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

BILL: SB 7016

INTRODUCER: Health Policy Committee

SUBJECT: Health Care

DATE: January 9, 2024 REVISED: ___ ___ ___ ___

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Brown, et al.	Brown		**HP Submitted as Comm. Bill/Fav**
1.	Brown, et al.	Yeatman	FP	**Pre-meeting**

I. Summary:

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.

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

II. Present Situation:

The Health Care Workforce Shortage

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

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and the growth of the U.S. population[3] and the expanded access to health care under the federal Affordable Care Act.[4] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than

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

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas*, *available at* https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited Dec. 4, 2023).

[3] The U.S. population is expected to increase by 79 million people by 2060, and average of 1.8 million people each year between 2017 and 2060. *See* U.S. *Census Bureau, Demographic Turning Points for the U.S.; Population Projections for 2020 to 2060* (February 2020), *available at* https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited Nov. 9, 2023).

[4] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034,* (June 2021), *available at* https://www.aamc.org/media/54681/download (last visited Nov 8, 2023).

younger populations.[5] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

Health Care Shortage Designations

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

Health Care Professional Shortage Areas

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

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

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[5] The nation's 65-and-older population is projected to nearly double in size in coming decades, from 49 million in 2016 to 95 million people in 2060. *See:* U.S. Census Bureau, *U.S. and World Population Clock*, *available at* https://www.census.gov/popclock/, and U.S. Census Bureau, *U.S. Population Projected to Begin Declining in Second Half of Century* (Nov. 9, 2023), *available at* https://www.census.gov/newsroom/press-releases/2023/population-projections.html (both sites last visited Dec. 4, 2023).

[6] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, *available at* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited Nov. 30, 2023).

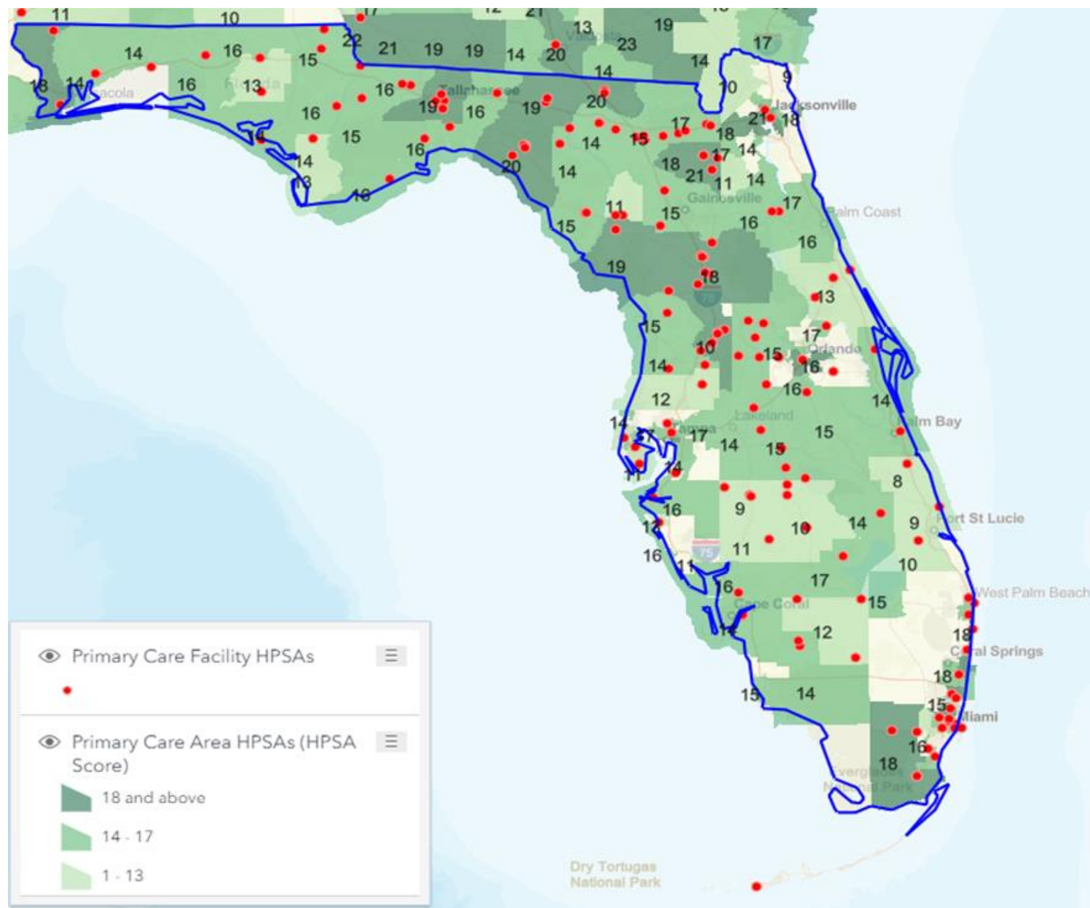
[7] *What is a Shortage Designation?*, HRSA, *available at* https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited Nov. 30, 2023).

[8] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), *available at* https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited December 4, 2023). To generate the report, select "Designated HPSA Quarterly Summary."

[9] HRSA, *Scoring Shortage Designations*, *available at* https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring, (last visited Nov. 30, 2023).

Primary Care HPSAs

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



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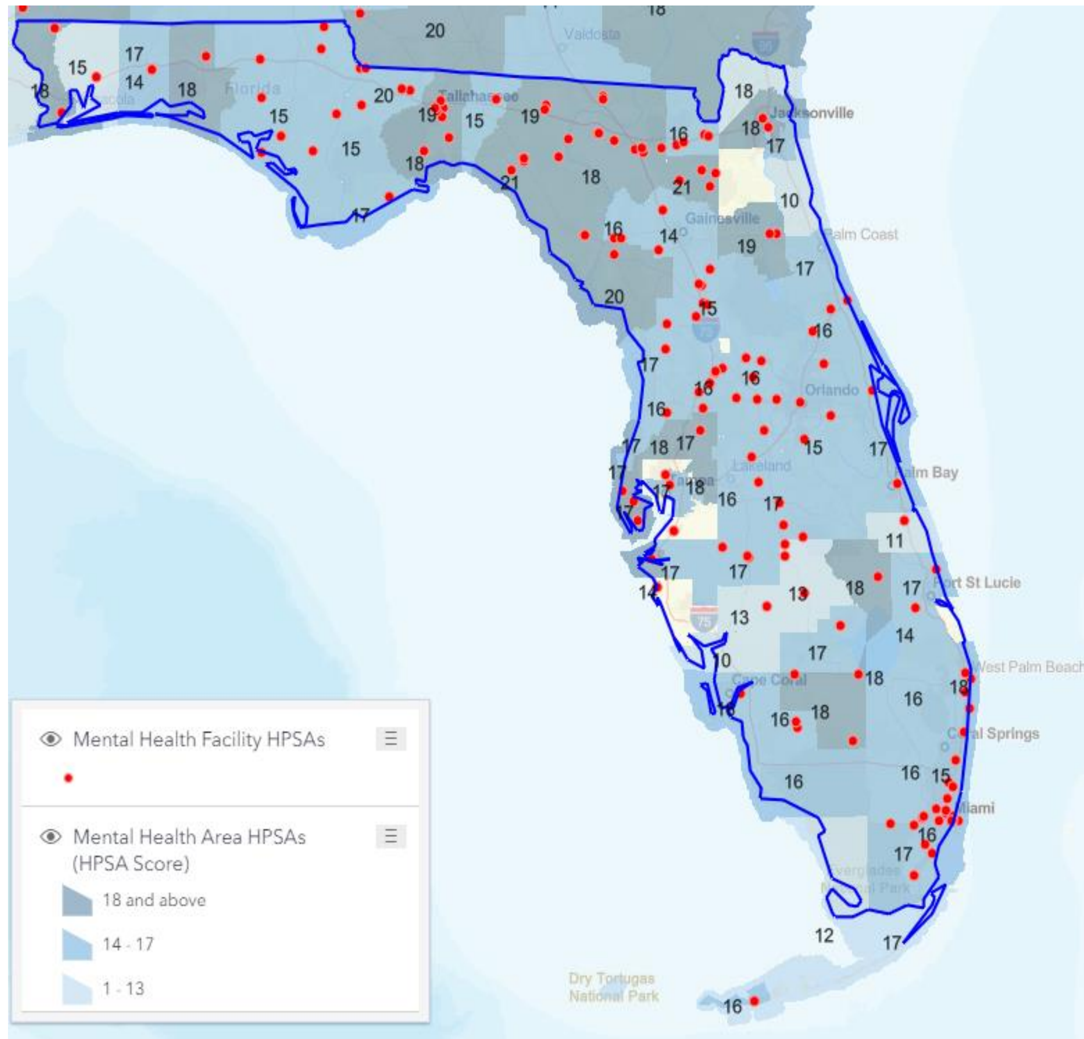
[10] The three maps were generated with HRSAs map tool, *available at* https://data.hrsa.gov/maps/map-tool/, (last visited Nov. 30, 2023).

