
6297	486.028 License to practice physical therapy requiredA No
6298	person may not shall practice, or hold herself or himself out as
6299	being able to practice, physical therapy in this state unless
6300	she or he is licensed under in accordance with the provisions of
6301	this chapter or holds a compact privilege in this state under
6302	the Physical Therapy Licensure Compact as specified in s.
6303	486.112. ; however, Nothing in This chapter does not shall
6304	prohibit any person licensed in this state under any other law
6305	from engaging in the practice for which she or he is licensed.
6306	Section 70. Section 486.031, Florida Statutes, is amended
6307	to read:
6308	486.031 Physical therapist; licensing requirements;
6309	exemption
6310	(1) To be eligible for licensing as a physical therapist,
6311	an applicant must:
6312	(a) (1) Be at least 18 years old;
6313	(b) (2) Be of good moral character; and
6314	(c)1.(3)(a) Have been graduated from a school of physical
6315	therapy which has been approved for the educational preparation
6316	of physical therapists by the appropriate accrediting agency
6317	recognized by the Council for Higher Education Accreditation or
6318	its successor Commission on Recognition of Postsecondary
6319	$\ensuremath{\underline{Accreditation}}$ or the United States Department of Education at
6320	the time of her or his graduation and have passed, to the
6321	satisfaction of the board, the American Registry Examination
6322	before prior to 1971 or a national examination approved by the
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6323	board to determine her or his fitness for practice as a physical	6352	country, if the standards for licensure in physical therapy in
6324	therapist under this chapter as hereinafter provided;	6353	such other state, district, territory, or foreign country are
6325	2. (b) Have received a diploma from a program in physical	6354	determined by the board to be as high as those of this state, as
6326	therapy in a foreign country and have educational credentials	6355	established by rules adopted <u>under</u> pursuant to this chapter. Any
6327	deemed equivalent to those required for the educational	6356	person who holds a license pursuant to this section may use the
6328	preparation of physical therapists in this country, as	6357	words "physical therapist" or "physiotherapist" or the letters
6329	recognized by the appropriate agency as identified by the board,	6358	"P.T." in connection with her or his name or place of business
6330	and have passed to the satisfaction of the board an examination	6359	to denote her or his licensure hereunder. A person who holds a
6331	to determine her or his fitness for practice as a physical	6360	license pursuant to this section and obtains a doctoral degree
6332	therapist under this chapter as hereinafter provided; or	6361	in physical therapy may use the letters "D.P.T." and "P.T." A
6333	3.(c) Be entitled to licensure without examination as	6362	physical therapist who holds a degree of Doctor of Physical
6334	provided in s. 486.081.	6363	Therapy may not use the title "doctor" without also clearly
6335	(2) A person licensed as a physical therapist in another	6364	informing the public of his or her profession as a physical
6336	state who is practicing under the Physical Therapy Licensure	6365	therapist.
6337	Compact pursuant to s. 486.112, and only within the scope	6366	(2) At the time of <u>filing an</u> making application for
6338	provided therein, is exempt from the licensure requirements of	6367	licensure without examination <u>under</u> pursuant to the terms of
6339	this section.	6368	this section, the applicant shall pay to the department a
6340	Section 71. Section 486.081, Florida Statutes, is amended	6369	nonrefundable fee not to exceed \$175, as determined fixed by the
6341	to read:	6370	board, no part of which will be returned.
6342	486.081 Physical therapist; issuance of license without	6371	(3) A person licensed as a physical therapist in another
6343	examination to person passing examination of another authorized	6372	state who is practicing under the Physical Therapy Licensure
6344	examining board; fee; exemption	6373	Compact pursuant to s. 486.112, and only within the scope
6345	(1) The board may grant cause a license without	6374	provided therein, is exempt from the licensure requirements of
6346	<u>examination</u> , to be issued by through the department, without	6375	this section.
6347	$\ensuremath{examination}$ to any applicant who presents evidence satisfactory	6376	Section 72. Section 486.102, Florida Statutes, is amended
6348	to the board of having passed the American Registry Examination	6377	to read:
6349	<u>before</u> prior to 1971 or an examination in physical therapy	6378	486.102 Physical therapist assistant; licensing
6350	before a similar lawfully authorized examining board of another	6379	requirements; exemption
6351	state, the District of Columbia, a territory, or a foreign	6380	(1) To be eligible for licensing by the board as a physical
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588-01852-24 20247016 6381 therapist assistant, an applicant must: 6382 (a) (1) Be at least 18 years old; 6383 (b) (2) Be of good moral character; and 6384 (c)1.(3)(a) Have been graduated from a school providing giving a course of at least not less than 2 years for physical 6385 6386 therapist assistants, which has been approved for the 6387 educational preparation of physical therapist assistants by the 6388 appropriate accrediting agency recognized by the Council for 6389 Higher Education Accreditation or its successor Commission on 6390 Recognition of Postsecondary Accreditation or the United States 6391 Department of Education, at the time of her or his graduation 6392 and have passed to the satisfaction of the board an examination 6393 to determine her or his fitness for practice as a physical 6394 therapist assistant under this chapter as hereinafter provided; 6395 2.(b) Have been graduated from a school providing giving a 6396 course for physical therapist assistants in a foreign country 6397 and have educational credentials deemed equivalent to those 6398 required for the educational preparation of physical therapist 6399 assistants in this country, as recognized by the appropriate 6400 agency as identified by the board, and passed to the 6401 satisfaction of the board an examination to determine her or his 6402 fitness for practice as a physical therapist assistant under 6403 this chapter as hereinafter provided; 6404 3.(c) Be entitled to licensure without examination as 6405 provided in s. 486.107; or 6406 4.(d) Have been enrolled between July 1, 2014, and July 1, 6407 2016, in a physical therapist assistant school in this state 6408 which was accredited at the time of enrollment; and 6409 a.1. Have been graduated or be eligible to graduate from Page 221 of 234 CODING: Words stricken are deletions; words underlined are additions.

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6410	such school no later than July 1, 2018; and
6411	b.2. Have passed to the satisfaction of the board an
6412	examination to determine his or her fitness for practice as a
6413	physical therapist assistant as provided in s. 486.104.
6414	(2) A person licensed as a physical therapist assistant in
6415	another state who is practicing under the Physical Therapy
6416	Licensure Compact pursuant to s. 486.112, and only within the
6417	scope provided therein, is exempt from the licensure
6418	requirements of this section.
6419	Section 73. Section 486.107, Florida Statutes, is amended
6420	to read:
6421	486.107 Physical therapist assistant; issuance of license
6422	without examination to person licensed in another jurisdiction;
6423	fee; exemption
6424	(1) The board may grant cause a license without
6425	<u>examination</u> , to be issued by through the department, without
6426	examination to any applicant who presents evidence to the board,
6427	under oath, of licensure in another state, the District of
6428	Columbia, or a territory, if the standards for registering as a
6429	physical therapist assistant or licensing of a physical
6430	therapist assistant, as <u>applicable</u> the case may be , in such
6431	other state are determined by the board to be as high as those
6432	of this state, as established by rules adopted \underline{under} pursuant to
6433	this chapter. Any person who holds a license pursuant to this
6434	section may use the words "physical therapist assistant," or the
6435	letters "P.T.A.," in connection with her or his name to denote
6436	licensure hereunder.
6437	(2) At the time of <u>filing an</u> making application for
6438	licensing without examination <u>under</u> pursuant to the terms of
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6439	this section, the applicant shall pay to the department a	6468	court where the licensee resides or serves as a physical therapy
6440	<u>nonrefundable</u> fee not to exceed \$175 <u></u> , as <u>determined</u> fixed by the	6469	practitioner. The licensee against whom the petition is filed
6441	board, no part of which will be returned.	6470	may shall not be named or identified by initials in any public
6442	(3) A person licensed as a physical therapist assistant in	6471	court records or documents, and the proceedings $\underline{\text{must}}$ shall be
6443	another state who is practicing under the Physical Therapy	6472	closed to the public. The department shall be entitled to the
6444	Licensure Compact pursuant to s. 486.112, and only within the	6473	summary procedure provided in s. 51.011.
6445	scope provided therein, is exempt from the licensure	6474	2. A physical therapist or physical therapist assistant
6446	requirements of this section.	6475	whose license is suspended or revoked pursuant to this
6447	Section 74. Section 486.125, Florida Statutes, is amended	6476	subsection shall, at reasonable intervals, be given an
6448	to read:	6477	opportunity to demonstrate that she or he can resume the
6449	486.125 Refusal, revocation, or suspension of license;	6478	competent practice of physical therapy with reasonable skill and
6450	administrative fines and other disciplinary measures	6479	safety to patients.
6451	(1) The following acts constitute grounds for denial of a	6480	3. Neither the record of proceeding nor the orders entered
6452	license or disciplinary action, as specified in s. 456.072(2) $\underline{\text{or}}$	6481	by the board in any proceeding under this subsection may be used
6453	<u>s. 486.112</u> :	6482	against a physical therapist or physical therapist assistant in
6454	(a) Being unable to practice physical therapy with	6483	any other proceeding.
6455	reasonable skill and safety to patients by reason of illness or	6484	(b) Having committed fraud in the practice of physical
6456	use of alcohol, drugs, narcotics, chemicals, or any other type	6485	therapy or deceit in obtaining a license as a physical therapist
6457	of material or as a result of any mental or physical condition.	6486	or as a physical therapist assistant.
6458	1. In enforcing this paragraph, upon a finding of the State	6487	(c) Being convicted or found guilty regardless of
6459	Surgeon General or the State Surgeon General's designee that	6488	adjudication, of a crime in any jurisdiction which directly
6460	probable cause exists to believe that the licensee is unable to	6489	relates to the practice of physical therapy or to the ability to
6461	practice physical therapy due to the reasons stated in this	6490	practice physical therapy. The entry of any plea of nolo
6462	paragraph, the department shall have the authority to compel a	6491	contendere \underline{is} shall be considered a conviction for purpose of
6463	physical therapist or physical therapist assistant to submit to	6492	this chapter.
6464	a mental or physical examination by a physician designated by	6493	(d) Having treated or undertaken to treat human ailments by
6465	the department. If the licensee refuses to comply with such	6494	means other than by physical therapy, as defined in this
6466	order, the department's order directing such examination may be	6495	chapter.
6467	enforced by filing a petition for enforcement in the circuit	6496	(e) Failing to maintain acceptable standards of physical
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588-01852-24 20247016 588-01852-24 20247016 6497 therapy practice as set forth by the board in rules adopted 6526 (k) Violating any provision of this chapter or chapter 456, 6498 pursuant to this chapter. 6527 or any rules adopted pursuant thereto. 6499 (f) Engaging directly or indirectly in the dividing, 6528 (2) (a) The board may enter an order denying licensure or 6500 transferring, assigning, rebating, or refunding of fees received 6529 imposing any of the penalties in s. 456.072(2) against any 6501 for professional services, or having been found to profit by 6530 applicant for licensure or licensee who is found quilty of 6502 means of a credit or other valuable consideration, such as an 6531 violating any provision of subsection (1) of this section or who 6503 unearned commission, discount, or gratuity, with any person 6532 is found guilty of violating any provision of s. 456.072(1). 6504 referring a patient or with any relative or business associate 6533 (b) The board may take adverse action against a physical 6505 6534 of the referring person. Nothing in This chapter may not shall therapist's or a physical therapist assistant's compact 6506 be construed to prohibit the members of any regularly and 6535 privilege under the Physical Therapy Licensure Compact pursuant 6507 properly organized business entity which is comprised of 6536 to s. 486.112 and may impose any of the penalties in s. physical therapists and which is recognized under the laws of 456.072(2), if a physical therapist or physical therapist 6508 6537 assistant commits an act specified in subsection (1) or s. 6509 this state from making any division of their total fees among 6538 6510 themselves as they determine necessary. 6539 456.072(1). 6511 (g) Having a license revoked or suspended; having had other 6540 (3) The board may shall not reinstate the license of a 6512 disciplinary action taken against her or him; or having had her 6541 physical therapist or physical therapist assistant or approve 6513 or his application for a license refused, revoked, or suspended 6542 cause a license to be issued to a person it has deemed 6514 by the licensing authority of another state, territory, or 6543 unqualified until such time as it is satisfied that she or he 6515 country. 6544 has complied with all the terms and conditions set forth in the 6516 (h) Violating a lawful order of the board or department 6545 final order and that such person is capable of safely engaging 6517 previously entered in a disciplinary hearing. 6546 in the practice of physical therapy. 6518 (i) Making or filing a report or record which the licensee 6547 Section 75. Paragraph (j) is added to subsection (10) of 6519 knows to be false. Such reports or records shall include only 6548 section 768.28, Florida Statutes, to read: 6520 those which are signed in the capacity of a physical therapist. 6549 768.28 Waiver of sovereign immunity in tort actions; 6521 (j) Practicing or offering to practice beyond the scope 6550 recovery limits; civil liability for damages caused during a 6522 permitted by law or accepting and performing professional 6551 riot; limitation on attorney fees; statute of limitations; 6523 responsibilities which the licensee knows or has reason to know 6552 exclusions; indemnification; risk management programs.-6524 that she or he is not competent to perform, including, but not 6553 (10)6525 limited to, specific spinal manipulation. 6554 (j) For purposes of this section, the individual appointed Page 225 of 234 Page 226 of 234 CODING: Words stricken are deletions; words underlined are additions. CODING: Words stricken are deletions; words underlined are additions.

