FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

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BILL #: CS/HB 1427	**COMPANION BILL:** None
TITLE: Rural Communities	**LINKED BILLS:** None
SPONSOR(S): Griffitts, Abbott	**RELATED BILLS:** CS/SB 110 (Simon); CS/CS/HB 21 (Chaney); HB 1297 (Partington); HB 1101 (Albert)

Committee References

Health & Human Services
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SUMMARY

Effect of the Bill:

The bill addresses issues and policies to increase access to health care and reduce administrative burdens for patients:

- The bill creates and revises multiple health care funding programs in order to expand access to health care in rural communities, including the Florida Reimbursement Assistance for Medical Education Program, the Rural Access to Primary and Preventative Care Grant Program, the Stroke, Cardiac, and Obstetric Response and Education Grant Program, and the Rural Hospital Capital Improvement Grant Program.
- The bill expands the scope of practice for dental hygienists and creates the licensed profession of "dental therapist." The bill also broadens the circumstances in which Medicaid may provide reimbursement for services provided in a mobile dental unit.
- The bill requires health care providers to notify patients of potential higher costs when referring them to out-of-network providers. Insurers must apply patient payments for covered services by non-preferred providers to the patient's deductible and out-of-pocket maximum in certain circumstances.
- The bill aligns Florida's exceptions to the electronic prescribing requirement in current law with exceptions in federal rule by removing state-specific exemptions and adding federal exemptions.

Fiscal or Economic Impact:

The Department of Health will incur an indeterminate, recurring negative fiscal impact related to the licensure, regulation, and enforcement of dental therapy with an annual cost of approximately $156,108. Implementation of the health care grant programs expanded and established under the bill are subject to specific legislative appropriations not included in the bill.

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ANALYSIS

EFFECT OF THE BILL:

Access to Health Care

Rural Communities

To improve access to healthcare in rural communities, the bill:

- Expands the Florida Reimbursement Assistance for Medical Education (FRAME) Program to make medical doctors and doctors of osteopathic medicine who are board certified in emergency medicine and employed by or under contract with a rural hospital or a rural emergency hospital to provide medical care in the hospital's emergency department eligible to participate in the program. (Section 1);

- Creates the Rural Access to Primary and Preventative Care Grant Program (RAPP-C) program within the Department of Health (DOH) to provide incentive funding for primary care physicians, physician assistants, and autonomous Advanced Practice Registered Nurses to open new practice locations in rural and underserved areas of the state. (Section 2);
- Creates the Stroke, Cardiac, and Obstetric Response and Education (SCORE) Grant Program within the DOH to implement training, purchase equipment, establish telehealth capabilities, and develop quality improvement programs with the goal of improving patient outcomes and increasing access to high-quality stroke, cardiac, and obstetric care in rural communities. (Section 3); and
- Expands the existing Rural Hospital Capital Improvement Grant Program (RHCI) to allow rural hospitals to use grant funds to establish mobile care units to provide primary care services, behavioral health services, or obstetric and gynecological services in rural health professional shortage areas (HPSA) or to establish telehealth kiosks to provide urgent care services in rural HPSAs. (Section 4).

Dental Health Professions

Dental Therapy

The bill establishes the new licensed profession of "dental therapy," to be licensed and regulated by DOH and the Board of Dentistry (BOD). Under the bill, licensed dental therapists are mid-level dental care professionals who are trained to provide a scope of dental care between that of a dental hygienist and a dentist. Dental therapists may only provide services under the supervision of a licensed dentist, and only a Florida-licensed dentist may employ or supervise a dental therapist under the bill. (Sections 12 and 22).

Dental Therapist Licensure

The bill establishes licensure requirements for dental therapists. To be eligible for licensure as a dental therapist, a person must apply to DOH and meet the following requirements:

- Be at least 18 years of age;
- Have graduated from a dental therapy school or college accredited by the American Dental Association Commission on Dental Accreditation (CODA), or accredited by any other dental therapy accrediting entity recognized by the US Department of Education;
- Successfully complete a dental therapy practical or clinical exam produced by the American Board of Dental Examiners (ADEX) within three attempts;
- Not have been disciplined by the BOD with the exception of minor violations or citations;
- Not have been convicted, or pled nolo contendere to a misdemeanor or felony related to the practice of dental therapy; and
- Pass a written exam on the laws and rules regulating the practice of dental therapy. (Sections 16 and 21).