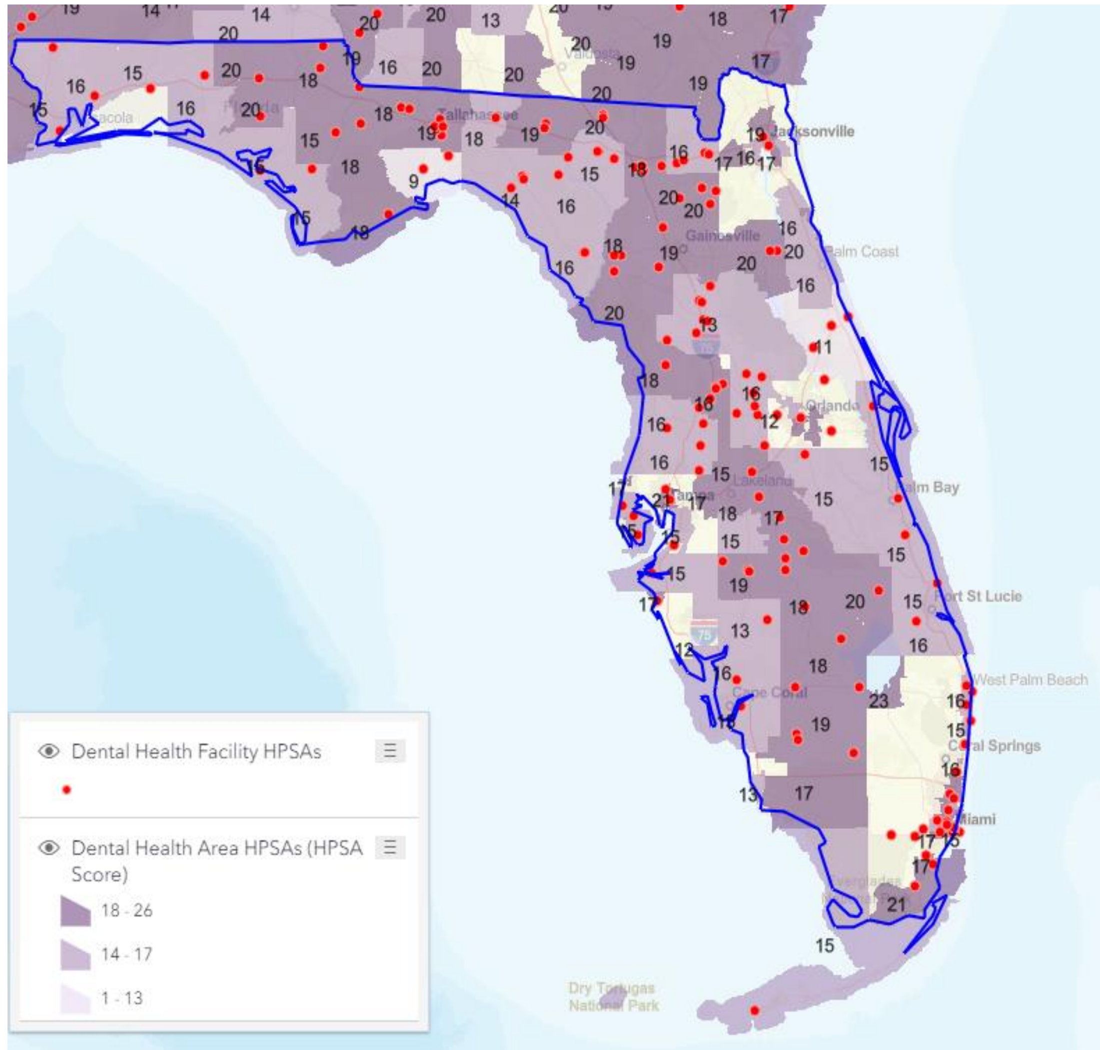
Mental Health HPSAs

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



Dental HPSAs

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

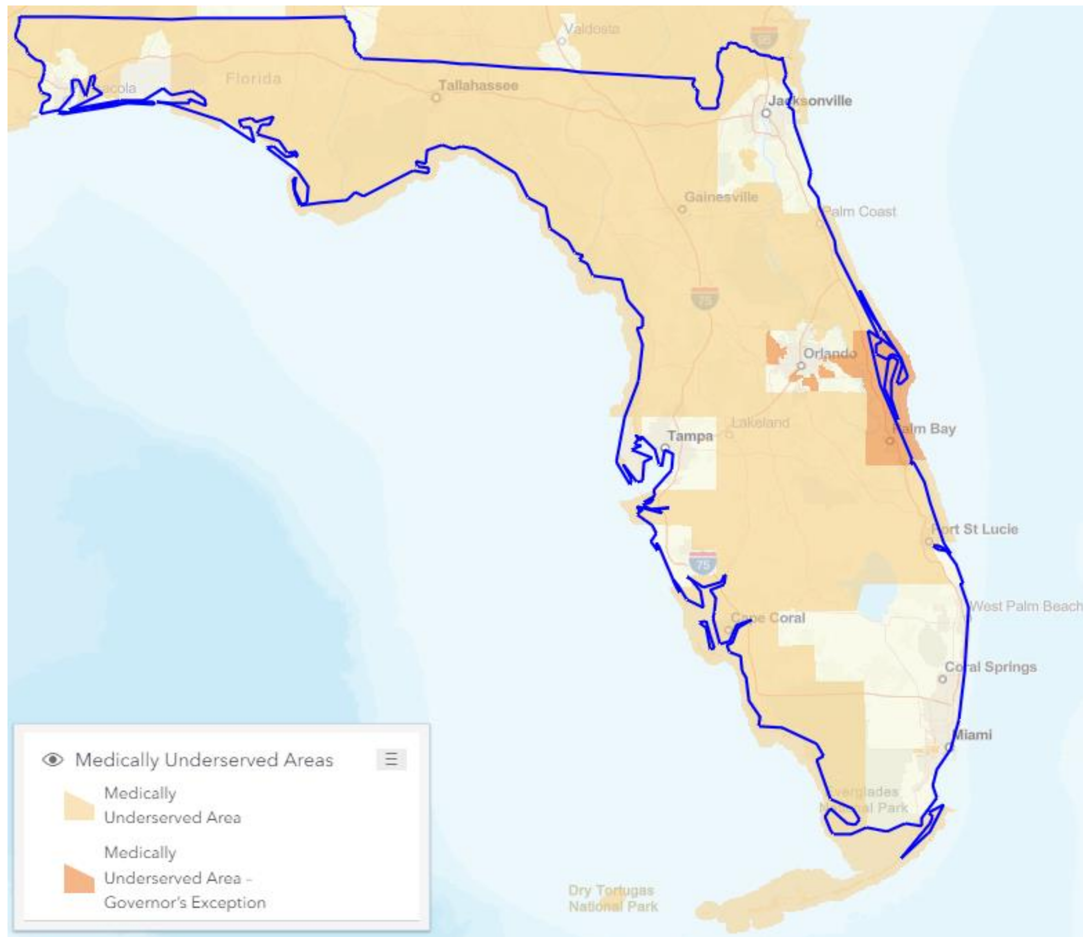


Medically Underserved Areas

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

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

Below is a map of the MUAs in Florida.



[11] National Health Service Corps, *Health Professional Shortage Areas (HPSAs) and Your Site, available at* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited Nov. 30, 2023).

The Florida Physician Workforce

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

- Of these physicians, there were 56,769 or 72 percent 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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[12] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034,* (June 2021), prepared for the AAMC by HIS, Ltd., p. viii, *available at* https://www.aamc.org/media/54681/download (last visited Nov 8, 2023). This includes both allopathic and osteopathic physicians.

[13] Department of Health, *2023 Florida Physician Workforce Annual Report*, Nov. 1, 2023, *available at* https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/physician-workforce-development-and-recruitment/2023DOHPhysicianWorkforceAnnualReport-FINAL.pdf (last visited Nov. 8, 2023).

[14] *Id.*

with projections on workforce changes out to 2035.[15] Between 2019 and 2035, the report estimates that while physician supply will increase by six percent overall and by three percent to four percent for primary care, the demand for physician services in Florida will grow by 27 percent.[16] While there is already supply and demand deficits for physician services (estimated by 2019 numbers to be at 1,977 for primary care and 1,650 for non-primary care), the significant growth in the demand for physician services that may outpace the growth in the physician workforce over the next decade is estimated to create a shortfall of 7,872 in primary care physicians by 2035 and an overall decline in the adequacy for all non-primary care specialties from 95 percent in 2019 to 77 percent in 2035.[17]

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

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

Source: IHS Markit © 2021 IHS Markit

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

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

Florida Center for Nursing

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

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

The Florida Nursing Workforce

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

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

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

[19] Florida Center for Nursing, *The State of the Nursing Workforce in Florida, 2023*, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., *available at* https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1957&PortalId=0&TabId=151 (last visited Nov. 16, 2023).
[20] *Id.*

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

There were 45,181 APRNs licensed 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 program[25] offers student loan reimbursement to various health care practitioners to offset their educational expenses in order to entice them to practice in underserved locations where there are shortages of such practitioners. The Department of Health (DOH) is authorized to reimburse as follows:

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

[21] The Department of Economic Opportunity, Bureau of Workforce Statistics and Economic Research, 2020- 2028 Employment Projections, updated Feb. 9, 2021, *2020 - 2028 College Projections Report, available at* https://lmsresources.labormarketinfo.com/college_projections/index.html (last visited Nov. 16, 2023).
[22] Florida Center for Nursing, *The State of the Nursing Workforce in Florida, 2023*, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., *available at* https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1957&PortalId=0&TabId=151 (last visited Nov. 16, 2023).
[23] Florida Commerce, Bureau of Workforce Statistics and Economic Research, *Occupational Data Search, 29-2061 Licensed Practical or Vocational Nurses*, *available at* https://floridajobs.org/economic-data/employment-projections/occupational-data-search (last visited Nov. 16, 2023).
[24] Florida Center for Nursing, *Florida Autonomous Practice 2020-2021*, *available at* https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1975&PortalId=0&TabId=151 (last visited Nov. 16, 2023).
[25] Section 1009.65, F.S., titles the program the "Medical Education Reimbursement and Loan Repayment Program" however, the DOH and other stake holders refer to the program as the FRAME program. To reduce confusion, this analysis will refer to the program as the FRAME program.
[26] Primary care specialties are defined as obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties which may be identified by the DOH.