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6555	under s. 486.023(5) as the state's delegate on the Physical	6584	486.0715 Physical therapist; issuance of temporary permit
6556	Therapy Compact Commission, when serving in that capacity	6585	(1) The board shall issue a temporary physical therapist
6557	pursuant to s. 486.112, and any administrator, officer,	6586	permit to an applicant who meets the following requirements:
6558	executive director, employee, or representative of the Physical	6587	(b) Is a graduate of an approved United States physical
6559	Therapy Compact Commission, when acting within the scope of his	6588	therapy educational program and meets all the eligibility
6560	or her employment, duties, or responsibilities in this state, is	6589	requirements for licensure under ch. 456, s. 486.031(1)(a), (b),
6561	considered an agent of the state. The commission shall pay any	6590	and (c)1. s. 486.031(1)-(3)(a) , and related rules, except
6562	claims or judgments pursuant to this section and may maintain	6591	passage of a national examination approved by the board is not
6563	insurance coverage to pay any such claims or judgments.	6592	required.
6564	Section 76. Section 486.025, Florida Statutes, is amended	6593	Section 78. Paragraph (b) of subsection (1) of section
6565	to read:	6594	486.1065, Florida Statutes, is amended to read:
6566	486.025 Powers and duties of the Board of Physical Therapy	6595	486.1065 Physical therapist assistant; issuance of
6567	PracticeThe board may administer oaths, summon witnesses, take	6596	temporary permit
6568	testimony in all matters relating to its duties under this	6597	(1) The board shall issue a temporary physical therapist
6569	chapter, establish or modify minimum standards of practice of	6598	assistant permit to an applicant who meets the following
6570	physical therapy as defined in s. 486.021, including, but not	6599	requirements:
6571	limited to, standards of practice for the performance of dry	6600	(b) Is a graduate of an approved United States physical
6572	needling by physical therapists, and adopt rules pursuant to ss.	6601	therapy assistant educational program and meets all the
6573	120.536(1) and 120.54 to implement this chapter. The board may	6602	eligibility requirements for licensure under ch. 456, <u>s.</u>
6574	also review the standing and reputability of any school or	6603	486.102(1)(a), (b), and (c)1. s. 486.102(1)-(3)(a), and related
6575	college offering courses in physical therapy and whether the	6604	rules, except passage of a national examination approved by the
6576	courses of such school or college in physical therapy meet the	6605	board is not required.
6577	standards established by the appropriate accrediting agency	6606	Section 79. Effective July 1, 2024, for the 2024-2025
6578	referred to in <u>s. 486.031(1)(c)</u> s. 486.031(3)(a) . In determining	6607	fiscal year, the sum of \$50 million in recurring funds from the
6579	the standing and reputability of any such school and whether the	6608	General Revenue Fund is appropriated in the Grants and Aids -
6580	school and courses meet such standards, the board may	6609	Health Care Education Reimbursement and Loan Repayment Program
6581	investigate and personally inspect the school and courses.	6610	category to the Department of Health for the Florida
6582	Section 77. Paragraph (b) of subsection (1) of section	6611	Reimbursement Assistance for Medical Education Program
6583	486.0715, Florida Statutes, is amended to read:	6612	established in s. 381.402, Florida Statutes.
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6613	Section 80. Effective July 1, 2024, for the 2024-2025
6614	fiscal year, the sum of \$13.2 million in recurring funds from
6615	the General Revenue Fund is appropriated in the Dental Student
6616	Loan Repayment Program category to the Department of Health for
6617	the Dental Student Loan Repayment Program established in s.
6618	381.4019, Florida Statutes.
6619	Section 81. Effective July 1, 2024, for the 2024-2025
6620	fiscal year, the sum of \$23,357,876 in recurring funds from the
6621	General Revenue Fund is appropriated in the Grants and Aids -
6622	Minority Health Initiatives category to the Department of Health
6623	to expand statewide the telehealth minority maternity care
6624	program, established in s. 383.2163, Florida Statutes. The
6625	department shall establish 15 regions in which to implement the
6626	program statewide based on the location of hospitals providing
6627	obstetrics and maternity care and pertinent data from nearby
6628	counties for severe maternal morbidity and maternal mortality.
6629	The department shall identify the criteria for selecting
6630	providers for regional implementation and, at a minimum,
6631	consider the maternal level of care designations for hospitals
6632	within the region, the neonatal intensive care unit levels of
6633	hospitals within the region, and the experience of community-
6634	based organizations to screen for and treat common pregnancy-
6635	related complications.
6636	Section 82. Effective July 1, 2024, for the 2024-2025
6637	fiscal year, the sum of \$40 million in recurring funds from the
6638	General Revenue Fund is appropriated to the Agency for Health
6639	Care Administration to implement the Training, Education, and
6640	Clinicals in Health (TEACH) Funding Program established in s.
6641	409.91256, Florida Statutes, as created by this act.
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6642	
6643	fiscal year, the sum of \$2 million in recurring funds from the
6644	General Revenue Fund is appropriated to the University of
6645	Florida, Florida State University, Florida Atlantic University,
6646	and Florida Agricultural and Mechanical University for the
6647	purpose of implementing lab school articulated health care
6648	programs required by s. 1002.32, Florida Statutes. Each state
6649	university shall receive \$500,000 from this appropriation.
6650	Section 84. Effective July 1, 2024, for the 2024-2025
6651	fiscal year, the sum of \$5 million in recurring funds from the
6652	General Revenue Fund is appropriated in the Aid to Local
6653	Governments Grants and Aids - Nursing Education category to the
6654	Department of Education for the purpose of implementing the
6655	Linking Industry to Nursing Education (LINE) Fund established in
6656	s. 1009.8962, Florida Statutes.
6657	Section 85. Effective July 1, 2024, for the 2024-2025
6658	fiscal year, the sums of \$29,428,000 in recurring funds from the
6659	General Revenue Fund and \$40,572,000 in recurring funds from the
6660	Medical Care Trust Fund are appropriated in the Graduate Medical
6661	Education category to the Agency for Health Care Administration
6662	for the Slots for Doctors Program established in s. 409.909,
6663	Florida Statutes.
6664	Section 86. Effective July 1, 2024, for the 2024-2025
6665	fiscal year, the sums of \$42,040,000 in recurring funds from the
6666	Grants and Donations Trust Fund and \$57,960,000 in recurring
6667	funds from the Medical Care Trust Fund are appropriated in the
6668	Graduate Medical Education category to the Agency for Health
6669	Care Administration to provide to statutory teaching hospitals
6670	as defined in s. 408.07(46), Florida Statutes, which provide
	Page 230 of 234
(CODING: Words stricken are deletions; words <u>underlined</u> are additions.

1	588-01852-24 20247016_
6671	highly specialized tertiary care, including comprehensive stroke
6672	and Level 2 adult cardiovascular services; NICU II and III; and
6673	adult open heart; and which have more than 30 full-time
6674	equivalent (FTE) residents over the Medicare cap in accordance
6675	with the CMS-2552 provider 2021 fiscal year-end federal Centers
6676	for Medicare and Medicaid Services Healthcare Cost Report, HCRIS
6677	data extract on December 1, 2022, worksheet E-4, line 6 minus
6678	worksheet E-4, line 5, shall be designated as a High Tertiary
6679	Statutory Teaching Hospital and be eligible for funding
6680	calculated on a per Graduate Medical Education resident-FTE
6681	proportional allocation that shall be in addition to any other
6682	Graduate Medical Education funding. Of these funds, \$44,562,400
6683	shall be first distributed to hospitals with greater than 500
6684	unweighted fiscal year 2022-2023 FTEs. The remaining funds shall
6685	be distributed proportionally based on the total unweighted
6686	fiscal year 2022-2023 FTEs. Payments to providers under this
6687	section are contingent upon the nonfederal share being provided
6688	through intergovernmental transfers in the Grants and Donations
6689	Trust Fund. In the event the funds are not available in the
6690	Grants and Donations Trust Fund, the State of Florida is not
6691	obligated to make payments under this section.
6692	Section 87. Effective July 1, 2024, for the 2024-2025
6693	fiscal year, the sums of \$64,030,325 in recurring funds from the
6694	General Revenue Fund and \$88,277,774 in recurring funds from the
6695	Medical Care Trust Fund are appropriated to the Agency for
6696	Health Care Administration to establish a Pediatric Normal
6697	Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis
6698	Related Grouping (DRG) reimbursement methodology and increase
6699	the existing marginal cost percentages for transplant
1	Page 231 of 234
	1490 201 01 201

 $\textbf{CODING: Words } \underline{stricken} \text{ are deletions; words } \underline{underlined} \text{ are additions.}$