The bill establishes procedures for applicants who fail portions of the licensure exam. (Section 15).

The bill requires dental therapists to complete at least 24 hours and up to 36 hours of continuing education biennially in order to maintain licensure, pursuant to BOD rule. The continuing education must be approved by the BOD and contribute directly to the dental education of the dental therapist. Individuals who are licensed as both a dental therapist and dental hygienist may use two hours of continuing education to satisfy both dental therapy and dental hygiene continuing education requirements. The bill allows the BOD to excuse licensees from the continuing education requirements due to unusual circumstance, emergency, or hardship.[1] (Section 17).

The bill makes unlicensed practice of dental therapy is a third degree felony and the use of the title "dental therapist," the initials "D.T.," or otherwise fraudulently holding oneself out as a licensed dental therapist is a first degree misdemeanor.[2] (Sections 24 and 28).

[1] This requirement is consistent with the continuing education requirements for dental hygienists. *See*, ss. 466.0135, F.S., and 466.014, F.S., for continuing education requirements for dentists and dental hygienists.
[2] This is consistent with existing prohibitions related to the unlicensed practice of dentistry and dental hygiene. *See*, s. 466.026, F.S.

Dental Therapy Scope of Practice

The bill authorizes licensed dental therapists, subject to a written collaborative management agreement with a supervising dentist, to perform all of the services, treatments, and competencies listed in the table below.[3] (Sections 19 and 22).

Dental Therapy Scope	
Oral evaluation and assessment of dental disease and formulation of an individualized treatment plan	Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis
Identify oral and systemic conditions requiring evaluation and/or treatment by dentists, physicians or other healthcare providers, and manage referrals	Applying topical preventive or prophylactic agents, including fluoride varnish, antimicrobial agents, and pit and fissure sealants
Comprehensive charting of the oral cavity	Applying desensitizing medication or resin
Pulp vitality testing	Fabricating athletic mouthguards and soft occlusal guards
Exposure and evaluation of radiographic images	Changing periodontal dressings
Dental prophylaxis including sub-gingival scaling and/or polishing procedures	Administering local anesthetic and nitrous oxide
Dispensing and administering via the oral and/or topical route non-narcotic analgesics, anti-inflammatory, and antibiotic medications as prescribed by a licensed healthcare provider	Nonsurgical extraction of periodontally diseased permanent teeth with tooth mobility of +3 to +4 to the extent authorized in the dental therapist's collaborative management agreement, except for the extraction of a tooth that is unerupted, impacted, or fractured or that needs to be sectioned for removal
Fabrication and placement of single-tooth temporary crowns	Indirect and direct pulp capping on permanent teeth, indirect pulp capping on primary teeth and permanent teeth
Preparation and placement of direct restoration in primary and permanent teeth	Emergency palliative treatment of dental pain for dental therapy services
Recementing of a permanent crown	Simple extraction of erupted primary teeth
Preparation and placement of preformed crowns on primary teeth	Minor adjustments and repairs on removable prostheses
Intraoral suture placement and removal	Placement and removal of space maintainers
Pulpotomy on primary teeth	Tooth reimplantation and stabilization

The bill allows the BOD to expand the services, treatments, and procedures included in the scope of dental therapists by rule. (Section 22).

The bill authorizes a dental therapist to administer local anesthesia only if they have successfully completed an accredited or BOD-approved course[4] on the administration of anesthesia and have been issued a certificate by DOH

[3] *See*, Commission on Dental Accreditation, *Accreditation Standards for Dental Therapy Education Programs* (2023). Available at https://coda.ada.org/-/media/project/ada-organization/ada/coda/files/dental_therapy_standards.pdf?rev=19eb824b20474dbbae0e92061072b944&hash=F0AF0859DEB9D7DBCE733776254F78D5 (last visited April 12, 2025).