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

In order to qualify for reimbursement, a listed health care practitioner, other than an autonomous APRN, must:
- Be a U.S. citizen;
- Possess a clear active Florida health care professional license;
- Provide in-person services to persons in an underserved location[27] in Florida;
- Not have received an award from any other State of Florida-funded student loan repayment program since July 1 of the previous year; and
- Have a qualified loan.[28]

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

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

DSLR Program

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

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

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

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

[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.

Health Care Screening Statutes

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

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

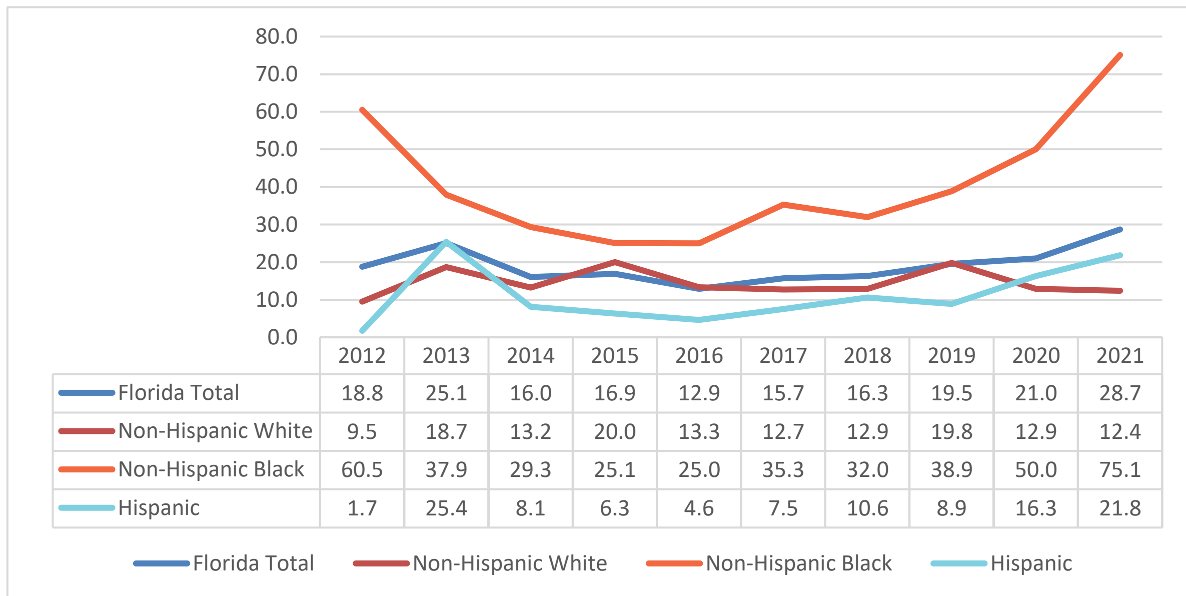
381.93	Breast and Cervical Cancer	“Mary Brogan Breast and Cervical Cancer Early Detection Program.” The Department of Health, using available federal funds and state funds appropriated for that purpose, is authorized to establish the Mary Brogan Breast and Cervical Cancer Screening and Early Detection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

381.985	Lead Poisoning	Lead poisoning screenings for children at risk for exposure to lead.	DOH
383.011, 383.14-383.147	Newborn Screenings	Various required test for newborns and infants.	DOH
385.103	Cancer, diabetes, heart disease, stroke, hypertension, renal disease, and chronic obstructive lung disease.	Chronic Disease Intervention Programs The department shall assist the county health departments in developing and operating community intervention programs throughout the state. At a minimum, the community intervention programs shall address one to three of the following chronic diseases: cancer, diabetes, heart disease, stroke, hypertension, renal disease, and chronic obstructive lung disease. Uses community funding, gifts, 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:



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

[33] U.S. Dep't of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health*, (Dec. 2020), *available at* https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (last visited Dec. 5, 2023).
[34] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021,* (March 2023), *available at* https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf (last visited Dec. 5, 2023).
[35] *Id.*
[36] *Id.*
[37] United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic*, (Oct. 2022), *available at* https://www.gao.gov/assets/gao-23-105871.pdf (last visited Dec. 5, 2023).
[38] Presentation by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), *available at* https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited Dec. 5, 2023).

Severe Maternal Morbidity

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

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

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

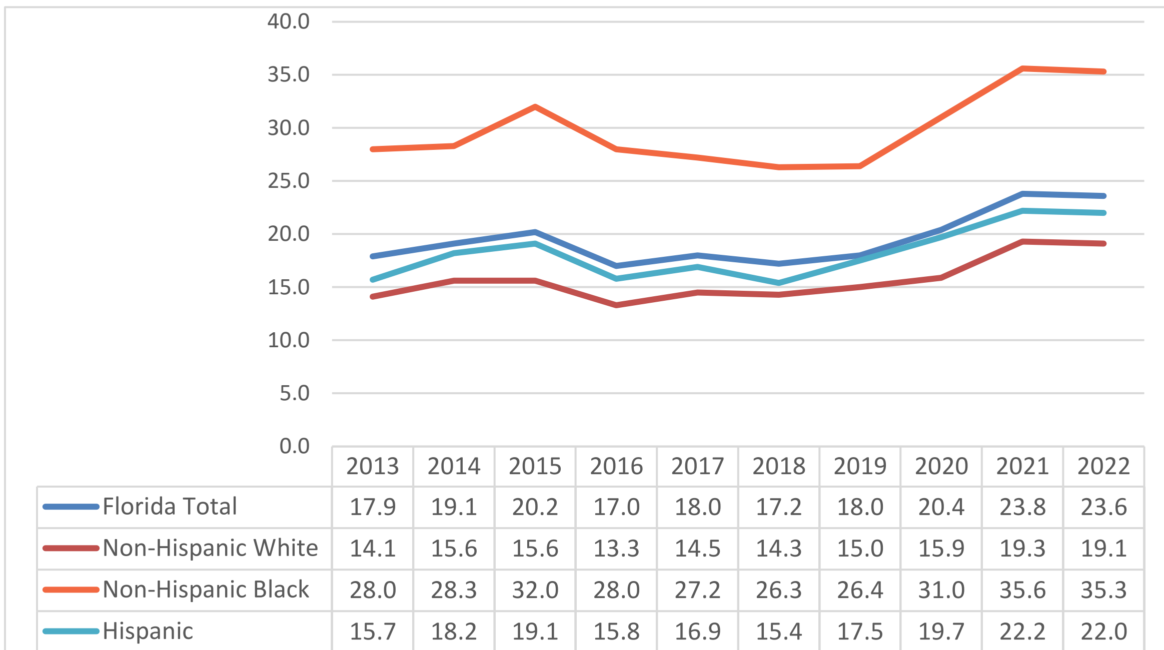
[39] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), *available at* https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited Dec. 5, 2023).

[40] *Id.,* and CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), *available at* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited Dec. 5, 2023).

[41] CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), *available at* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited Dec. 5, 2023).

[42] Florida Perinatal Quality Collaborative, *Opportunities for Florida Hospital Participation*, (Aug. 23, 2022), *available at* https://health.usf.edu/-/media/Files/Public-Health/Chiles-Center/FPQC/FPQC-Informational-Webinar-FINAL-23-AUG-22.ashx?la=en&hash=93B16B88819045E16DA5C84EEE3A6C416B3E457A (last visited Dec. 5, 2023).

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



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

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

Telehealth

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

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

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[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 Dec. 5, 2023).

[44] *Id.*

[45] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), *available at* https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited Dec. 5, 2023).

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

[47] *Id.*

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

The Telehealth Minority Maternity Care Pilot Program

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

The DOH received funding in the 2023-2024 FY[50] to expand the pilot program to an additional 18 counties.[51] The additional counties are Brevard, Broward, Collier, Escambia, Hillsborough, Lake, Lee, Leon, Manatee, Marion, Miami-Dade, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, and Volusia.

The pilot programs use telehealth to coordinate with prenatal home visiting programs to provide the following services and education to eligible pregnant women[52] up to the last day of their postpartum period:

- Referrals to Healthy Start's[53] coordinated intake and referral program to offer families prenatal home visiting services;
- Services and education addressing social determinants of health;[54]
- Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in prenatal and postpartum periods;
- For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers; and
- Medical devices for prenatal women to conduct key components of maternal wellness checks.[55]

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[48] Section 456.47, F.S.
[49] Chapter 2021-238, Laws of Florida, codified at s. 381.2163, F.S.
[50] Chapter 2023-239, Laws of Florida, line item 435.
[51] Florida Department of Health, Office of Minority Health, *Request for Applications: Programs to Reduce Severe Maternal Morbidity through Telehealth (SMMT) in Florida, RFA #22-002*, (April 19, 2023), *available at* https://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/RFA22-002.pdf#Open%20in%20new%20window (last visited Dec. 5, 2023).
[52] An "eligible pregnant woman" is a pregnant woman who is receiving, or is eligible to receive, maternal or infant services from the DOH under ch. 381, F.S. or ch. 383, F.S.
[53] Healthy Start is a free home visiting program that provides education and care coordination to pregnant women and families of children under the age of three. The goal of the program is to lower risks factors associated with preterm birth, low birth weight, infant mortality, and poor development outcomes. *See* DOH, *Healthy Start*, *available at* https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html (last visited Dec. 5, 2023).
[54] Social determinants of health refer to the conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. They are grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environments, and social and community context. *See* U.S. Dep't of Health and Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health*, *available at* https://health.gov/healthypeople/priority-areas/social-determinants-health (last visited Dec. 5, 2023).
[55] Section 383.2163(3), F.S.