	588-01852-24 20247016
6700	pediatrics, pediatrics, and neonates.
6701	Section 88. Effective October 1, 2024, for the 2024-2025
6702	fiscal year, the sums of \$14,682,841 in recurring funds from the
6703	General Revenue Fund and \$20,243,041 in recurring funds from the
6704	Medical Care Trust Fund are appropriated to the Agency for
6705	Health Care Administration to provide a Medicaid reimbursement
6706	rate increase for dental care services. Health plans that
6707	participate in the Statewide Medicaid Managed Care program shall
6708	pass through the fee increase to providers in this
6709	appropriation.
6710	Section 89. Effective July 1, 2024, for the 2024-2025
6711	fiscal year, the sums of \$82,301,239 in recurring funds from the
6712	General Revenue Fund and \$113,467,645 in recurring funds from
6713	the Operations and Maintenance Trust Fund are appropriated in
6714	the Home and Community Based Services Waiver category to the
6715	Agency for Persons with Disabilities to provide a uniform
6716	iBudget Waiver provider rate increase. The sum of \$195,768,884
6717	in recurring funds from the Medical Care Trust Fund is
6718	appropriated in the Home and Community Based Services Waiver
6719	category to the Agency for Health Care Administration to
6720	establish budget authority for Medicaid services.
6721	Section 90. Effective July 1, 2024, for the 2024-2025
6722	fiscal year, the sum of \$11,525,152 in recurring funds from the
6723	General Revenue Fund is appropriated in the Grants and Aids -
6724	Community Mental Health Services category to the Department of
6725	Children and Families to enhance crisis diversion through mobile
6726	response teams established under s. 394.495, Florida Statutes,
6727	by adding an additional 16 mobile response teams to ensure
6728	coverage in every county.
	Page 232 of 234

	588-01852-24 20247016
6729	Section 91. Effective July 1, 2024, for the 2024-2025
6730	fiscal year, the sum of \$10 million in recurring funds from the
6731	General Revenue Fund is appropriated to the Department of Health
6732	to implement the Health Care Screening and Services Grant
6733	Program established in s. 381.9855, Florida Statutes, as created
6734	by this act.
6735	Section 92. Effective July 1, 2024, for the 2024-2025
6736	fiscal year, the sum of \$150,000 in nonrecurring funds from the
6737	General Revenue Fund and \$150,000 in nonrecurring funds from the
6738	Medical Care Trust Fund are appropriated to the Agency for
6739	Health Care Administration to contract with a vendor to develop
6740	a reimbursement methodology for covered services at advanced
6741	birth centers. The agency shall submit the reimbursement
6742	methodology and estimated fiscal impact to the Executive Office
6743	of the Governor's Office of Policy and Budget, the chair of the
6744	Senate Appropriations Committee, and the chair of the House
6745	Appropriations Committee no later than December 31, 2024.
6746	Section 93. Effective July 1, 2024, for the 2024-2025
6747	fiscal year, the sum of \$2.4 million in recurring funds from the
6748	General Revenue Fund is appropriated to the Agency for Health
6749	Care Administration for the purpose of providing behavioral
6750	health family navigators in state-licensed specialty hospitals
6751	providing comprehensive acute care services to children pursuant
6752	to s. 395.002(28), Florida Statutes, to help facilitate early
6753	access to mental health treatment. Each licensed specialty
6754	hospital shall receive \$600,000 from this appropriation.
6755	Section 94. Effective October 1, 2024, for the 2024-2025
6756	fiscal year, the sums of \$12,067,327 in recurring funds from the
6757	General Revenue Fund, \$127,300 in recurring funds from the
ļ	Page 233 of 234

588-01852-24 20247016_ 6758 Refugee Assistance Trust Fund, and \$16,812,576 in recurring 6759 funds from the Medical Care Trust Fund are appropriated to the
6759 funds from the Medical Care Trust Fund are appropriated to the
6760 Agency for Health Care Administration to provide a Medicaid
6761 reimbursement rate increase for private duty nursing services
6762 provided by licensed practical nurses and registered nurses.
6763 Health plans that participate in the Statewide Medicaid Managed
6764 Care program shall pass through the fee increase to providers in
6765 this appropriation.
6766 Section 95. Effective October 1, 2024, for the 2024-2025
6767 fiscal year, the sums of \$14,378,863 in recurring funds from the
6768 General Revenue Fund and \$19,823,951 in recurring funds from the
6769 Medical Care Trust Fund are appropriated to the Agency for
6770 <u>Health Care Administration to provide a Medicaid reimbursement</u>
6771 rate increase for occupational therapy, physical therapy, and
6772 speech therapy providers. Health plans that participate in the
6773 Statewide Medicaid Managed Care program shall pass through the
6774 fee increase to providers in this appropriation.
6775 Section 96. Effective October 1, 2024, for the 2024-2025
6776 fiscal year, the sums of \$9,532,569 in recurring funds from the
6777 General Revenue Fund and \$13,142,429 in recurring funds from the
6778 Medical Care Trust Fund are appropriated to the Agency for
6779 Health Care Administration to provide a Medicaid reimbursement
6780 rate increase for Current Procedural Terminology codes 97153 and
6781 97155 related to behavioral analysis services. Health plans that
6782 participate in the Statewide Medicaid Managed Care program shall
6783 pass through the fee increase to providers in this
6784 appropriation.
6785 Section 97. Except as otherwise expressly provided in this
6786 act, this act shall take effect upon becoming a law.
Page 234 of 234
CODING: Words stricken are deletions; words underlined are addition

THE FLORIDA SENATE			
APPEARANCE RECORD			
Deliver BOTH copies of this form to the Senator or Senate Professional St Meeting Date	taff conducting the meeting) SB 7016 Bill Number (if applicable)		
Topic Health Care	Amendment Barcode (if applicable)		
NameJoeAnnettart			
Job Title Chief Vegislative Officer			
Address 118 East Jefferson Street	Phone 850.224.1089		
City Tallohasseg F2 32301	Email jaharte floride dentel y		
Speaking: Against Information Waive S	peaking: In Support Against		
Representing The Florida Dental Associa	tion		
Appearing at request of Chair: Yes No Lobbyist regist	ered with Legislature: Yes No		
While it is a Senate tradition to encourage public testimony, time may not permit all meeting. Those who do speak may be asked to limit their remarks so that as many			

This form is part of the public record for this meeting.

S-001 (10/14/14)

	The Florida Senate	
FISCA	APPEARANCE RECORD Deliver both copies of this form to Senate professional staff conducting the meeting	-7616 # 520732
Name EILYN BOGD	lanoff Phone 95	Amendment Barcode (if applicable) 4364-6005
Address <u>Freet</u>	Email <u>eb</u>	ogdanoff @ beckerlawyer
City State	<u>FL 33301</u> Zip	
Speaking: For Against	Information OR Waive Speaking:	In Support Against
	PLEASE CHECK ONE OF THE FOLLOWING:	
I am appearing without compensation or sponsorship.	R3 Education	I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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

This form is part of the public record for this meeting.

The Florida Senate
APPEARANCE RECORD 7016
Meeting Date Deliver both copies of this form to Bill Number or Topic Fiscol Policy Senate professional staff conducting the meeting Bill Number or Topic
Name <u>Committee</u> Amendment Barcode (if applicable) Name <u>JJOB HARRIS</u> Phone <u>870-232-0720</u>
Address <u>AGIB Contonnia Place</u> Email <u>bharris Coloufla.com</u>
Lallahaner FC 32308 City State Zip
Speaking: For Against Information OR Waive Speaking: In Support Against
PLEASE CHECK-ONE OF THE FOLLOWING:
 I am appearing without compensation or sponsorship. I am a registered lobbyist, representing: R 3 Education f A atalem

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

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THE FLORIDA SENATE			
APPEARANCE RECORD			
JAM. 11, 2024 (Deliver BOTH copies of this form to the Senator or Senate Professional S Meeting Date	Staff conducting the meeting) SB 7016 Bill Number (if applicable)		
Topic Health Care	<i>640410</i> Amendment Barcode (if applicable)		
NameJoe Anne Hart	_		
Job Title Chief Legislative Officer	_		
Address <u>IIB East Jefferson St.</u>	Phone 850.224.1089		
Tallahasses FL 32301	Email jaha A@ Gondadental on		
	Speaking: In Support Against air will read this information into the record.)		
Representing The Florida Dental ASSOC	iation		
Appearing at request of Chair: Yes No Lobbyist regis	stered with Legislature:		
While it is a Senate tradition to encourage public testimony, time may not permit a meeting. Those who do speak may be asked to limit their remarks so that as many			

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate			
Jan 11, 2024 Meeting Date Fiscal Policy Committee	Deliver both copies of this form to Senate professional staff conducting the	Bill Number or Topic	
Name Benjamih Brow	uning (FLASSOL. of Comm H14P Contres)	hone 850 942 1827	
Address 2340 Hanser Street	r Lane Ei	mail ben & factor org	
Tallahassee City	FL 32301 State Zip	a.	
Speaking: Sor	Against Information OR Waive	Speaking: In Support Against	
PLEASE CHECK ONE OF THE FOLLOWING:			
Tam appearing without compensation or sponsorship.	I am a registered lobbyist, representing:	I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:	

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

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	The Florida Sena	te	7.011
-1/1/24	APPEARANCE R	ECORD	7016
Health Fiscal Pa	Deliver both copies of this for Senate professional staff conducting		Bill Number or Topic
Name Volut Grop	raler	_ Phone _ 305 4	Amendment Barcode (if applicable) QS-ZCESC
Address 9040 Su	usef Drive	Email VGONZALEL	Osunnsegroup
Miann	F1 33173	5	ORG
City Stat	e Zip	/	
Speaking: Sor Against	Information OR W	aive Speaking: 🗶 In Sup	oport 🗌 Against
	PLEASE CHECK ONE OF THE	OLLOWING:	
I am appearing without compensation or sponsorship.	I am a registered lobbyist, representing:		am not a lobbyist, but received omething of value for my appearance
Summine Con	nmunty D		ravel, meals, lodging, etc.), conspred/by:
terreter a sub set of the sub-		X 1	

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

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The Florida Senate

APPEARANCE RECORD



Deliver both copies of this form to Senate professional staff conducting the meeting

Name	Committee Fdda T	vonne "Fernandez Phone_	Amendment Barcode (if applicable) 954-850-7262
Address	215 Street	Stonroe Street Email	Ifernandez @ zarp.org
	tallah ass	e FL 3230J State Zip	
	Speaking: 🗌 F	or Against Information OR Waive Speakin	ng: 🕅 In Support 🔲 Against
		PLEASE CHECK ONE OF THE FOLLOWING	G:
	n appearing without npensation or sponsorshi	b. I am a registered lobbyist, representing:	I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.),
		AARP	sponsored by:

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

This form is part of the public record for this meeting.