[4] *See*, s. 466.017, F.S. The course must include at least 30 hours of didactic instruction and 30 hours of clinical instruction and cover the following subjects: the theory of pain control, selection-of-pain-control modalities, anatomy, neurophysiology, pharmacology of local

affirming that they are certified in basic or advanced cardiac life support. A dental therapist must notify the BOD of any adverse incidents related to the administration of local anesthesia within 48 hours of the incident and submit a written report within 30 days.[5] (Section 19).

Dentist Supervision of Dental Therapists

A dental therapist may only provide dental therapy services under the supervision of a Florida-licensed dentist and pursuant to the terms of a written collaborative management agreement with the supervising dentist. The level of supervision required by the bill is dependent on the setting where the dental therapist is practicing. A dental therapist providing services in a mobile dental unit may do so under the *general* supervision of a dentist. In all other practice settings, a dental therapist must be under the *direct* supervision of a dentist.[6] (Section 22).

Through the written collaborative management agreement, the supervising dentist may limit the dental therapist's scope of practice and may require the dental therapist practice under a higher level of supervision for a set number of hours prior to providing services under general supervision. If a patient requires follow-up services that exceed the permitted scope of the dental therapist, the supervising dentist is responsible for providing or arranging such services. The supervising dentist is ultimately responsible for all services performed by the dental therapist in accordance with the written collaborative management agreement. (Section 22).

The written collaborative management agreement must include:

- Practice settings where the dental therapist may provide services and to what populations;
- Any limitations on the scope of services that the dental therapist may provide;
- Age-specific and procedure-specific practice protocols;
- A procedure for creating and maintaining dental records;
- A plan for managing medical emergencies in each relevant practice setting;
- A quality assurance plan;
- Protocols for the administration of medications;
- Criteria for the provision of care for patients with specific conditions or complex medical histories;
- Supervision criteria;
- A plan for the provision of clinical resources and referrals in situations beyond the capabilities of the dental therapist; and
- Protocols for circumstances in which the dental therapist is authorized to provide services to a patient before the supervising dentist has examined the patient. (Section 22).

Council on Dental Therapy

The bill establishes the Council on Dental Therapy (Council) to advise the BOD on matters relating to the practice and regulation of dental therapy. Under current law, a Council on Dental Hygiene and Council on Dental Assisting exist to serve similar advisory roles on behalf of their respective professions.[7] The bill requires the chair of the BOD to appoint members to the Council 28 months after the first dental therapy license is granted. Council members must include one BOD member to chair the council and three dental therapists actively engaged in the practice of dental therapy in Florida. The bill requires the council to meet at least three times per year following its establishment, and at the request of the BOD chair, a majority of BOD members, or the Council chair. (Section 13).

Dental Therapy Implementation Report

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anesthetics, pharmacology of vasoconstrictors, psychological aspects of pain control, systematic complications, techniques of maxillary anesthesia, techniques of mandibular anesthesia, infection control, and medical emergencies involving local anesthesia.

[5] These requirements are consistent with those imposed on dentists and dental hygienists; see, s. 466.017, F.S.

[6] Under *general* supervision, a dentist authorizes the procedures to be performed but does not need to be present when the authorized procedures are performed. Under *direct* supervision, a dentist examines the patient, diagnoses a condition to be treated, authorizes the procedure to be performed, is on the premises while the procedure is performed, and approves the work performed prior to the patient's departure from the premises. *See*, Rule 64B5-16.001, F.A.C.

[7] *See*, s. 466.004(2), F.S.

The bill requires DOH, in consultation with the BOD and the Agency for Health Care Administration (AHCA), to submit a progress report to the President of Senate and the Speaker of the House by July 1, 2028, and a final report four years after the first dental therapy license is issued in order to monitor the development of this new licensed profession and its impact on dental care in Florida. (Section 29).