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

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

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

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

Birth Centers

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

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

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

[56] Section 383.2163(4), F.S.
[57] Email correspondence 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 staff[67] member for every two clients in labor;
- Have a clinical staff member or qualified personnel[68] available on site during the entire time a client is in the birth center;
- Ensure that services during labor and delivery are provided by a physician, certified nurse midwife, or licensed midwife, assisted by at least one other staff member, under protocols developed by clinical staff;
- Ensure that all qualified personnel and clinical staff are trained in infant and adult resuscitation;
- Have qualified personnel or clinical staff who are able to perform neonatal resuscitation present during each birth;
- Maintain complete and accurate medical records;
- Evaluate the quality of care by reviewing clinical records;
- Review admissions with respect to eligibility, course of pregnancy and outcome, evaluation of services, condition of mother and newborn on discharge, or transfer to other providers; and
- Surveil infection risk and infection cases and promote preventive and corrective programs designed to minimize hazards.

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[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.
[66] Fla. Admin. Code R. 59A-11.005(3).
[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]

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

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

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

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

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

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

The AHCA may impose an administrative fine not to exceed $500 per violation per day for the violation of any provision of the Birth Center Licensure Act, part II of chapter 408, or applicable rules.[88] The AHCA may also impose an immediate moratorium on elective admissions to any birth center when it determines that any condition in the facility presents a threat to the public health or safety.[89]

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[79] Section 383.308(2)(a), F.S.
[80] Section 383.316, F.S.
[81] *Id.*
[82] 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* https://medlineplus.gov/ency/article/003402.htm (last visited on Dec. 8, 2023).
[84] Section 383.315(1), F.S.
[85] Section 383.302(4), F.S.
[86] Section 383.315(2), F.S.
[87] Section 383.3105, F.S.
[88] Section 383.33, F.S.
[89] *Id.*

The Florida Mental Health Act

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

Involuntary Examination

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

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[94]
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[95] or
- A physician, clinical psychologist,[96] psychiatric nurse,[97] an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the practitioner's observations supporting such conclusion.[98]

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

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

receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment or transportation to the appropriate service provider.[99]

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

Involuntary Placement

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

Voluntary Admissions

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

Psychologists

The practice of psychology is the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral

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

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

The Board of Psychology within the DOH oversees the licensure and regulation of psychologists in this state.[107] To be licensed as a psychologist in this state, an individual must:
- Hold a doctoral degree from a program accredited by the American Psychological Association;[108]
- Have at least two years or 4,000 hours of supervised experience in the field of psychology;
- Pass the Examination for Professional Practice in Psychology; and
- Pass an examination on Florida laws and rules.[109]

An applicant may also apply for licensure by endorsement. The applicant must:
- Be a diplomate in good standing with the American Board of Professional Psychology and pass an examination on Florida laws and rules; or
- Hold a doctoral degree in psychology and have at least 10 years' experience as a licensed psychologist in any U.S. jurisdiction within the preceding 25 years.[110]

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

Psychiatric Nurses

Psychiatric nurses are licensed as advanced practice registered nurses pursuant s. 464.012, F.S. The Board of Nursing within the DOH oversees the licensure and regulation of advanced practice registered nurses in this state. To be licensed as an advanced practice registered nurse in this state, an individual must:
- Hold a current license to practice professional nursing in this state;
- Be certified by the appropriate specialty board; and
- Hold a master's degree in a clinical nursing specialty area with preparation in specialized practitioner skills.[112]

For psychiatric nurses, the applicant must hold one of the following certifications recognized by the Board of Nursing:
- Psychiatric Mental Health Nurse Practitioner Certification;
- Family Psychiatric and Mental Health Nurse Practitioner;

[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.

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

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

Mental Health Services in Florida

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

Managing Entities

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

Mobile Response Teams (MRTs)

MRTs are behavioral health crisis response mechanisms that can be beneficial to individuals, their family, and any involved first responder when an individual is experiencing a behavioral health crisis. MRTs provide on-demand, community-based crisis intervention services 24 hours a day, seven days per week, in any setting in which a behavioral health crisis is occurring.[118] An MRT is most commonly a team of crisis-intervention trained professionals and paraprofessionals that use face-to-face professional and peer intervention, deployed in real time to the location of the person in crisis in order to achieve the best outcomes necessary for that individual, ensuring timely access to assessment, evaluation, support, and other services.[119]

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

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

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

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

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

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

Offshore Usage of Clinical Training Opportunities

One problem facing Florida medical schools seeking to increase their student body is a lack of availability of clinical training opportunities. According to a new AAMC (Association of American Medical Colleges) report, 84 percent of medical school deans were concerned about

[120] Chapter 1996-169, Laws of Florida.
[121] Section 394.457, F.S.
[122] Chapter 2020-39, Laws of Florida, codified as section 394.495, F.S.
[123] Fla. Admin. Code R. 65E-5.400(6).
[124] Department of Children and Families, *Specialty Treatment Team Maps, Mobile Response Teams*, *available at* https://www.myflfamilies.com/specialty-treatment-team-maps, (last visited Nov. 28, 2023).
[125] Department of Children and Families, *Triennial Plan for the Delivery of Mental Health and Substance Abuse Services: State Fiscal Years 2023-2024 and 2025-2026, pg. 6, available at* https://www.google.com/url?client=internal-element-cse&cx=b5f7422ffe5734ed7&q=https://www.myflfamilies.com/sites/default/files/2023-06/Substance%2520Abuse%2520%2526%2520Mental%2520Health%2520Services%2520Triennial%2520State%2520and%2520Regional%2520Master%2520Plan%2520%25202023-2025.pdf (last visited Nov. 28, 2023).
[126] *Id*.

the number of clinical training sites for medical school students even before the COVID-19 pandemic.

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

Florida's Health Information Exchange Program

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

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

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

- 95 percent of Licensed Acute Care Hospitals
- 225 Skilled Nursing Facilities
- 64 Urgent Care Centers
- 22 Hospice Providers
- Five Crisis Stabilization Units
- Statewide Emergency Medical Services Treat-and-Release Providers
- All 67 County Health Departments.[129]

Hospitals that receive Low Income Pool funding are required to participate in the FHIE's Encounter Notification Service, and Medicaid Managed Care Plans also participate as part of

[127] *So Many Medical Students, so Few Clerkship Sites*, AAMCNEWS, Sep. 10, 2020, *available at* https://www.aamc.org/news/so-many-medical-students-so-few-clerkship-sites#:~:text=According%20to%20a%20new%20AAMC,sites%20even%20before%20the%20pandemic., (last visited Dec. 4, 2023).
[128] AHCA analysis document, on file with Senate Health Policy Committee staff.
[129] *Id.*

their contractual agreements. To participate as subscribers of the ENS service, the AHCA has a standard rate per organization type. The lowest fees are $500 per year for less than 5,000 subscribed patients. Other payment structures vary with the highest minimum annual fee not exceeding $7,500.

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

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

Emergency Department (ED) Diversion

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

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

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

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

[130] *Id.*
[131] Section 395.002(9), F.S.
[132] The Journal of Urgent Care Medicine, *Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program, available at* https://www.jucm.com/reducing-low-acuity-preventable-emergency-room-visits-by-utilizing-urgent-care-center-services-via-mobile-health-unit-diversion-program/ (last visited Dec. 5, 2023).
[133] Section 641.31097(1), F.S.

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

The Florida Medicaid Program

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

Medicaid Provider Enrollment

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

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

Statewide Medicaid Managed Care

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each services provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. In Florida, the majority of Medicaid enrollees receive their services through a managed care plan contracted with the AHCA under SMMC.[139]

[134] Section 409.9121, F.S.
[135] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Dec. 4, 2023).
[136] Section 20.42, F.S.
[137] Florida Agency for Health Care Administration & Gainwell Technologies, *Florida Medicaid Provider Enrollment Application Guide, available at* https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Public%20Misc%20Files/Florida%20Medicaid%20Provider%20Enrollment%20App%20Guide.pdf (last visited Dec. 6, 2023).
[138] *Id*.
[139] Section 20.42, F.S.

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

Qualifying Community-Based Mobile Crisis Intervention Services

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

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

Primary Care Initiative Program

At present, plans operating in the MMA component of SMMC must establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan is required to:[144]

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

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[140] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited Dec. 5, 2023).
[141] Florida Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program, available at* https://ahca.myflorida.com/content/download/9126/file/SMMC_Snapshot.pdf (last visited Dec. 5, 2023).
[142] *Centers for Medicare & Medicaid Services, SHO # 21-008: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, available at* https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf (last visited Dec. 6, 2023).
[143] *Id*.
[144] Section 409.973(4), F.S.