	The Florida Senate	
Meeting Date Fiscal Policy	APPEARANCE RECORD Deliver both copies of this form to Senate professional staff conducting the meeting	7016 Bill Number or Topic
Committee Name JEFF SCOT	Phone 85	Amendment Barcode (if applicable)
Address <u>1403 Piedmout Dr. E.</u> Street Tallabassee Fr	Email <u>50</u>	offerfinedical, org
City Stat		In Support 🔲 Against
I am appearing without compensation or sponsorship.	PLEASE CHECK ONE OF THE FOLLOWING: I am a registered lobbyist, representing: Florida Medical Association	I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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

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	The Florida Senate		
1 11 24	APPEARANCE RECORD	7016	
Fiscal Policy_	Deliver both copies of this form to Senate professional staff conducting the meeting	Bill Number or Topic	
Committee		Amendment Barcode (if applicable)	
Name Jarah Massey	Phone 850). 545.0543	
Address	Email <u>smas</u>	sey Ofichamber.com	
City State	Zip		
Speaking: 🗌 For 🗌 Against	Information OR Waive Speaking:	In Support 🗌 Against	
PLEASE CHECK ONE OF THE FOLLOWING:			
I am appearing without compensation or sponsorship.	Lam a registered lobbyist, representing:	I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.),	
Flonda	Chamber of Commerce	sponsored by:	

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

This form is part of the public record for this meeting.

I II 24 Meeting Date	The Florida Senate APPEARANCE RECORD Deliver both copies of this form to Senate professional staff conducting the meeting	SB 7016 Bill Number or Topic After Amends
Name Lindy Keinedy	Phone $\frac{859}{100}$	Amendment Barcode (if applicable) 4452740
Address 1255. Gadsden	Email Lina	ly ashlat net
Street Tallahasse FL City State	323-09 Zip	
Speaking: 🗍 For 🗌 Against 🗌	Information OR Waive Speaking:	In Support 🔲 Against
Р	LEASE CHECK ONE OF THE FOLLOWING:	
I am appearing without compensation or sponsorship. Safety Net Hospi	La Alliance of 1	I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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

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THE FLORIDA SENATE	
APPEARANCE RECOI	RD
Deliver BOTH copies of this form to the Senator or Senate Professional State	Bill Number (if applicable)
Topic Health Care	Amendment Barcode (if applicable)
Name Joe Anne Havt	
Job Title Chief Legislative Officer	
Address 118 East Jefferson St.	Phone 850, 224.1089
Street Tallahasseg E 32301 City City State Zip	Email jahart@ Gondadental.
Speaking: For Against Information Waive Sp (The Chair	eaking: In Support Against r will read this information into the record.)
Representing The Florida Dental Asso	piation
Appearing at request of Chair: Yes No Lobbyist register	ered with Legislature: Yes No
While it is a Senate tradition to encourage public testimony, time may not permit all meeting. Those who do speak may be asked to limit their remarks so that as many p	persons wishing to speak to be heard at this persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

	The Florida Senate	
1-11-24	APPEARANCE RECORD	7016
Meeting Date Health Palicy	Deliver both copies of this form to Senate professional staff conducting the meeting	Bill Number or Topic
Committee		Amendment Barcode (if applicable)
Name Tyler Sunund	Phone	851-228-4DC
Address 1/13 E Tegn St. Street	Email	sunupperida arting
Tallahassec FL City State	32305 Zip	
Speaking: 🖾 For 🗌 Against	Information OR Waive Speaking	: 🗌 In Support 🗌 Against
	PLEASE CHECK ONE OF THE FOLLOWING:	
I am appearing without compensation or sponsorship. I am a registered lobbyist, representing: I am a registered lobbyist, representing: I am not a lobbyist, but received something of value for my appear (travel, meals, lodging, etc.), sponsored by: Facilities Facilities Facilities		I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:
	· (() / · · · · · · · · · · · · · · · · · ·	

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

This form is part of the public record for this meeting.

	Meeting Date FISAL POLICY	The Florida Se APPEARANCE Deliver both copies of th Senate professional staff conduct	RECORD his form to	SB 7016 Bill Number or Topic
Name	Committee ALAN		Phone	Amendment Barcode (if applicable) 850-241-3232
Addres	Street	MAHAN DR.	Email	(EO C ARCFIORING, ORG
	City	FL 32308 State Zip	*	
	Speaking: Kor	Against Information OR	Waive Speakin	g: 🗌 In Support 🔲 Against
		PLEASE CHECK ONE OF TH	HE FOLLOWING	:
I am appearing without compensation or sponsorship.		The Arc of Floriph		I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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

This form is part of the public record for this meeting.

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.)

	Prepa	red By: Th	ne Professional S	taff of the Committe	ee on Fiscal Policy
BILL:	SB 7018				
INTRODUCER:	Health Poli	cy Comn	nittee		
SUBJECT:	Health Care	e Innovat	tion		
DATE:	January 9, 2	2024	REVISED:		
ANAL	YST	STAF	FDIRECTOR	REFERENCE	ACTION
Brown, et al.		Brown	n		HP Submitted as Comm. Bill/Fav
1. Brown, et al.		Yeatn	nan	FP	Favorable

I. Summary:

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

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

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

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

- Fill a demonstrated need;
- Obtain or upgrade necessary equipment, hardware, and materials;
- Adopt new technologies or systems; or

• A combination thereof to improve the quality and delivery of health care in measureable and sustainable ways that will lower costs and allow that value to be passed onto health care consumer.

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

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

The bill makes the following appropriations:

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

The bill takes effect upon becoming a law.

II. Present Situation:

Challenges of the Health Care System

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

Health Care Professional Shortages

The United States has a current health care professional shortage. The U. S. Department of Health and Human Services designates an area, population group, or facility as a Health

¹ Centers for Disease Control and Prevention, U.S. Health Disadvantage: Causes and Potential Solutions, available at <u>https://www.cdc.gov/policy/chep/health/index.html</u> (last visited December 3, 2023).

Professional Shortage Area (HPSA) if it is experiencing a shortage of professionals.² The three types of HPSAs are:

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

As of December 3, 2023, there are 8,544 Primary Care HPSAs, 7,651 Dental HPSAs, and 6,822 Mental Health HPSAs nationwide. To eliminate the shortages, an additional 17,637 primary care practitioners, 13,354 dentists, and 8,504 psychiatrists are needed, respectively.³

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population.⁴ Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.⁵ By 2030, all baby-boomers will be over the age of 65, and by 2034, it is projected that the number of individuals over the age of 65 will surpass the number of children under the age of 18 for the first time in U.S. history.⁶ Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

Health care workers may experience an extreme amount of stress due to the demanding work conditions, including taxing work, exposure to infectious diseases, long hours, and challenging interactions with coworkers, patients, and their families.⁷ Prior to the COVID-19 pandemic, the National Academy of Medicine found that burnout had reached a crisis level, with 35-45 percent of nurses and physicians and 45-60 percent of medical students and residents reporting

³ U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas*, available at <u>https://data.hrsa.gov/topics/health-workforce/shortage-areas</u> (last visited December 4, 2023).

⁴ The U.S. population is projected to increase from almost 336 million in 2023 to nearly 370 million in 2080, before decreasing to 366 million in 2100. *See* U.S. Census Bureau, *U.S. and World Population Clock*, available at

² U.S. Department of Health and Human Services, Guidance Portal, *Health Professional Shortage Areas (HPSAs and Medically Underserved Populations (MUA/P) Shortage Designation Types* (Aug. 1, 2019), available at https://www.hhs.gov/guidance/document/hpsa-and-muap-shortage-designation-types (last visited December 4, 2023).

https://www.census.gov/popclock/, and U.S. Census Bureau, U.S. Population Projected to Begin Declining in Second Half of Century (Nov. 9, 2023), available at https://www.census.gov/newsroom/press-releases/2023/population-projections.html (both sites last visited December 4, 2023).

⁵ *Id*, at p. 33.

⁶ J. Vespa, L. Medina, and D. Armstrong, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060* (Mar. 208, rev. Feb, 2020), available at

https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited December 4, 2023). ⁷ J. Nigam, et. al., *Vital Signs: Health Worker-Perceived Working Conditions and Symptoms of Poor Mental Health – Quality of Worklife Survey, United States, 2018-2022*, MORBIDITY AND MORTALITY WEEKLY REPORT (Oct. 24, 2023), available at https://www.cdc.gov/mmwr/volumes/72/wr/pdfs/mm7244e1-H.pdf (last visited December 4, 2023).

symptoms of burnout.⁸ During the pandemic, the high levels of stress and the increased demands for care led to record numbers of health care workers quitting or planning to quit.⁹ In 2022, nearly one half of health care workers reported burnout.¹⁰

Florida is not immune to the national problem and is also experiencing a health care practitioner shortage. This is evidenced by the fact that as of September 30, 2023, there are 304 primary care HPSAs, 266 dental HPSAs, and 228 mental health HPSAs designated within the state. It would take 1,803 primary care physicians, 1,317 dentists, and 587 psychiatrists to eliminate these shortage areas.¹¹

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

Access to Health Care

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

¹² Presentation before the Florida Senate Committee on Health Policy by Emma Spencer, Department of Health, *Florida's Physician and Nursing Workforce* (Nov. 14, 2023), available at

https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504 MeetingPacket 5979 4.pdf (last visited December 4, 2023).

https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation (last visited December 4, 2023).

⁸ Office of the Surgeon General, *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce* (2022),, available at <u>https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf</u> (last visited December 4, 2023). "Burnout" is an occupational syndrome characterized by a high degree of emotional exhaustion and depersonalization and a low sense of personal accomplishment at work.

⁹ *Id*. at p. 14.

¹⁰ Supra, note 7.

¹¹ Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at <u>https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs</u> (last visited December 4, 2023). To generate the report, select "Designated HPSA Quarterly Summary."

¹³ *Id.* Those counties are Glades, Gulf, Hamilton, Madison, Union, Calhoun, Hendry, Levy, and Liberty. ¹⁴ *Id.*

¹⁵ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030, *Access to Health Services*, available at <u>https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services</u> (last visited December 4, 2023). (Hereinafter "Healthy People 2030").

¹⁶ Health and Resources Services Administration, *What is Shortage Designation?*, available at

¹⁷ See, Heath Resources and Services Administration, *MUA Find*, available at <u>https://data.hrsa.gov/tools/shortage-area/mua-find</u> (last visited December 4, 2023). To generate a list of medically underserved areas and populations, select Florida as the search criteria.

Other factors that play a role in access to health care include health care affordability and the lack of health insurance coverage.¹⁸ Studies show that having health insurance is associated with improved access to health services and better health monitoring. Additionally, nonfinancial barriers significantly impact a patient's ability to access care. Among the most prevalent nonfinancial barriers are the ability to get an appointment and inconvenient or unreliable transportation.¹⁹

Health Care Outcomes

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

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

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.²⁵ In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019. The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births. Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births,

¹⁸ Centers for Disease Control and Prevention, Division of Heart Disease and Stroke Prevention, *Health Care Access*, available at https://www.cdc.gov/dhdsp/health-equity/health-care-access.htm (last visited December 4, 2023).