The bill makes technical and conforming changes to reference dental therapists throughout Chapter 466, F.S. (Multiple Sections).

Dental Hygiene

A dental hygienist provides education, preventive, and delegated therapeutic dental services under varying levels of supervision by a licensed dentist.[8] Dental hygienists are not authorized to use lasers under current law.

The bill expands dental hygienist scope of practice to allow licensed dental hygienists to use lasers in the practice of dental hygiene under the general supervision of a dentist. The bill specifies that the laser use by a dental hygienist must be consistent with the minimum standards of care and limited to the dental hygienists' scope of practice. The bill specifies that the use of a laser or laser devise of any type is not a remediable task, unless used as an assessment device. (Sections 12 and 23).

In order to use a laser for nondiagnostic purposes, a dental hygienist must first complete a continuing education course in laser use specific to the procedures to be performed by the dental hygienist. The continuing education must consist of at least 12 hours of in-person training, of which three hours must include clinical simulation laser training. The continuing education must be provided by an educational course provider recognized by the BOD, but the bill does not require that the specific course be approved by the BOD. (Section 23).

The bill specifies that a dentist supervising a dental hygienist in the use of lasers must have the education and training in the use of lasers sufficient to adequately supervise such activities, including, but not limited to, completion of the continuing education course described above. The bill restates current law which establishes that the delegating dentist is primarily responsible for all procedures delegated to the dental hygienist,[9] and specifies that this applies to the use of lasers. (Section 23).

Medicaid – Dental Services

Current law authorizes Medicaid to reimburse providers for dental services provided in mobile dental units only under limited specified circumstances.[10] The bill expands such circumstances to allow Medicaid to reimburse providers for dental services provided in a mobile dental unit owned by, operated by, or having a contractual relationship with a health access setting[11] or similar program serving underserved populations. (Section 5).

Out-of-Network Providers

Current law does not obligate health care practitioners to inform patients when referring them to other providers who do not have a contract with the patient's insurer, so are not in the insurer's provider network, or inform them of the possible financial consequences of treatment by out-of-network providers.

[8] Ss. 466.003(4), F.S., and 466.003(5), F.S.
[9] *See*, s. 466.024(9), F.S.
[10] S. 409.906, F.S.; Medicaid may reimburse services provided in a mobile dental unit owned or operated by, or under contract with, a county health department, a federally qualified health center, a state-approved dental educational institution, or a mobile dental unit providing adult dental services at a nursing home.
[11] *See*, s. 466.003(15), F.S.; a "health access setting" is a program or institution of the Department of Children and Families, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start Center, a federally qualified health center or look-alike program, a school-based prevention program, a clinic operated by an accredited college or dentistry or dental hygiene program which adheres to requirements to report certain violations to the BOD.

The bill requires health care practitioners to give a written notice to a patient any time the health care provider refers a patient to a provider who is not in the provider network covered by the patient's insurance. The bill requires health care practitioners to notify patients in writing when referring them to out-of-network providers that the providers are out-of-network and that using such providers may result in higher out-of-pocket patient costs. This applies to all practitioners governed by Chapter 456, F.S.[12] (Section 6).

Currently, insurers may contract with a network of providers, such as health care practitioners or facilities, at an alternative or reduced rate, called preferred providers. Insurers may encourage patients to use preferred providers by imposing additional cost-sharing for the use non-preferred providers, and by not including the patient's out-of-pocket expenses for a non-preferred provider in the patient's deductible or out-of-pocket maximum.

The bill requires all health insurers and multiple-employer welfare arrangements[13] to apply patient payments for covered services by nonpreferred providers to the patient's deductible and out-of-pocket maximum under the policy. This applies only to non-emergency services[14] covered under the policy, and only if the cost of the out-of-network treatment is the same as or less than the insurer's average payments for that service or the statewide average on the Florida Health Price Finder website. (Section 27)

Electronic Prescribing

Florida law requires prescribers who have an electronic health record system to prescribe all medications electronically unless one of eight exemptions apply. Current federal regulations require prescribers to electronically prescribe controlled substances under a Medicare Part D drug plan unless one of three exemptions apply.