- Report to the AHCA the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Medicaid Encounter Data System

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

The AHCA is responsible for validating the data submitted by the plans and has developed methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of SMMC enrollees to allow comparison of service utilization among plans and against expected levels of use. Presently, the analysis is used to identify possible cases of inappropriate service utilization, such as higher-than-expected emergency department encounters[146] or PPEs, to improve access to quality health care services while also reducing expenditures.[147]

Graduate Medical Education

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.[148] Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.[149]

Every U.S. state requires at least one year of residency training to receive an unrestricted license to practice medicine, and some require two or three years. However, most physicians train

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[145] Section 409.967(2)(e), F.S.
[146] *Id*.
[147] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).
[148] *Graduate Medical Education That Meets the Nation's Health Needs*, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited Nov. 30, 2023).
[149] *Id.*

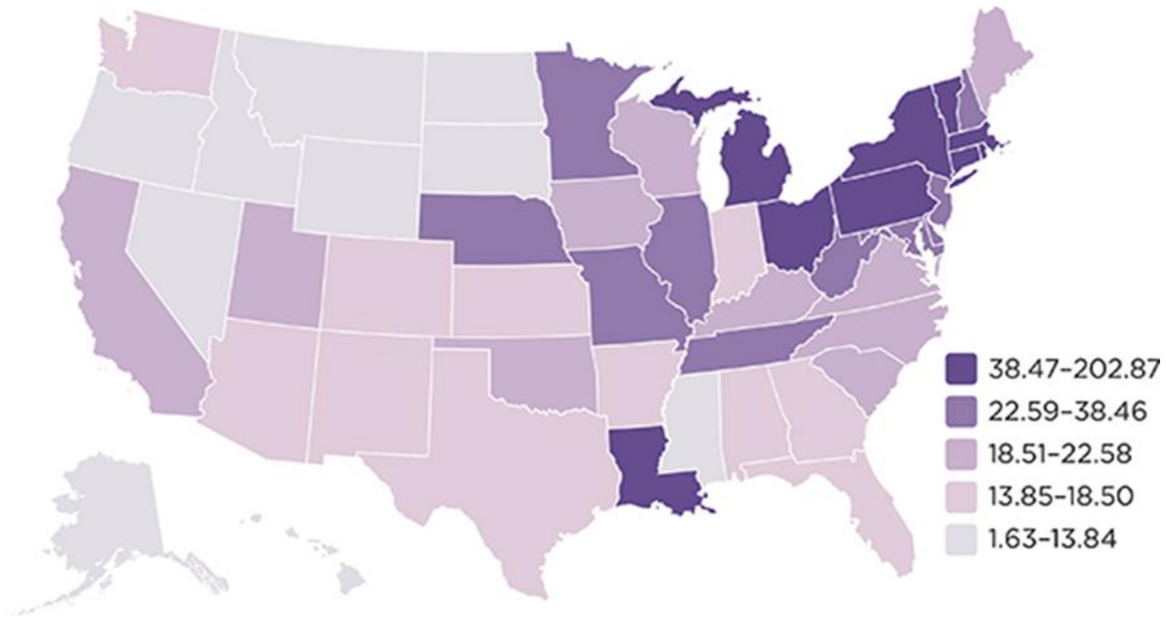
beyond the minimum licensure requirement in order to become board certified in a "pipeline" specialty (i.e., those that lead to initial board certification). The number of pipeline training positions determines the total number of physicians that the entire continuum can produce. For many years, the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

Medicare Funding of GME

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

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

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



Medicaid Funding of GME

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

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

Startup Bonus Program (SBP)[157]

The SBP was established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit. The program allocates a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty in statewide supply-and-demand deficit. For the purposes of the program, physician specialties in statewide supply-and-demand deficit are identified in the General Appropriations Act (GAA).[158]

[153] *Id.*
[154] *Id.*
[155] Section 409.909, F.S.
[156] SFY 2023-24 Statewide Medicaid Residency Program Distribution, AHCA, *available at* https://ahca.myflorida.com/content/download/23217/file/SFY%2023-24%20GME%20SMRP%20Calculation%20Clean.pdf, (last visited Nov. 30, 2023).
[157] Section 409.909(5), F.S.
[158] Chapter 2023-239, Laws of Florida

The Slots for Doctors Program (SDP)

The SDP requires the AHCA to annually allocate $100,000 to hospitals and qualifying institutions for each newly created slot that is first filled on or after June 1, 2023, and remains filled thereafter.[159] The new slot must be accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit. The sections specifies that the program is designed to generate matching funds under the Medicaid program and distribute those funds to participating hospitals and qualifying institutions and that specialties and sub-specialties are those that are identified in the GAA.

Specialties and Sub-Specialties in Supply and Demand Deficit

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

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

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

- Vascular surgery.

Ohio's Primary Care Workforce Initiatives (OPCWI)

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

Health centers may host students in the following disciplines: medicine, dentistry, advanced practice nursing, physician assisting, and behavioral health. These structured clinical experiences are designed to increase primary care capacity in some of the most underserved neighborhoods in Ohio. Located throughout the state, Ohio's FQHCs serve over 850,000 Ohioans each year. Participating health centers have, or commit to obtaining, national recognition as PCMHs so that students can experience an advanced primary care practice model.[160]

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

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

Potentially Preventable Health Care Events (PPEs)

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

Potentially Preventable Hospital Emergency Department Visits

Potentially preventable hospital emergency department visits happen when a patient seeks services at an emergency department for a health condition that could have been prevented or treated in a non-emergency setting.[163] The AHCA has identified a variety of causes that may result in these visits, e.g., failure to access primary care, lack of ambulatory care coordination,

[160] Y8 Ohio Primary Care Workforce Initiative (OPCWI) User Manual, Ohio Association of Community Health Centers, *available at* Y8_OPCWI_User_Manual.pdf (ymaws.com), (last visited Dec. 4, 2023).
[161] *Id.* at p. 6.
[162] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).
[163] *Id*.

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

Throughout federal fiscal year (FFY) 2019-2020, 294,220 potentially preventable emergency department visits were identified, compared to 388,257 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[165]

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

Potentially Preventable Hospital Admissions

Potentially preventable hospital admissions are when a patient is admitted for necessary treatment to an acute care hospital[166], but the admission could have been avoided, or when a patient is admitted and could have been treated outside of an inpatient hospital setting.[167]

Throughout federal fiscal year (FFY) 2019-2020, 71,541 potentially preventable hospital admissions were identified, compared to 67,048 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[168]

- Septicemia;
- Heart failure;
- Pneumonia diagnoses;

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[164] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

[165] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Emergency Room Visits (PPVs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPVsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

[166] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

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

[168] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Hospital Admissions (PPAs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPAsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

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

Potentially Preventable Hospital Readmissions

Potentially preventable hospital readmissions are when a patient is readmitted to an acute care hospital for a reason that is clinically related to the initial hospitalization or from deficiencies in a post-hospital discharge follow-up after a prior acute care admission[169] within thirty days of a hospital discharge.[170]

Throughout FFY 2019-2020, 30,593 PPEs were identified with at least one potentially preventable hospital readmission, compared to 31,689 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[171]

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

Acute Hospital Care at Home (AHCAH) Initiative

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

[169] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).
[170] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).
[171] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Readmissions (PPRs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPRsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited Dec. 4, 2023).

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

Specifically, CMS issued AHCAH flexibilities under the "Hospital Without Walls" initiative on November 25, 2020, which waived s. 482.23(b) and (b)(1) of the Medicare Hospital Conditions of Participation (CoPs), thereby suspending the requirement for nursing services to be provided on premises 24 hours a day, seven days a week, and for the immediate availability of a registered nurse (RN) for care of any hospital patient. Medicare inpatient payments did not change as a result of this waiver; payments to a hospital providing AHCAH services remained the same as if the care was provided in a traditional inpatient setting. This represented the first example of payment for this level of care at home for Medicare beneficiaries.[173]

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

Waiver requests for AHCAH are divided into two categories:[175]
- Tier 1: Expedited Waivers for experienced programs that have treated at least 25 patients meeting inpatient admission criteria; and
- Tier 2: Detailed Waivers for all other submitters.

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

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

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

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

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

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

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

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

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

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

Licensure of Health Care Practitioners

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

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

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

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

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

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

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

Board of Medicine

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

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

[185] Section 456.072(2), F.S.

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

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

Board of Osteopathic Medicine

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

Financial Responsibility

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

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

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

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

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

- Be at least 21 years of age;
- Be of good moral character;
- Not have committed an act or offense that would constitute the basis for disciplining a physician under s. 458.331, F.S.;
- Have completed two years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry;
- Have graduated from an allopathic medical school approved by an accrediting agency recognized by the U.S. Office of Education or recognized by a governmental body of a U.S. territorial jurisdiction;
- Have completed at least one year of approved residency training; and
- Have obtained a passing score on:
    - The USMLE;[196]
    - A combination of the USMLE, the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX),[197] or the examination of the National Board of Medical Examiners (NBME) up to the year 2000; or
    - The SPEX exam,[198] if the applicant was licensed on the basis of a state board examination, is currently licensed in at least one other jurisdiction of the U.S. or Canada, and has practiced at least 10 years.

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

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

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

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

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

Allopathic Licensure by Examination: Foreign-Trained Applicants

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

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

Foreign-Trained Medical Students and Medical Graduates Practicing in Florida

Certification and Residency Programs

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

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

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

[200] *Id.*

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

[202] Section 458.311, F.S.

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

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

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

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

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

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

Allopathic Restricted Licenses

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

In 1986 the Legislature created requirements for Cuban-licensed medical doctors which authorized the BOM to issue a one-year restricted license to any Cuban- licensed medical physician who passed the Florida BOM examination and met certain criteria. It also provided that the Florida BOM examination could be translated into a foreign language at the request of at 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.[209] This pathway for Cuban

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

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

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

Current law authorizes the BOM to issue restricted licenses to applicants to practice medicine in Florida, for allopathic physicians under three specific circumstances:
- Certain foreign-licensed physicians;[212]
- BOM designated areas of critical need;[213] and
- Certain experienced foreign trained physicians.[214]

Restricted Licenses for Certain Foreign Licensed Physicians

A restricted licensee under s. 458.3115, F.S., permits a foreign licensed physician to practice under the direct supervision of a BOM approved full licensee and the second year being under indirect supervision. A restricted license under s. 458.3115, F.S., is valid for two years. Upon expiration a restricted licensee will become a full licensee if the restricted licensee:
- Is not under discipline, investigation, or prosecution; and
- Pays all renewal fees required of a full licensee.