¹⁹ Healthy People 2030, *supra*, note 156.

²⁰ M. Gunja, Evan Gumas, and R. Williams, The Commonwealth Fund, U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes (Jan. 31, 2023), available at

https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 (last visited December 4, 2023). Other wealthy nations included in the study are Australia, Canada, France, Germany, Japan, the Netherlands, New Zealand, Norway, South Korea, Sweden, Switzerland, and the United Kingdom.

²¹ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *About Chronic Diseases*, available at <u>https://www.cdc.gov/chronicdisease/about/index.htm</u> (last visited December 4, 2023).

 ²² W. Raghupathi and V. Rahupathi, An Empirical Study of Chronic Diseases in the United States: A Visual Analytics Approach to Public Health, INTERNATIONAL JOURNAL ON ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH, 15(3):431 (Mar. 2018), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5876976/ (last visited December 4, 2023).
 ²³ Id., and CDC, supra, note 22.

²⁴ Id.

²⁵ U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health* (Dec. 2020), available at <u>https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf</u> (last visited November 9, 2023).

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

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.²⁸ Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida.

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

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

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

Advancements in Health Care

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

²⁶ Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States*, 2021 (March 2023), available at <u>https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf</u> (last visited December 4, 2023).

²⁷ United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic* (Oct. 2022), available at <u>https://www.gao.gov/assets/gao-23-105871.pdf</u> (last visited December 4, 2023).

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

²⁹ Centers for Disease Control and Prevention, Infant Mortality, available at

https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last visited December 4, 2023). ³⁰ D. Ely and K. Driscoll, Centers for Disease Control and Prevention, National Center for Health Statistics, *Infant Mortality in the United States: Provisional Data from the 2022 Period Linked Birth/Infant Death File*, Vital Statistics Rapid Release, Report No. 33 (Nov. 2023), available at https://www.cdc.gov/nchs/data/vsrr/vsrr033.pdf (last visited December 4, 2023). ³¹ *Id*.

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

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

care technology, the health care delivery system has been slower to change.

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

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

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

³³ The vaccine for polio was developed in the early 1950s. *See* World Health Organization, *History of the Polio Vaccine*, available at <u>https://www.who.int/news-room/spotlight/history-of-vaccination/history-of-polio-vaccination</u> (last visited December 2, 2023).

³⁴ Institute of Medicine, *Evidence-Based Medicine and the Changing Nature of Healthcare: 2007 IOM Annual Meeting Summary*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK52825/ (last visited December 2, 2023).

³⁵ Gary Ahlquist, et. al, Strategy&, *The (R)evolution of Healthcare*, available at

https://www.strategyand.pwc.com/gx/en/industries/health/the-revolution-of-healthcare.pdf (last visited December 2, 2023). ³⁶ Institute of Medicine, *supra*, note 37.

 ³⁷ Julia Shaver, M.D., *The State of Telehealth Before and After the COVID-19 Pandemic*, PRIMARY CARE 49(4): 517-530 (Dec. 2022), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9035352/ (last visited December 2, 2023).
 ³⁸ Telehealth.HHS.gov, *Telehealth and Remote Patient Monitoring*, available at

<u>https://telehealth.hhs.gov/providers/preparing-patients-for-telehealth/telehealth-and-remote-patient-monitoring</u> (last visited December 2, 2023).

³⁹ An electronic health record is a digital version of a patient's paper chart. *See* The Office of the National Coordinator for Health Information Technology, HealthIT.gov, *Frequently Asked Questions*, available at <u>https://www.healthit.gov/faq/what-electronic-health-record-ehr</u> (last visited December 3, 2023).

⁴⁰ Centers for Medicare and Medicaid Services, *Electronic Health Records*, available at <u>https://www.cms.gov/priorities/key-initiatives/e-health/records</u> (last visited December 3, 2023).

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

Health Care Innovation Initiatives

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

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

The Office of Economic and Demographic Research

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

The Office of Program Policy Analysis and Government Accountability

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

https://catalyst.nejm.org/doi/full/10.1056/CAT.17.0558 (last visited December 3, 2023).

⁴¹ NEJM Catalyst, *What is Value-Based Healthcare?* (Jan. 1, 2017), available at

⁴² For example, see the Delaware Center for Health Innovation, available at <u>https://www.dehealthinnovation.org/</u>; Rhode Island Health Care Innovation Initiative, available at <u>https://eohhs.ri.gov/initiatives/healthcare-innovation</u>; Oklahoma Center for Health Innovation and Effectiveness, available at <u>https://oklahoma.gov/health/about-us/center-for-health-innovation-and-effectiveness.html</u> (all sites last visited December 3, 2023).

⁴³ Centers for Medicare and Medicaid Services, *About the CMS Innovation Center*, available at <u>https://www.cms.gov/priorities/innovation/About</u> (last visited December 3, 2023).

⁴⁴ Centers for Medicare and Medicaid Services, *CMS Innovation Center Programs*, available at <u>https://data.cms.gov/cms-innovation-center-programs</u> (last visited December 3, 2023).

III. Effect of Proposed Changes:

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

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

Health Care Innovation Council

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

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

The remainder of the council consists of the following appointments by the Governor:

- A licensed physician;
- An employee of a licensed hospital;
- A licensed nurse;
- A Florida resident to represent the interest of health care patients;
- An employee of a health insurer or health maintenance organization; and
- A representative of the long-term care facility industry.

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

⁴⁵ The section expires on July 1, 2043.

⁴⁶ The bill provides that the legislative appointees, the physician, and the nurse all serve initial terms of three years in order to create staggered terms.

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

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

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

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

Council Duties

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

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

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

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

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

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

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

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

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

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

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

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

The council must submit an annual report each December 1 on the council's activities, including:

- An update on the status of the delivery of health care in Florida;
- Information on implementation of best practices by Florida health care industry stakeholders; and
- Highlights of exploration, development, or implementation of innovative technologies, workforce pathways, service delivery models, or other solutions by Florida health care industry stakeholders.

Revolving Loan Program

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

The bill requires the DOH to establish eligibility criteria that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Technical Assistance for Funding Opportunities

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

Rulemaking

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

Reporting

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

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

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

Evaluation

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

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

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

Each report must include recommendations for consideration by the Legislature.

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

Appropriations

The bill makes the following appropriations:

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

Effective Date

The bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

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

C. Government Sector Impact:

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

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

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

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 381.4015 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

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

588-01851-24

20247018

SB 7018

By the Committee on Health Policy

1 A bill to be entitled 2 An act relating to health care innovation; creating s. 381.4015, F.S.; defining terms; providing legislative 3 intent; creating the Health Care Innovation Council within the Department of Health for a specified purpose; providing for membership, meetings, and conflicts of interest of the council; specifying conflicts of interest with respect to the revolving ç loan program established under the act; defining the 10 terms "business relationship" and "relative"; 11 specifying duties of the council; requiring the 12 council, by a specified date, to adopt, and update as 13 necessary, a certain document; requiring the council 14 to submit annual reports to the Governor and the 15 Legislature; requiring state agencies and statutorily 16 created state entities to assist and cooperate with 17 the council as requested; requiring the department to 18 provide administrative support to the council; 19 requiring the department to maintain a link to 20 specified information on the homepage of its website; 21 requiring the department to publish specified 22 information on its website; requiring the department 23 to provide technical assistance to certain applicants 24 upon request; requiring the department to administer a 2.5 revolving loan program for applicants seeking to 26 implement certain health care innovations in this 27 state; providing for administration of the program; 28 requiring the department to adopt certain rules; 29 specifying eligibility and application requirements; Page 1 of 22 CODING: Words stricken are deletions; words underlined are additions.

588-01851-24 20247018 30 specifying terms, authorized uses, and repayment 31 options for loans; requiring the department to create 32 and maintain a separate account in the Grants and 33 Donations Trust Fund within the department to fund the 34 revolving loan program; providing that funds for the 35 program are not subject to reversion; authorizing the 36 department to contract with a third party to 37 administer the program, including loan servicing, and 38 manage the revolving loan fund; specifying 39 requirements for the contract; requiring the 40 department to publish and update specified information 41 and reports on its website annually; requiring the Office of Economic and Demographic Research and the 42 43 Office of Program Policy Analysis and Government 44 Accountability to each develop and present an 45 evaluation of the program to the Governor and the 46 Legislature every 5 years, beginning on specified 47 dates; specifying requirements for the evaluations; 48 requiring that the offices be given access to all data 49 necessary to complete the evaluation, including 50 confidential data; authorizing the offices to 51 collaborate on data collection and analysis; requiring 52 the department to adopt rules; providing for future 53 expiration; authorizing the department to adopt 54 emergency rules to implement the act; providing 55 appropriations; providing an effective date. 56 57 Be It Enacted by the Legislature of the State of Florida: 58

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59	Section 1. Section 381.4015, Florida Statutes, is created
60	to read:
61	381.4015 Florida health care innovation
62	(1) DEFINITIONSAs used in this section, the term:
63	(a) "Council" means the Health Care Innovation Council.
64	(b) "Department" means the Department of Health.
65	(c) "Health care provider" means any person or entity
66	licensed, certified, registered, or otherwise authorized by law
67	to provide health care services in this state.
68	(2) LEGISLATIVE INTENTThe Legislature intends to harness
69	the innovation and creativity of entrepreneurs and businesses,
70	together with the state's health care system and stakeholders,
71	to lead the discussion and highlight advances and innovations
72	that will address challenges in the health care system as they
73	develop in real time and transform the delivery and strengthen
74	the quality of health care in Florida. Innovative technologies,
75	workforce pathways, service delivery models, or other solutions
76	that improve the quality of care in measurable and sustainable
77	ways, that can be replicated, and that will lower costs and
78	allow that value to be passed on to health care consumers shall
79	be highlighted for adoption across all neighborhoods and
80	communities in this state.
81	(3) HEALTH CARE INNOVATION COUNCILThe Health Care
82	Innovation Council, a council as defined in s. 20.03, is created
83	within the department to tap into the best knowledge and
84	experience available by regularly bringing together subject
85	matter experts in a public forum to explore and discuss
86	innovations in technology, workforce, and service delivery
87	$\underline{\mbox{models}}$ that can be exhibited as best practices, implemented, or
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88	scaled in order to improve the quality and delivery of health
89	care in this state in measurable, sustainable, and reproducible
90	ways.
91	(a) Membership
92	1. The Lieutenant Governor shall serve as an ex officio,
93	nonvoting member and shall act as the council chair.
94	2. The council shall be composed of the following voting
95	members, to be appointed by July 1, 2024:
96	a. One member appointed by the President of the Senate and
97	one member appointed by the Speaker of the House of
98	Representatives. The appointing officers shall make appointments
99	prioritizing members who have the following experience:
100	(I) A representative of the health care sector who has
101	senior level experience in reducing inefficiencies in health
102	care delivery systems;
103	(II) A representative of the private sector who has senior
104	level experience in cybersecurity or software engineering in the
105	health care sector;
106	(III) A representative who has expertise in emerging
107	technology that can be used in the delivery of health care; or
108	(IV) A representative who has experience in finance or
109	investment or in management and operation of early stage
110	companies.
111	b. A physician licensed under chapter 458 or chapter 459,
112	appointed by the Governor.
113	c. A nurse licensed under chapter 464, appointed by the
114	Governor.
115	d. An employee of a hospital licensed under chapter 395 who
116	has executive-level experience, appointed by the Governor.