The bill aligns Florida's exceptions to the electronic prescribing requirement with the federal exceptions for electronic prescribing by removing state-specific exemptions and adding federal exemptions. Specifically, the bill requires all prescribers, not just those who have an electronic health record system, to prescribe all medications electronically unless:

- Electronic prescribing is not available due to a temporary technological or electrical failure that is not in the control of the prescribing practitioner, and such failure is documented in the patient record;
- The Department of Health issues a waiver to the prescriber because the prescriber cannot meet the requirement due to circumstances beyond the prescriber's control;
- The prescriber issues 100 or fewer prescriptions per year; or
- The prescriber is in the geographic areas for which a state of emergency is declared pursuant to s. 252.36. (Section 7).

The bill provides construction stating that the electronic prescribing requirements may not be construed to:

- Prohibit a pharmacist from filling or refilling a valid prescription submitted electronically or in writing;

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[12] Chapter 456 applies to professionals licensed under the following laws: s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; and ch. 491. These provisions apply to these occupations: behavioral analyst, nurse, acupuncturist, pharmacist, allopathic physician, dentist, osteopathic physician, dental hygienist, chiropractor, midwife, podiatrist, speech therapist, occupational therapist, medical physicist, radiology technician, emergency medical technician, electrologist, paramedic, orthotist, massage therapist, pedorthist, optician, prosthetist, hearing aid specialist, clinical laboratory personnel, dietician/nutritionist, respiratory therapist, athletic trainer, psychologist, clinical social worker, psychotherapist, marriage and family therapist, optometrist, mental health counselor, and genetic counselor.

[13] Multiple-employer welfare arrangements, or MEWAs, are employee benefit arrangements established to offer health insurance benefits to the employees of two or more employers. *See,* S. 624.437, F.S.

[14] Under the insurance code, nonemergency services are services other than those for medical conditions that manifest by acute symptoms of sufficient severity such that that absence of immediate medical attention could reasonably be expected to result in serious jeopardy to health of a pregnant woman or fetus, serious impairment of bodily functions, serious dysfunction of a bodily organ or part. *See,* ss. 627.62194, F.S., 641.74, F.S.

- Require or authorize a change in prescription drug claims adjudication and review procedures by payors; or
- Prohibit a pharmacist from filling or refilling a valid prescription issued in writing by a prescriber located in another state. (Section 7).

Under current law, DOH receives and investigates complaints against prescribers who fail to comply with the electronic prescribing requirements on behalf of the regulatory boards.[15] Current law authorizes the regulatory boards, or DOH if there is no regulatory board, to determine any disciplinary action against the prescriber. DOH is responsible for ensuring that prescribers comply with the terms and penalties imposed by the regulatory boards.[16]

The bill updates cross references. (Sections 8 and 9).

The bill provides an effective date of July 1, 2025. (Section 30).

RULEMAKING:
Current law authorizes the Board of Dentistry to adopt rules to implement Chapter 466, F.S.[17] In addition to existing rulemaking authority, the bill directs the Board of Dentistry to adopt rules relating to the continuing education requirements of licensed dental therapists.

The bill charges the Council on Dental Therapy, to be formed 28 months after the first dental therapy license is issued, with recommending rules and policies pertaining to the practice of dental therapy to the Board of Dentistry.

Lawmaking is a legislative power; however, the Legislature may delegate a portion of such power to executive branch agencies to create rules that have the force of law. To exercise this delegated power, an agency must have a grant of rulemaking authority and a law to implement.

FISCAL OR ECONOMIC IMPACT:

STATE GOVERNMENT:

Rural Communities

The implementation of the Stroke, Cardiac, and Obstetric Response and Education (SCORE) Grant Program and Rural Access to Primary and Preventative Care (RAPP-C) Grant Program established under the bill are subject to specific appropriation by the Legislature.