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

Restricted Licenses For Certain Experienced Foreign-Trained Physicians

Section 458.3124, F.S., was created in 1997 as 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.

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

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

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

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

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

Temporary Certificates for Practice in Areas of Critical Need

Current law does not authorize the BOOM to issue restricted licenses, but both the BOM and the BOOM may issue a temporary 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:[220]

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

The BOM and the BOOM are authorized to administer an abbreviated oral examination to determine a physician's competency. A written examination is not required.[221] The boards may deny the application, issue the temporary certificate with reasonable restrictions, or require the applicant to meet any reasonable conditions of the BOM or BOOM prior to issuing the temporary certificate if it has been more than three years since the applicant has actively practiced and the respective board determines the applicant lacks clinical competency, adequate skills, necessary medical knowledge, or sufficient clinical decision-making.[222]

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

Fees for the temporary certificate for practice in areas of critical need include a $300 application fee and $429 initial licensure fee; however, these fees may be waived if the individual is not compensated for his or her practice.[223] The temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.[224] However, the boards must review the temporary certificate holder at least annually to ensure that he or she is in compliance with the practice act and rules adopted thereunder.[225] A board may revoke or restrict the temporary certificate for practice in areas of critical need if noncompliance is found.[226]

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

Temporary Certificates to Practice in Areas

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

Limited Licenses

Both the BOM and the BOOM are authorized to issue limited licenses. Licensed allopathic physicians are issued limited licenses to practice in areas of critical need, and licensed osteopathic physicians are issued limited licenses to practice in areas of critical need or medically underserved areas, though the process and authorizations for each are slightly different.[228]

An allopathic physician wishing to obtain a limited license to practice in the employ of a public or private 501(c)(3) non-profit[229] agency or institution located in a BOM determined area of critical medical need, must submit an application and fee, unless the applicant includes an employer's statement that the position is uncompensated, in which case all fees are waives, and demonstrates:

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

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

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

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

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

The BOOM is also 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:[230]

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

If it has been more than three years since the osteopathic limited license applicant has actively practiced medicine, the full-time director of the local county health department must supervise the applicant for at least six months after the issuance of the limited license unless the BOOM determines a shorter period will be sufficient.[231]

The BOOM must review the practice of each osteopathic physician who holds a limited license at least biennially to ensure that he or she is in compliance with the practice act and rules adopted thereunder.[232]

Board of Nursing

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

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

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

Advanced Practice Registered Nurses

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

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

Section 464.003(2), F.S., defines the term "advanced or specialized nursing practice" to include, in addition to practices of professional nursing that registered nurses (RNs) are authorized to perform, advanced-level nursing acts approved by the BON as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[237] In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain *medical acts*, as opposed to *nursing* acts, as trained and authorized within the framework of an established protocol with a supervisory physician.[238]

To be eligible to be licensed as an APRN, an applicant must be licensed as a RN, have a master's degree or higher in a clinical nursing specialty with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a BON-approved nursing specialty board.[239] A nursing specialty board must:[240]
- Attest to the competency of nurses in a clinical specialty area;
- Require a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.

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

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

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

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

Autonomous APRN Practice

Current law authorizes an APRN who meets certain eligibility criteria to engage in autonomous practice only in primary care, which includes family practices, general pediatrics and general internal medicine, as defined by BON rule, without a supervising physician or written protocol with a physician.[249] The BON has defined primary care by rule to include the "physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance,

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

[242] Sections 458.348, and 459.025, F.S.

[243] *Id*.

[244] Chapter 2016-224, Laws of Florida.

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

[246] Controlled substances may only be prescribed or dispensed if the APRN has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.

[247] Section 310.081, F.S.

[248] Sections 464.012(3)-(4), and 464.003, F.S.

[249] Section 464.0123(3)(a)1., F.S.

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

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

- Completed at least 3,000 clinical practice hours or clinical instructional hours[251] supervised by a physician with an active license within the five year period immediately preceding the registration request;
- Not have been subject to any disciplinary action during the five years immediately preceding the application;
- Completed three graduate-level semester hours, *or the equivalent*, in pharmacology and three graduate-level semester hours, *or the equivalent,* in differential diagnosis within the five year period preceding the registration request;[252] and
- Any other registration requirements provided by BON rule.

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

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

An autonomous APRN registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN and RN. To maintain autonomous APRN registration, an autonomous APRN must complete at least 10 hours of BON approved CE for each biennial renewal in addition to the 30 hours of CE required for renewal of the APRN license.[253]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regulation of Audiology and Speech-Language Pathology

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

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

An audiologist or speech-language pathologist who holds a valid license in another U.S. state or jurisdiction may apply for licensure by endorsement if the criteria for issuance of such license were substantially equivalent or more stringent than Florida's requirements.[261] Additionally, an individual who holds a valid certificate of clinical competence of the American Speech-Language and Hearing Association or board certification in audiology from the American Board of Audiology qualifies for licensure.[262]

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

Regulation of Physical Therapy

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

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

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[260] Florida Department of Health, Board of Speech-Language Pathology and Audiology, *available at* https://floridasspeechaudiology.gov/licensing/ (last visited Dec. 7, 2023). The necessary semester hours needed for an academic degree vary depending on when the degree was earned.
[261] Section 468.1185(3)(a), F.S.
[262] Section 468.1185(3)(b), F.S.
[263] Florida Department of Health, Board of Speech-Language Pathology and Audiology, *available at* https://floridasspeechaudiology.gov/licensing/ (last visited 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;[264] and
- Pass an examination on Florida laws and rules.[265]

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

Licensure Discipline

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

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

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

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[264] If an applicant fails the licensure examination five times, he or she is precluded from licensure, regardless of the jurisdiction through which the examination is taken.
[265] Sections 486.031 and 486.102, F.S., and Fla. Admin. Code R. 64B17-3.002.
[266] Section 486.081, F.S., and Fla. Admin. Code R. 64B17.3001(3).
[267] Florida Department of Health, Division of Medical Quality Assurance, *Enforcement Process, available at* https://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/process-chart.pdf (last visited Dec. 7, 2023).
[268] Section 456.073, F.S.
[269] Florida Department of Health, *Administrative Complaint Process – Consumer Services, available at* https://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html (last visited Dec. 7, 2023).
[270] *Id*.
[271] Florids Department of Health, Medical Quality Assurance, *A Quick Guide to the MQA Disciplinary Process Probable Cause Panels*, *available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/_documents/a-quick-guide-to-the-mqa-disciplinary-process.pdf (last visited 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.[272] The issue of whether a licensee has violated the laws and rules regulating the profession, including determining the reasonable standard of care, is a conclusion of law determined by the board.[273] The appropriate board will issue a final order in each disciplinary case.[274]

Interstate Licensing Compacts

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

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

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

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

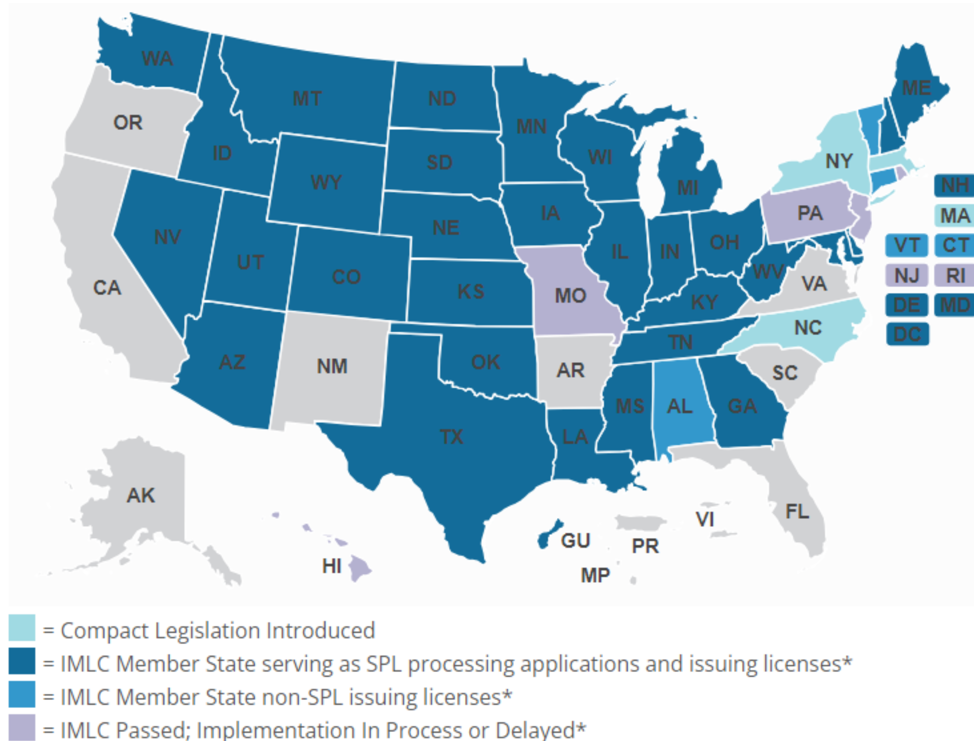
[272] Section 456.073(5), F.S.
[273] *Id*.
[274] Section 456.073(6), F.S.
[275] *See* Audiology and Speech Language Pathology Interstate Compact, What is a Compact?, *available at* https://aslpcompact.com/wp-content/uploads/2019/08/80057-What-is-a-Compact_Final.pdf (last visited Dec. 7, 2023).
[276]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