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117	e. A representative of the long-term care facility
118	industry, appointed by the Governor.
119	f. An employee of a health insurer or health maintenance
120	organization who has executive-level experience, appointed by
121	the Governor.
122	g. A resident of this state who can represent the interest
123	of health care patients in this state, appointed by the
124	Governor.
125	3. The chair of the Council of Florida Medical School Deans
126	shall serve as a voting member of the council.
127	4. The council shall be composed of the following ex
128	officio, nonvoting members:
129	a. The State Surgeon General.
130	b. The Secretary of Health Care Administration.
131	c. The Secretary of Children and Families.
132	d. The director of the Agency for Persons with
133	Disabilities.
134	e. The Secretary of Elderly Affairs.
135	5. Except for ex officio members, the term of all
136	appointees shall be for 2 years unless otherwise specified.
137	However, to achieve staggered terms, the appointees in sub-
138	subparagraphs 2.ac. shall serve initial terms of 3 years. The
139	appointees may be reappointed for no more than four consecutive
140	terms.
141	5. Any vacancy occurring on the council must be filled in
142	the same manner as the original appointment. Any member who is
143	appointed to fill a vacancy occurring because of death,
144	resignation, or ineligibility for membership shall serve only
145	for the unexpired term of the member's predecessor.
1	
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146	6. Members whose terms have expired may continue to serve
147	until replaced or reappointed. However, members whose terms have
148	expired may not serve longer than 6 months after the expiration
149	of their terms.
150	7. Members shall serve without compensation but are
151	entitled to reimbursement for per diem and travel expenses
152	pursuant to s. 112.061.
153	8. Members may be removed for cause by the appointing
154	entity.
155	9. Each member of the council who is not otherwise required
156	to file a financial disclosure statement pursuant to s. 8, Art.
157	II of the State Constitution or s. 112.3144 must file a
158	disclosure of financial interests pursuant to s. 112.3145.
159	(b) MeetingsThe council shall convene its first
160	organizational meeting by September 1, 2024. Thereafter, the
161	council shall meet as necessary, but at least quarterly, at the
162	call of the chair. In order to provide an opportunity for the
163	broadest public input, the chair shall ensure that a majority of
164	the meetings held in a year are geographically dispersed within
165	this state. As feasible, meetings are encouraged to provide an
166	opportunity for presentation or demonstration of innovative
167	solutions in person. A majority of the members of the council
168	constitutes a quorum, and a meeting may not be held with less
169	than a quorum present. In order to establish a quorum, the
170	council may conduct its meetings through teleconference or other
171	electronic means. The affirmative vote of a majority of the
172	members of the council present is necessary for any official
173	action by the council.
174	(c) Conflicts of interest
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175	1. A council member may not vote on any matter that would
	vide:
177	a. Direct financial benefit to the member;
178	b. Financial benefit to a relative of the member, including
	entity of which a relative is an officer, partner, director,
	proprietor or in which the relative has a material interest;
181 or	proprietor of in which the relative has a material interest,
182 <u>01</u>	c. Financial benefit to a person or entity with whom the
	ber has a business relationship.
184	2. With respect to the revolving loan program established
	subsection (7):
185 <u>111</u> 186	a. Council members may not receive loans under the program;
187 <u>and</u> 188	-
	b. A person or entity that has a conflict-of-interest
	ationship with a council member as described in sub-
	paragraph 1.b. or sub-subparagraph 1.c. may not receive a
	n under the program unless that council member recused
	self or herself from consideration of the person's or
	ity's application.
194	3. For purposes of this paragraph, the term:
195	a. "Business relationship" means an ownership or
	trolling interest, an affiliate or subsidiary relationship, a
	mon parent company, or any mutual interest in any limited
-	tnership, limited liability partnership, limited liability
	pany, or other entity or business association.
200	b. "Relative" means a father, mother, son, daughter,
	band, wife, brother, sister, grandparent, father-in-law,
	her-in-law, son-in-law, or daughter-in-law of a person.
203	(d) Public meetings and recordsThe council and any
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204	subcommittees it forms are subject to the provisions of chapter
205	119 relating to public records and the provisions of chapter 286
206	relating to public meetings.
207	(4) HEALTH CARE INNOVATION COUNCIL DUTIESIn order to
208	facilitate and implement this section, the council shall:
209	(a) By February 1, 2025, adopt and update as necessary a
210	document that sets forth and describes a mission statement,
211	goals, and objectives for the council to function and meet the
212	purposes of this section.
213	(b) Facilitate public meetings across this state at which
214	innovators, developers, and implementers of technologies,
215	workforce pathways, service delivery models, and other solutions
216	may present information and lead discussions on concepts that
217	address challenges to the health care system as they develop in
218	real time and advance the delivery of health care in this state
219	through technology and innovation.
220	1. Consideration must be given to how such concepts
221	increase efficiency in the health care system in this state,
222	reduce strain on the state's health care workforce, improve
223	patient outcomes, expand public access to health care services
224	in this state, or reduce costs for patients and the state
225	without reducing the quality of patient care.
226	2. Exploration and discussion of concepts may include how
227	concepts can be supported, cross-functional, or scaled to meet
228	the needs of health care consumers, including employers, payors,
229	patients, and the state.
230	3. The council may coordinate with the Small Business
231	Development Center Network, the Florida Opportunity Fund, the
232	Institute for Commercialization of Florida Technology, and other
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business incubators, development organizations, or institutions
of higher education to include emerging and early stage
innovators, developers, and implementers of technology, models,
or solutions in health care in the exploration and discussion of
concepts and breakthrough innovations.
4. To support adoption and implementation of innovations
and advancements, specific meetings may be held which bring
together technical experts, such as those in system integration,
cloud computing, artificial intelligence, and cybersecurity, to
lead discussions on recommended structures and integrations of
information technology products and services and propose
solutions that can make adoption and implementation efficient,
effective, and economical.
5. The council may also highlight broad community or
$\underline{\text{statewide}}$ issues or needs of providers and users of health care
delivery and may facilitate public forums in order to explore
and discuss the range of effective, efficient, and economical
technology and innovative solutions that can be implemented.
(c) Annually distinguish the most impactful concepts by
recognizing the innovators, developers, and implementers whose
work is helping Floridians to live brighter and healthier lives
In seeking out projects, initiatives, and concepts that are
having a positive impact in Florida, have huge potential to
scale that impact throughout this state through growth or
replication, or are cutting-edge advancements, programs, or
other innovations that have the capability to accelerate
transformation of health care in this state, the council may
issue awards to recognize these strategic and innovative
thinkers who are helping Floridians live brighter and healthier

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262	lives. The council may develop a logo for the award for use by
263	awardees to advertise their achievements and recognition.
264	(d) Consult with and solicit input from health care
265	experts, health care providers, and technology and manufacturing
266	experts in the health care or related fields, users of such
267	innovations or systems, and the public to develop and update:
268	1. Best practice recommendations that will lead to the
269	continuous modernization of the health care system in this state
270	and make the Florida system a nationwide leader in innovation,
271	technology, and service. At a minimum, recommendations must be
272	made for how to explore implementation of innovations, how to
273	implement new technologies and strategies, and health care
274	service delivery models. As applicable, best practices must be
275	distinguished by practice setting and with an emphasis on
276	increasing efficiency in the delivery of health care, reducing
277	strain on the health care workforce, increasing public access to
278	health care, improving patient outcomes, reducing unnecessary
279	emergency room visits, and reducing costs for patients and the
280	state without reducing the quality of patient care. Specifically
281	for information technology, best practices must also recommend
282	actions to guide the selection of technologies and innovations,
283	which may include, but need not be limited to, considerations
284	for system-to-system integration, consistent user experiences
285	for health care workers and patients, and patient education and
286	practitioner training.
287	2. A list of focus areas in which to advance the delivery
288	of health care in this state through innovative technologies,
289	workforce pathways, or service delivery models. The focus areas
290	may be broad or specific, but must, at a minimum, consider all
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291	of the following topics:
292	a. The health care workforce. This topic includes, but is
293	not limited to, all of the following:
294	(I) Approaches to cultivate interest and growth in the
295	workforce, including concepts resulting in increases in the
296	number of providers.
297	(II) Efforts to improve the use of the workforce, whether
298	through techniques, training, or devices to increase
299	effectiveness or efficiency.
300	(III) Educational pathways that connect students with
301	employers or result in attainment of cost-efficient and timely
302	degrees or credentials.
303	(IV) Use of technology to reduce the burden on the
304	workforce during decisionmaking processes such as triage, but
305	which leaves all final decisions to the health care
306	practitioner.
307	b. The provision of patient care in the most appropriate
308	setting and reduction of unnecessary emergency room visits.
309	These topics include, but are not limited to, all of the
310	following:
311	(I) Use of advanced technologies to improve patient
312	outcomes, provide patient care, or improve patient quality of
313	life.
314	(II) The use of early detection devices, including remote
315	communications devices and diagnostic tools engineered for early
316	detection and patient engagement.
317	(III) At-home patient monitoring devices and measures.
318	(IV) Advanced at-home health care.
319	(V) Advanced adaptive equipment.
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320	c. The delivery of primary care through methods, practices,
321	or procedures that increase efficiencies.
322	d. The technical aspects of the provision of health care.
323	These aspects include, but are not limited to, all of the
324	following:
325	(I) Interoperability of electronic health records systems
326	and the impact on patient care coordination and administrative
327	costs for health care systems.
328	(II) Cybersecurity and the protection of health care data
329	and systems.
330	(e) Identify and recommend any changes to Florida law or
331	changes that can be implemented without legislative action which
332	are necessary to:
333	1. Advance, transform, or innovate in the delivery and
334	strengthen the quality of health care in Florida, including
335	removal or update of any regulatory barriers or governmental
336	inefficiencies.
337	2. Implement the council's duties or recommendations.
338	(f) Recommend criteria for awarding loans as provided in
339	subsection (7) to the department and review loan applications.
340	(g) Annually submit by December 1 a report of council
341	activities and recommendations to the Governor, the President of
342	the Senate, and the Speaker of the House of Representatives. At
343	a minimum, the report must include an update on the status of
344	the delivery of health care in this state; information on
345	implementation of best practices by health care industry
346	stakeholders in this state; and highlights of exploration,
347	development, or implementation of innovative technologies,
348	workforce pathways, service delivery models, or other solutions
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349	
	by health care industry stakeholders in this state.
350	(5) AGENCY COOPERATIONAll state agencies and statutorily
351	created state entities shall assist and cooperate with the
352	council as requested.
353	(6) DEPARTMENT DUTIESThe department shall, at a minimum,
354	do all of the following to facilitate implementation of this
355	section:
356	(a) Provide reasonable and necessary support staff and
357	materials to assist the council in the performance of its
358	duties.
359	(b) Maintain on the homepage of the department a link to a
360	website dedicated to the council on which the department shall
361	post information related to the council, including the outcomes
362	of the duties of the council and annual reports as described in
363	subsection (4).
364	(c) Identify and publish on its website a list of any
365	sources of federal, state, or private funding available for
366	implementation of innovative technologies and service delivery
367	models in health care, including the details and eligibility
368	requirements for each funding opportunity. Upon request, the
369	department shall provide technical assistance to any person
370	wanting to apply for such funding. If the entity with oversight
371	of the funding opportunity provides technical assistance, the
372	department may foster working relationships that allow the
373	department to refer the person seeking funding to the
374	appropriate contact for such assistance.
375	(d) Incorporate recommendations of the council into the
376	department's duties or as part of the administration of this
377	section, or update administrative rules or procedures as
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378	appropriate based upon council recommendations.
379	(7) REVOLVING LOAN PROGRAMThe department shall administer
380	a revolving loan program for applicants seeking to implement
381	innovative solutions in this state.
382	(a) AdministrationThe council may make recommendations to
383	the department for the administration of the loans. The
384	department shall adopt rules:
385	1. Establishing an application process to submit and review
386	funding proposals for loans. Such rules must also include the
387	process for the council to review applications to ensure
388	compliance with applicable laws, including those related to
389	discrimination and conflicts of interest. If a council member
390	participated in the vote of the council recommending an award
391	for a proposal with which the council member has a conflict of
392	interest, the division may not award the loan to that entity.
393	2. Establishing eligibility criteria to be applied by the
394	council in recommending applications for the award of loans
395	which:
396	a. Incorporate the recommendations of the council. The
397	council shall recommend to the department criteria based upon
398	input received and the focus areas developed. The council may
399	recommend updated criteria as necessary, based upon the most
400	recent input, best practice recommendations, or focus areas
401	list.
402	b. Determine which proposals are likely to provide the
403	greatest return to the state if funded, taking into
404	consideration, at a minimum, the degree to which the proposal
405	would increase efficiency in the health care system in this
406	state, reduce strain on the state's health care workforce,
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407 improve patient outcomes, increase public access to health	n care
408 in this state, or provide cost savings to patients or the	state
409 without reducing the quality of patient care.	
410 3. It deems necessary to administer the program, incl	luding,
411 but not limited to, rules for application requirements, th	ne
412 ability of the applicant to properly administer funds, the	2
413 professional excellence of the applicant, the fiscal stabi	llity
414 of the applicant, the state or regional impact of the prop	oosal,
415 matching requirements for the proposal, and other requirem	nents
416 to further the purposes of the program.	
417 (b) Eligibility	
418 <u>1. The following entities may apply for a revolving l</u>	loan:
419 a. Entities licensed, registered, or certified by the	2
420 Agency for Health Care Administration as provided under s.	<u>.</u>
421 408.802, except for those specified in s. 408.802(1), (3),	(13),
422 (23), or (25).	
423 b. An education or clinical training provider in	
424 partnership with an entity under sub-subparagraph a.	
425 2.a. Council members may not receive loans under the	
426 program.	
427 b. An entity that has a conflict-of-interest relation	nship
428 with a council member as described in sub-subparagraph	
429 (3) (c) 1.b. or sub-subparagraph (3) (c) 1.c. may not receive	a loan
430 under the program unless that council member recused himse	elf or
431 herself from consideration of the entity's application.	
432 <u>3. Priority must be given to applicants located in a</u>	rural
433 or medically underserved area as designated by the departm	nent
434 which are:	
435 a. Rural hospitals as defined in s. 395.602(2).	
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436	b. Nonprofit entities that accept Medicaid patients.
437	4. The department may award a loan for up to 50 percent of
438	the total projected implementation costs, or up to 80 percent of
439	total projected implementation costs for an applicant under
440	subparagraph 3. The applicant must demonstrate the source of
441	funding it will use to cover the remainder of the total
442	projected implementation costs, which funding must be from
443	nonstate sources.
444	(c) Applications.—
445	1. The department shall set application periods to apply
446	for loans. The department may set multiple application periods
447	in a fiscal year, with up to four periods per year. The
448	department shall coordinate with the council when establishing
449	application periods to establish separate priority, in addition
450	to eligibility, within the loan applications for defined
451	categories based on the current focus area list. The department
452	shall publicize the availability of loans under the program to
453	stakeholders, education or training providers, and others.
454	2. Upon receipt of an application, the department shall
455	determine whether the application is complete and the applicant
456	has demonstrated the ability to repay the loan. Within 30 days
457	after the close of the application period, the department shall
458	forward all completed applications to the council for
459	consideration.
460	3. The council shall review applications for loans under
461	the criteria and pursuant to the processes and format adopted by
462	the department. The council shall submit to the department for
463	approval lists of applicants that it recommends for funding,
464	arranged in order of priority and as required for the
I	
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465	application period.		
466	4. A loan applicant must demonstrate plans to use the funds		
467	to implement one or more innovative technologies, workforce		
468	pathways, service delivery models, or other solutions in order		
469	to fill a demonstrated need; obtain or upgrade necessary		
470	equipment, hardware, and materials; adopt new technologies or		
471	systems; or a combination thereof which will improve the quality		
472	and delivery of health care in measurable and sustainable ways		
473	and which will lower costs and allow savings to be passed on to		
474	health care consumers.		
475	(d) Awards		
476	1. The amount of each loan must be based upon demonstrated		
477	need and availability of funds. The department may not award		
478	more than 10 percent of the total allocated funds for the fiscal		
479	year to a single loan applicant.		
480	2. The interest rate for each loan may not exceed 1		
481	percent.		
482	3. The term of each loan is up to 10 years.		
483	4. In order to equitably distribute limited state funding,		
484	applicants may apply for and be awarded only one loan per fiscal		
485	year. If a loan recipient has one or more outstanding loans at		
486	any time, the recipient may apply for funding for a new loan if		
487	the current loans are in good standing.		
488	(e) Written agreement		
489	1. Each loan recipient must enter into a written agreement		
490	with the department to receive the loan. At a minimum, the		
491	agreement with the applicant must specify all of the following:		
492	a. The total amount of the award.		
493	b. The performance conditions that must be met, based upon		
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494	the submitted proposal and the defined category or focus area,		
495	as applicable.		
496	c. The information to be reported on actual implementation		
497	costs, including the share from nonstate resources.		
498	d. The schedule for payment.		
499	e. The data and progress reporting requirements and		
500	schedule.		
501	f. Any sanctions that would apply for failure to meet		
502	performance conditions.		
503	2. The department shall develop uniform data reporting		
504	requirements for loan recipients to evaluate the performance of		
505	the implemented proposals. Such data must be shared with the		
506	council.		
507	3. If requested, the department shall provide technical		
508	assistance to loan recipients under the program.		
509	(f) Loan repaymentLoans become due and payable in		
510	accordance with the terms of the written agreement. All		
511	repayments of principal received by the department in a fiscal		
512	year shall be returned to the revolving loan fund and made		
513	available for loans to other applicants.		
514	(g) Revolving loan fundThe department shall create and		
515	maintain a separate account in the Grants and Donations Trust		
516	Fund within the department as a fund for the program. All		
517	repayments of principal must be returned to the revolving loan		
518	fund and made available as provided in this section.		
519	Notwithstanding s. 216.301, funds appropriated for the revolving		
520	loan program are not subject to reversion. The department may		
521	contract with a third-party administrator to administer the		
522	program, including loan servicing, and manage the revolving loan		
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588-01851-24 20247018 523 fund. A contract for a third-party administrator which includes 524 management of the revolving loan fund must, at a minimum, 525 require maintenance of the revolving loan fund to ensure that 526 the program may operate in a revolving manner. 527 (8) REPORTINGThe department shall publish on its website 528 information related to loan recipients, including the written			
524 management of the revolving loan fund must, at a minimum, 525 require maintenance of the revolving loan fund to ensure that 526 the program may operate in a revolving manner. 527 (8) REPORTING.—The department shall publish on its website 528 information related to loan recipients, including the written	5		
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528 information related to loan recipients, including the written			
	9		
FOO successful and former and the set of the			
529 agreements, performance conditions and their status, and the			
530 total amount of loan funds disbursed to date. The department			
531 shall update the information annually on the award date. The			
532 department shall, beginning on September 1, 2025, and annually			
533 thereafter, post on its website a report on this section for the	ne		
534 previous fiscal year which must include all of the following			
535 information:	information:		
536 (a) A summary of the adoption and implementation of			
537 recommendations of the council during the previous fiscal year	<u>.</u>		
538 (b) An evaluation of actions and related activities to mea	et		
539 the purposes set forth in this section.			
540 (c) Consolidated data based upon the uniform data reportin	ng		
541 by funding recipients and an evaluation of how the provision of	£		
542 the loans has met the purposes set forth in this section.			
543 (d) The number of applications for loans, the types of			
544 proposals received, and an analysis on the relationship between	n		
545 the proposals and the purposes of this section.			
546 (e) The amount of funds allocated and awarded for each los	an		
547 application period, as well as any funds not awarded in that	_		
548 period.			
549 (f) The amount of funds paid out during the fiscal year as	nd		
550 any funds repaid or unused.	_		
551 (g) The number of persons assisted and outcomes of any			

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2	technical assistance requested for loans and any federal, state
3	or private funding opportunities.
4	(9) EVALUATION
5	(a) Beginning October 1, 2029, and every 5 years
6	thereafter, the Office of Economic and Demographic Research
7	(EDR) shall develop and present to the Governor, the President
в	of the Senate, and the Speaker of the House of Representatives
9	comprehensive financial and economic evaluation of the
С	innovative solutions undertaken by the revolving loan program
1	administered under this section. The evaluation must include,
2	but need not be limited to, separate calculations of the state'
3	return and the economic value to residents of this state, as
4	well as the identification of any cost savings to patients or
5	the state and the impact on the state's health care workforce.
6	(b) Beginning October 1, 2030, and every 5 years
7	thereafter, the Office of Program Policy Analysis and Governmen
В	Accountability (OPPAGA) shall develop and present to the
9	Governor, the President of the Senate, and the Speaker of the
С	House of Representatives an evaluation of the administration an
1	efficiency of the revolving loan program administered under thi
2	section. The evaluation must include, but need not be limited
3	to, the degree to which the collective proposals increased
1	efficiency in the health care system in this state, improved
5	patient outcomes, increased public access to health care, and
5	achieved the cost savings identified in paragraph (a) without
7	reducing the quality of patient care.
3	(c) Both the EDR and OPPAGA shall include recommendations
9	for consideration by the Legislature. The EDR and OPPAGA must b
С	given access to all data necessary to complete the evaluation,
·	Page 20 of 22
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588-01851-24 20247018 581 including any confidential data. The offices may collaborate on 582 data collection and analysis. 583 (10) RULES.-The department shall adopt rules to implement 584 this section. 585 (11) EXPIRATION.-This section expires July 1, 2043. 586 Section 2. The Department of Health shall, and all 587 conditions are deemed met to, adopt emergency rules pursuant to 588 s. 120.54(4), Florida Statutes, for the purpose of implementing 589 s. 381.4015, Florida Statutes. Notwithstanding any other law, 590 emergency rules adopted pursuant to this section are effective 591 for 6 months after adoption and may be renewed during the 592 pendency of the procedure to adopt permanent rules addressing 593 the subject of the emergency rules. 594 Section 3. (1) For the 2023-2024 fiscal year, the sum of 595 \$250,000 in nonrecurring funds from the General Revenue Fund is 596 appropriated to the Department of Health to implement and 597 administer the Health Care Innovation Council under s. 381.4015, 598 Florida Statutes. 599 (2) For the 2024-2025 fiscal year, the recurring sum of \$1 600 million is appropriated from the General Revenue Fund to the 601 Department of Health to implement and administer the Health Care 602 Innovation Council under s. 381.4015, Florida Statutes. 603 (3) By August 1 of each year, beginning in the 2024-2025 604 fiscal year through the 2033-2034 fiscal year, the Chief 605 Financial Officer shall transfer \$75 million in nonrecurring 606 funds from the General Revenue Fund to the Grants and Donations 607 Trust Fund within the Department of Health. Each year, beginning 608 in the 2024-2025 fiscal year through the 2033-2034 fiscal year, 609 the nonrecurring sum of \$75 million is appropriated from the