Interstate Medical Licensure Compact

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

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

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



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

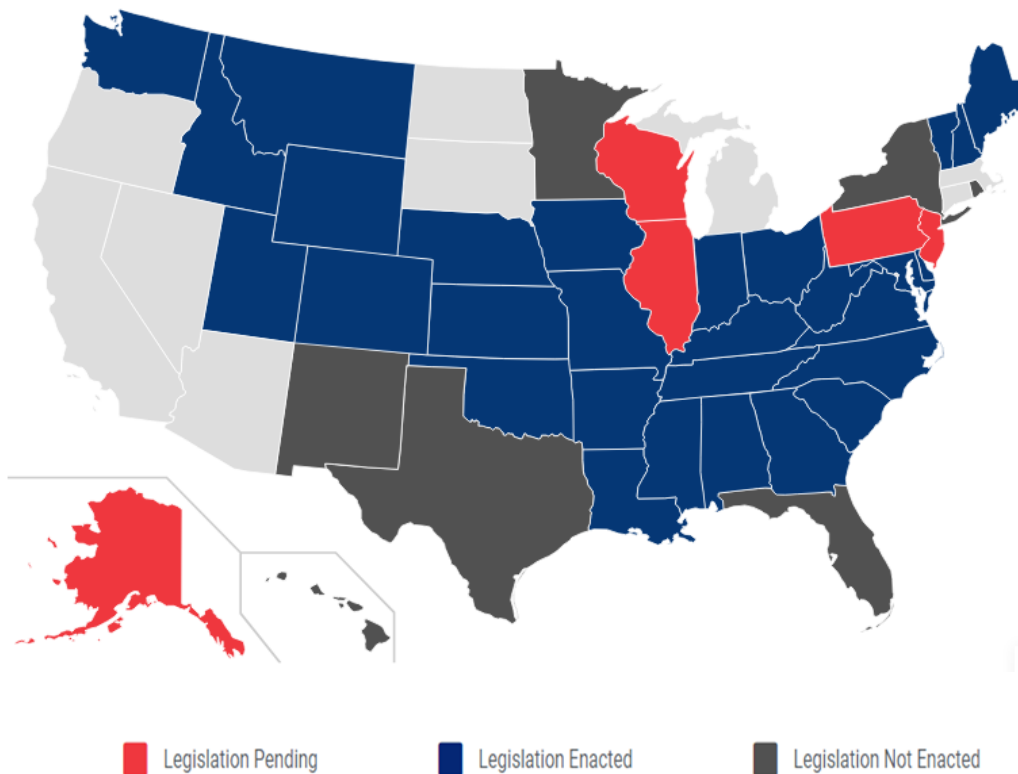
Audiology and Speech-Language Pathology Interstate Compact

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

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

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

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



[286] ASLP Compact, *Frequently Asked Questions*, *available at* https://aslpcompact.com/faq/ (last visited Dec. 7, 2023).
[287] 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.[288] To be eligible for compact privileges, a physical therapist or physical therapist assistant, must:

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

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

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

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

populations in Florida. The act provides that a health care provider that executes a contract with a governmental contractor[291] to provide health care services is considered an agent of the state for sovereign immunity purposes when acting under the scope of duties under the contract and may not be named as a defendant in any action arising out of medical care or treatment provided under the contracts entered into. For the purposes of the Access to Health Care Act, a health care provider includes:

- A birth center.
- An ambulatory surgical center.
- A hospital.
- A medical doctor, osteopathic physician, or PA.
- A chiropractic physician.
- A podiatric physician.
- A registered nurse, nurse midwife, licensed practical nurse (LPN), or APRN or any facility which employs nurses to supply all or part of the care delivered.
- A midwife.
- A health maintenance organization.
- A health care professional association and its employees or a corporate medical group and its employees.
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
- A dentist or dental hygienist.
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.[292]
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the listed professionals.

Developmental Research Laboratory Schools

Developmental research laboratory schools (lab schools) are an established category of public schools that provide sequential instruction and are affiliated with a college of education within the state university of closet geographic proximity.[293] Lab schools are required to establish admission processes that are designed to result in a representative sample of the public school enrollment based on gender, race, socioeconomic status, and academic ability.[294] As part of a lab school's mission, there must be an emphasis on mathematics, science, computer science, and foreign languages.[295] Additionally, as part of the lab school's primary goal, the school is required

[291] "Governmental contractor" is defined as the DOH, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.
[292] "Low-Income" is defined as A person who is Medicaid-eligible under Florida law; a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.
[293] Section 1002.32(2), F.S.
[294] Section 1002.32(4), F.S.
[295] Section 1002.34(3), F.S.

to enhance instruction and research in such specialized subjects by using the resources available on the university's campus. Currently, there are four universities that have lab schools:[296]

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

A university is limited to one lab school, except for a charter lab school or one that serves military families near a military installation.[297] State universities operate four charter lab schools, which are Florida State University Charter Lab K-12 School in Broward County, Florida Atlantic University Charter Lab K-12 School in Palm Beach County, Florida Atlantic University Charter Lab K-12 School in St. Lucie County[298]and the Florida State University Collegiate School in Bay County.[299] In considering an application to establish a charter lab school, a state university must consult with the district school board of the county in which the school is located. If a state university denies or does not act on the application, the applicant may appeal such decision to the State Board of Education (SBE).[300]

III. Effect of Proposed Changes:

FRAME and DSLR Program

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

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

Specific to the FRAME program, the bill expands the list of eligible practitioners to include mental health professionals, such as licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists. The bill consolidates autonomous ARNPs with the other practitioner types and eliminates specific requirements for such ARNPs to qualify for the program. The bill lengthens the amount of time over which awards may be given from year-to-year to over four years and increases the

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

maximum award amounts for every practitioner as follows (the following amounts reflect the total amount awarded over four years):

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

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

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

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

Student Loan Repayment Program Reporting

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

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

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

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

Health Care Screening and Services Grant Program

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

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

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

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

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

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

Advanced Birth Centers

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

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

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

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

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

Laboratory Services

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

Surgical Services

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

Administration of Analgesia and Anesthesia

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

Intrapartal Use of Chemical Agents

The bill authorizes the use of chemical agents to inhibit, stimulate, or augment labor during the first or second stage of labor at an ABC if prescribed by personnel who have the statutory authority to do so. Labor may be induced at the 39th week of gestation for a patient with a documented Bishop score of eight or greater.[302]

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

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

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

Hospital Requirements

Prohibition on Accepting Payments for Clinicals

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

Emergency Department Diversion Plan

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

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

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

Additionally, for patients enrolled in the Medicaid program and are members of a Medicaid managed care plan, the ED diversion plan must include outreach to that patient's managed care plan and coordination with the plan 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.

Participation in the Florida Health Information Exchange (FHIE) program

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

Statewide Medicaid Residency Program (SMRP)

Slots for Doctors Program

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

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

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

Reporting Requirements

The bill amends s. 409.909, F.S., to require any hospital or qualifying institution[303] that receives state funds under the SMRP, including, but not limited to intergovernmental transfers, to annually report data to the AHCA.

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

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

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

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

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

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

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

Residency Exit Survey

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

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

Graduate Medical Education Committee (GMEC)

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

- Three deans, or their designees, from medical schools in this state, appointed by the chair of the Council of Florida Medical School Deans.
- Four members appointed by the Governor, one of whom is a representative of the Florida Medical Association or the Florida Osteopathic Medical Association who has supervised or is currently supervising residents, one of whom is a member of the Florida Hospital Association, one of whom is a member of the Safety Net Hospital Alliance, and one of whom is a physician licensed under ch. 458 or ch. 459, F.S., practicing at a qualifying institution.
- Two members appointed by the Secretary of Health Care Administration, one of whom represents a teaching hospital as defined in s. 408.07, F.S., and one of whom is a physician who has supervised or is currently supervising residents.
- Two members appointed by the State Surgeon General, one of whom must represent a teaching hospital as defined in s. 408.07, F.S., and one of whom is a physician who has supervised or is currently supervising residents or interns.
- Two members, one appointed by the President of the Senate and one appointed by the Speaker of the House of the Representatives.

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

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

Beginning July 1, 2025, the committee is required to submit an annual report to the Governor and the Legislature detailing:
- The role of residents and medical faculty in the provision of health care.
- The relationship of graduate medical education to the state’s physician workforce.
- The typical workload for residents and the role such workload plays in retaining physicians in the long-term workforce.
- The costs of training medical residents for hospitals and qualifying institutions.
- The availability and adequacy of all sources of revenue available to support graduate medical education.
- The use of state funds, including, but not limited to, intergovernmental transfers, for graduate medical education for each hospital or qualifying institution receiving such funds.

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

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

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

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

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

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

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

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

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

- A medical resident at a rate of $50 per hour.
- A first-year medical student at a rate of $27 per hour.
- A second-year medical student at a rate of $27 per hour.
- A third-year medical student at a rate of $29 per hour.
- A fourth-year medical student at a rate of $29 per hour.
- A dental student at a rate of $22 per hour.
- An APRN student at a rate of $22 per hour.

- A PA student at a rate of $22 per hour.
- A behavioral health student at a rate of $15 per hour.