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588-01851-24 20247018_ 610 Grants and Donations Trust Fund to the Department of Health for 611 the revolving loan fund created in s. 381.4015, Florida 612 Statutes. The department may use up to 3 percent of the 613 appropriated funds for administrative costs to implement the 614 revolving loan program. 615 Section 4. This act shall take effect upon becoming a law.

Page 22 of 22 CODING: Words stricken are deletions; words <u>underlined</u> are additions.

	The Florida Senate		
Jan 11, 2024 Meeting Date	APPEARANCE RECOR Deliver both copies of this form to	Bill Number or Topic	
Fiscal Policy Committee	Senate professional staff conducting the meeting	Amendment Barcode (if applicable)	
Name Benjamin Bron	ming (FL Assoc. of Commphone.		
Address 2340 Hanson Lo Street	me Email	ben @fachc.org	
Tail ahassee City	FL 3230) State Zip		
Speaking: For Agai	nst 🗌 Information OR Waive Speal	king: 🛛 In Support 🗌 Against	
PLEASE CHECK ONE OF THE FOLLOWING:			
I am appearing without compensation or sponsorship.	I am a registered lobbyist, representing:	I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:	

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

This form is part of the public record for this meeting.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES: Military and Veterans Affairs, Space, and Domestic Security, Vice Chair Appropriations Committee on Criminal and Civil Justice Banking and Insurance Commerce and Tourism Fiscal Policy Rules Transportation

JOINT COMMITTEES: Joint Select Committee on Collective Bargaining

SENATOR VICTOR M. TORRES, JR. 25th District

January 10, 2024

Travis Hutson, Chair Fiscal Policy Committee 404 S Monroe Street Tallahassee

Please accept this letter of excusal from myself for the January 11th Fiscal Policy Committee due to an illness. Please accept this letter as a formal request for excusal of this absence. Please let me know if you have any questions or need any additional information.

Respectfully Submitted,

VML

Victor M. Torres, Jr. Florida State Senator District 25

REPLY TO:

101 Church Street, Suite 305, Kissimmee, Florida 34741 (407) 846-5187 FAX: (850) 410-4817
 214 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

Senate's Website: www.flsenate.gov

CourtSmart Tag Report

Type: Room: KB 412 Case No.: -Caption: Senate Fiscal Policy Committee Judge: Started: 1/11/2024 10:02:02 AM Ends: 1/11/2024 11:26:21 AM Length: 01:24:20 10:02:02 AM Chair Hutson calls meeting to order 10:02:08 AM Roll call 10:02:12 AM A quorum is present 10:02:43 AM Pledge of Allegiance Take up Tab 3, SB 7018 Health Care Innovation by Health Policy 10:03:22 AM Sen. Harrell explains bill 10:03:40 AM 10:06:20 AM Questions? Sen. Boyd 10:07:27 AM 10:07:41 AM Sen. Harrell responds 10:09:23 AM Sen. Boyd comments Benjamin Browning, Fla. Assoc. of Community Health Centers, waives in support 10:09:32 AM 10:09:43 AM No debate Sen. Harrell to close 10:09:48 AM 10:10:02 AM Bill reported favorably 10:10:47 AM Take up Tab 2, SB 7016 Health Care by Health Policy 10:10:56 AM Sen. Burton explains bill 10:23:17 AM Chair Hutson makes comments and asks if there are questions 10:24:58 AM Sen. Jones Sen. Burton responds 10:25:08 AM 10:25:37 AM Sen. Jones 10:26:29 AM Sen. Burton responds 10:27:04 AM Sen. Jones Sen. Burton responds 10:27:30 AM 10:27:56 AM Sen. Jones Sen. Burton responds 10:28:04 AM 10:28:29 AM Sen. Jones 10:29:00 AM Sen. Burton responds 10:30:37 AM Sen. Osgood 10:30:46 AM Sen. Burton responds 10:32:24 AM Sen. Osgood 10:33:25 AM Sen. Burton responds 10:34:12 AM Sen. Berman 10:34:19 AM Sen. Burton responds 10:34:41 AM Sen Berman 10:34:53 AM Sen. Burton responds 10:35:14 AM Sen. Berman 10:35:50 AM Sen. Burton responds Sen. Berman 10:36:11 AM 10:36:39 AM Sen. Burton responds 10:37:06 AM Sen. Berman 10:37:41 AM Sen. Burton responds 10:37:53 AM Sen. Berman 10:38:11 AM Sen. Burton responds 10:38:42 AM Sen. Berman 10:39:28 AM Sen. Burton responds 10:39:45 AM Sen. Berman 10:40:08 AM Sen. Burton responds 10:40:23 AM Sen. Berman 10:40:28 AM Sen. Burton responds 10:40:54 AM Sen. Berman 10:41:04 AM Sen. Burton responds 10:41:18 AM Sen. Berman

10:41:22 AM Sen. Burton responds 10:41:44 AM Sen. Thompson 10:42:44 AM Sen. Burton responds Sen. Thompson 10:43:30 AM Sen. Burton responds 10:43:39 AM 10:43:58 AM Sen. Thompson 10:44:11 AM Sen. Burton responds 10:44:33 AM Sen. Thompson Sen. Burton responds 10:44:38 AM 10:45:01 AM Sen. Thompson 10:46:16 AM Sen. Burton responds 10:47:43 AM Chair Hutson makes comments 10:47:53 AM Amendments: 10:48:05 AM Amendment #209374 taken up 10:48:10 AM Sen. Burton explains 10:49:16 AM no questions 10:49:24 AM Joe Anne Hart, Chief Legislative Officer, Florida Dental Assoc., waives in support amendment adopted 10:49:33 AM Amendment #325568 taken up 10:49:41 AM Sen Burton explains 10:49:49 AM 10:49:58 AM Sen. Berman question 10:50:16 AM Sen Burton responds Sen. Berman comments 10:51:01 AM 10:51:21 AM Sen. Burton responds 10:51:51 AM no appearance cards 10:51:55 AM no debate 10:51:58 AM amendment adopted 10:52:04 AM Amendment #655244 taken up Sen Burton explains 10:52:09 AM 10:52:17 AM no questions no appearance cards 10:52:33 AM 10:52:35 AM no debate 10:52:37 AM amendment adopted Amendment #520732 taken up 10:52:42 AM 10:52:47 AM Sen. Burton explains 10:52:55 AM no questions Amendment to Amendment 780532 taken up 10:53:56 AM 10:54:06 AM Sen. Thompson explains 10:55:59 AM no questions 10:57:14 AM debate? 10:57:19 AM Sen. Berman 10:57:31 AM Sen. Jones 11:00:33 AM Sen. Burton Sen. Thompson to close 11:01:34 AM AA withdrawn by Sen. Thompson 11:02:48 AM 11:03:51 AM back on amendment #520732 11:04:03 AM no questions Ellyn Bogdanoff, R3 Education, speaking to give information 11:04:10 AM 11:04:54 AM Bob Harris, R3 Education and Adtalem, speaking to give information 11:06:49 AM no debate 11:06:58 AM Sen. Burton waives close 11:07:04 AM amendment adopted 11:07:09 AM Amendment #640470 taken up 11:07:12 AM Sen. Burton explains 11:07:37 AM Amendment to Amendment 871294 taken up 11:07:45 AM Sen. Burton explains amendment 11:07:55 AM no questions, no debate 11:08:04 AM AA adopted; back on amendment 11:08:17 AM no appearance cards amendment #640470 adopted 11:08:24 AM 11:08:31 AM amendment #533656 taken up 11:08:38 AM Sen. Burton explains

11:09:10 AM	Questions?
11:09:35 AM	Sen. Berman
11:09:52 AM	Sen. Burton explains
11:10:07 AM	no debate
11:10:13 AM	amendment adopted
11:10:20 AM	Amendment #263310 taken up
11:10:25 AM	Sen. Burton explains
11:10:46 AM	no questions, no debate
11:10:51 AM	amendment adopted
11:10:55 AM	Amendment #595448 taken up
11:10:59 AM	Sen. Burton explains
11:11:09 AM	no questions, no debate
11:11:13 AM	amendment adopted
11:11:20 AM	Amendment #181804 taken up
11:11:23 AM	Sen. Burton explains
11:11:49 AM	no questions, no debate
11:12:18 AM	amendment adopted
11:12:28 AM	back on bill as amended
11:12:33 AM	no questions
11:12:36 AM	Appearance cards:
11:12:53 AM	Alan Abramowitz, The Arc of Florida, speaking in support
11:14:34 AM	Tyler Sununu, Fla. Assoc. of Rehabilitation Facilities, speaking in support
11:16:16 AM	Joe Anne Hart, FL Dental Assoc., speaking in support
11:20:54 AM	Chair read those who waive into the record
11:21:33 AM	No debate
11:21:46 AM	Sen. Burton to close on bill
11:22:42 AM	Bill reported favorably
11:23:43 AM	Tab 1, SB 322 Public Records and Meetings by Sen. Burton
11:23:48 AM	Sen. Burton explains the bill
11:24:02 AM	Sen. Berman for question
11:24:12 AM	Sen. Burton responds
11:24:44 AM	no debate
11:24:49 AM	Sen. Burton waives close
11:24:58 AM	Bill reported favorably
11:25:23 AM	Sen. DiCeglie requests vote after yes on 7016
11:25:45 AM	Sen. Albritton requests vote after on 7018
11:26:02 AM	Chair notes Sen. Mayfield rules request

11:26:02 AMChair notes Sen. Mayfield rules request**11:26:08 AM**Vice Chair Stewart moves to adjourn; meeting adjourned