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

A qualified facility that receives payments under the program must provide information to the AHCA for the purpose of the AHCA's reporting requirements in the bill. The AHCA is required to submit an annual report to the Governor and the Legislature, with the first report due by December 1, 2025, detailing, at a minimum:
- The number of students trained in the program, by school, area of study, and clinical hours earned.
- The number of students trained and the amount of program funds received by each participating federally qualified health center or certified community behavioral health clinic.
- The number of program participants found to be employed by a federally qualified health center or a certified community behavioral health clinic or in a federally designated health professional shortage area upon completion of their education and training.
- Any other data the agency deems useful for determining the effectiveness of the program.

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

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

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

Florida Center for Nursing Annual Report

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

Charitable Care at Free Clinics

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

Lab Schools

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

LINE

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

Telehealth Minority Maternity Care Pilot Program

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

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

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

Clinical Psychologists

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

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

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

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

Psychiatric Nurses

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

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

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

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

Mobile Response Teams

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

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

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

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

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

Potentially Preventable Health Care Events

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

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

Emergency Department Diversion for Medicaid Managed Care Plans

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

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

Acute Hospital Care at Home

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

Additional Path to Florida Licensure for Foreign-Trained Allopathic Physicians

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

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

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

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

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

Restricted Allopathic Medical License

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

Certification of Foreign Educational Institutions

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

Medical Faculty Certificates for Allopathic Physicians

The bill amends s. 458.3145, F.S., to revise the criteria for issuing medical faculty certificates for medical doctors to:
- Exclude applicants who the BOM determines have not graduated from a medical school institution that provides medical education that is reasonably comparable to similar accredited institutions in the U.S ; and
- Deletes the cap on the maximum number of certificates that may be issued at specified institutions.

Temporary Certificates to Practice in Areas of Critical Need

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

The bill creates s. 464.0121, F.S., which authorizes the BON to issue temporary certificates to APRNs who 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 requires that an APRN's temporary certificate to practice in areas of critical need is only valid so long as the State Surgeon General maintains the determination that the critical need that supported the issuance of the temporary certificate remains a critical need.

The bill required the BON to review each temporary certificateholder at least annually to ascertain that the certificateholder is complying with the minimum requirements of the Nurse Practice Act and its adopted rules. If the BON determines that the certificateholder is not meeting

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

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

The bill waves all licensure fees, and neurological injury compensation assessments, for those persons obtaining a temporary certificate to practice in areas of critical need for the purpose of providing volunteer, uncompensated care for low-income residents. The applicant must submit an affidavit from the employing agency or institution stating that the APRN will not receive any compensation for any health care services that he or she provides.

Limited Licenses for Graduate Assistant Physicians

The bill amends ss. 458.317 and 459.0075, F.S.; to make conforming changes and create limited licenses for both allopathic and osteopathic graduate assistant physicians (GAPs). The BOM and the BOOM, respectively, must issue a GAP a limited license for a duration of two years to an applicant who 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 authorizes a limited licensed GAP to only provide health care services under the direct supervision of the board approved Florida physician, with a full, active, and unencumbered license. The supervising physician:
- May supervise no more than two GAPS with limited licenses;
- Must be physically presence at the location where the services are rendered; and
- Must draft the protocol to specify the duties and responsibilities of the limited licensed GAP as specified by board rule, and must ensure that:
  - There is a process for the evaluation of the limited licensed GAP's performance;
  - The delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the GAP's level of competency;
  - The limited licensed GAP's prescriptive authority is governed by the physician-drafted protocol and may not exceed that of his or her supervising physician; and
  - Any prescriptions and orders issued by the GAP must identify both the GAP and the supervising physician.

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

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

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

The bill amends s. 464.0123, F.S., to require an autonomous APRN certified nurse 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 speech-language pathology services.

ASLP Compact State Participation

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

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

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

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

To be eligible for compact privileges, an audiologist must:

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

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

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

All applicants for compact privileges must:

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

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

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

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

ASLP Compact Privileges

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

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

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

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

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

ASLP Compact Privileges to Practice Telehealth

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

ASLP Compact Active Duty Military Personnel or Their Spouses

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

ASLP Compact Adverse Action

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

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

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

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

Additional Provisions Related to the Enactment of the ASLP Compact

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

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

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

Physical Therapy Compact

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

PT Compact Purpose

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

State Participation in the PT Compact

To participate in the PT Compact, a state must:
- Fully participate in the PT Compact Commission's data system.

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

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

PT Compact Privileges

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

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

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

Active Duty Military Personnel and Their Spouses

For active duty military personnel or the spouse of an individual who is active duty military, one of the following may be designated as his or her home state:
- Home of record;
- Permanent change of station location; or

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

Adverse Action

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

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

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

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

Additional Provisions Related to the Enactment of the PT Compact

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

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

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

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

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

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

Coordinated Data System

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

Compact Commission

Each of the compacts also establish a compact commission that has duties, powers, and responsibilities under the respective compacts. Generally, each member state's licensure board selects one individual (PT Compact) or two individuals (IMLC and ASLP Compact) to represent the state on the commission. Each commissioner is entitled to one vote. Each compact's 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 program due to changes made in the bill.

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

C. Government Sector Impact:

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

SPB 7016 provides the following appropriations for the 2024-2025 state fiscal year:
- The sum of $50 million in recurring funds from the General Revenue Fund is appropriated to the DOH for FRAME.
- The sum of $13.2 million in recurring funds from the General Revenue Fund is appropriated to the DOH for the DSLR Program.
- The sum of $23,357,876 in recurring funds from the General Revenue Fund is appropriated to the DOH to expand statewide the telehealth minority maternity care program. This appropriation directs the DOH to establish 15 regions in which to implement the program statewide based on the location of hospitals providing obstetrics and maternity care and pertinent data from nearby counties for severe

maternal morbidity and maternal mortality. The DOH must identify the criteria for selecting providers for regional implementation and, at a minimum, consider the maternal level of care designations for hospitals within the regions, the neonatal intensive care unit levels of hospitals within the regions, and the experience of community-based organizations to screen for and treat common pregnancy-related complications.

- The sum of $40 million in recurring funds from the General Revenue Fund is appropriated to the AHCA to implement the TEACH Funding Program.
- The sum of $2 million in recurring funds from the General Revenue Fund is appropriated to the University of Florida, Florida State University, Florida Atlantic University, and Florida Agricultural and Mechanical University for the purpose of implementing lab school articulated health care programs. Each state university will receive $500,000 from this appropriation.
- The sum of $5 million in recurring funds from the General Revenue Fund is appropriated to the Department of Education for the purpose of implementing the Linking Industry to Nursing Education (LINE) Fund.
- The sums of $29,428,000 in recurring funds from the General Revenue Fund and $40,572,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA for the Slots for Doctors Program.
- The sums of $42,040,000 in recurring funds from the Grants and Donations Trust Fund and $57,960,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide to statutory teaching hospitals as defined in s. 408.07(46), F.S., meeting certain criteria, distributed according to specified parameters.
- The sums of $64,030,325 in recurring funds from the General Revenue Fund and $88,277,774 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping (DRG) reimbursement methodology and increase the existing marginal cost percentages for transplant pediatrics, pediatrics, and neonates.
- The sums of $82,301,239 in recurring funds from the General Revenue Fund and $113,467,645 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community Based Services Waiver category to the Agency for Persons with Disabilities to provide a uniform iBudget Waiver provider rate increase. The sum of $195,768,884 in recurring funds from the Medical Care Trust Fund is appropriated in the Home and Community Based Services Waiver category to the AHCA to establish budget authority for Medicaid services.
- The sum of $11,525,152 in recurring funds from the General Revenue Fund is appropriated to the Department of Children and Families to enhance crisis diversion through mobile response teams by adding an additional 16 mobile response teams to ensure coverage in every county.
- The sum of $10 million in recurring funds from the General Revenue Fund is appropriated to the DOH to implement the Health Care Screening and Services Grant Program.
- The sum of $150,000 in nonrecurring funds from the General Revenue Fund and $150,000 in nonrecurring funds from the Medical Care Trust Fund are appropriated to

the AHCA to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers.

- The sum of $2.4 million in recurring funds from the General Revenue Fund is appropriated to the Agency for Health Care Administration for the purpose of providing behavioral health family navigators in state-licensed specialty hospitals providing comprehensive acute care services to children pursuant to s. 395.002(28), F.S., to help facilitate early access to mental health treatment. Each licensed specialty hospital will receive $600,000 from this appropriation.
- Effective October 1, 2024, the sums of $14,682,841 in recurring funds from the General Revenue Fund and $20,243,041 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for dental care services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $12,067,327 in recurring funds from the General Revenue Fund, $127,300 in recurring funds from the Refugee Assistance Trust Fund, and $16,812,576 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $14,378,863 in recurring funds from the General Revenue Fund and $19,823,951 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $9,532,569 in recurring funds from the General Revenue Fund and $13,142,429 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.4018, 381.4019, 383.2163, 383.302, 383.309, 383.313, 383.315, 383.316, 383.318, 394.455, 394.457, 394.4598,

394.4615, 394.4625, 394.463, 394.4655, 394.467, 394.4781, 394.4785, 394.875, 395.1055, 395.602, 408.051, 409.909, 409.967, 409.973, 456.073, 456.076, 458.311, 458.313, 458.314, 458.3145, 458.315, 458.316, 458.3165, 458.317, 459.0075, 459.0076, 464.0123, 464.019, 468.1135, 468.1185, 468.1295, 486.023, 486.025, 486.028, 486.031, 486.0715, 486.081, 486.102, 486.1065, 486.107, 486.125, 766.1115, 768.28, 1002.32, and 1009.8962.

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

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

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

This bill repeals section 458.3124 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

None.

B. Amendments:

None.