The expansion of the Florida Reimbursement Assistance for Medical Education (FRAME) Program and the Rural Hospital Capital Improvement (RHCI) Grant Program under the bill are also subject to specific appropriation by the Legislature.

The House proposed General Appropriations Act for Fiscal Year 2025-2026 does not include appropriations for these programs.

Dental Therapy

DOH will incur a negative fiscal impact related to the licensure and regulation of a new profession. DOH estimates the total cost of implementing HB 21 to be $156,108 in the following categories:[18]

- Expense category: $21,756 Recurring;
- Contracted Services category: $111,240 Non-Recurring, $22,112 Recurring; and

[15] The Boards of Medicine, Osteopathic Medicine, Podiatric Medicine, Dentistry, Nursing, and Optometry.
[16] Ss. 456.072 and 456.073, F.S.
[17] S. 466.004(4), F.S.
[18] Department of Health, *2025 Agency Legislative Analysis for House Bill 21*, on file with the Health & Human Services Committee.

- Other Personal Services category: $1,000 Recurring.

Current law requires that all costs for regulating a health care profession and practitioners be borne by licensees and licensure applicants.[19] A separate fee bill, which must pass by a supermajority vote, is required to establish or raise a licensure fee.[20] A fee bill has not been filed for the costs associated with regulating the practice of dental therapy.

However, DOH can absorb the costs associated with regulating dental therapists can be absorbed within current resources. According to DOH, as of the end of Fiscal Year 2023-2024, the BOD had a total negative cash balance of $3,154,151.[21] Current law requires all boards to ensure that licensure fees are adequate to cover all anticipated costs to maintain a reasonable cash balance and establishes measures to be taken by DOH if a board is operating with a negative cash balance. Specifically, current law authorizes DOH to set licensure fees on behalf of a board if the board has failed to act sufficiently to remedy the negative cash balance. DOH may advance funds to a board in such circumstances for up to two years; the board must pay interest on any such funds.[22]

Electronic Prescribing

DOH will incur nonrecurring costs for rulemaking, which can be absorbed within current resources. DOH will also incur nonrecurring increase in workload associated with notifying and communicating changes to electronic prescribing requirements, which can be absorbed within current resources.[23]

PRIVATE SECTOR:

Out-of-Network Providers

The bill's practitioner notice requirement may have a workload impact on practitioners to provide notices or look up insurer provider networks to avoid an out-of-network referral. It may have a positive economic impact on insurers if the practitioner notice requirement results in greater fidelity to in-network referrals.

The bill's non-preferred provider provision may have a negative impact on insurers for the administrative costs of including out-of-network patient expenditures in deductible and out-of-pocket maximums. To the extent the bill results in a greater patient utilization of non-preferred providers, it may have a negative impact on insurers related revenue/expenditure assumptions insurers might make with regard to preferred provider service utilization volume; or may have a positive impact if the non-preferred providers cost less for the insurers.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Florida Reimbursement Assistance for Medical Education Program

Section 381.402, F.S., establishes the Florida Reimbursement Assistance for Medical Education Program (FRAME). The FRAME program offers student loan reimbursement to various health care practitioners to offset their loans and educational expenses to entice them to practice in underserved locations where there are shortages of such practitioners. The Department of Health (DOH) is authorized to reimburse over a four-year period as follows:

- Up to $150,000 for medical and osteopathic doctors with primary care specialties;[24]

[19] S. 456.025, F.S.
[20] Fla. Const. Art. VII, Sec. 19.
[21] *Id.*
[22] *See*, s. 456.025, F.S.
[23] Department of Health, *2025 Agency Legislative Bill Analysis on HB 1297*, on file with the Health Professions & Programs Subcommittee.

- Up to $90,000 for autonomous advanced practice registered nurses (APRN) who are practicing autonomously;
- Up to $75,000 for APRNs, physician assistants, and mental health professionals;[25] and
- Up to $45,000 for licensed practical nurses (LPN) and registered nurses (RN).

To be eligible for the FRAME program, a practitioner must:

- Provide proof of primary care practice in a rural hospital or an underserved area. The section specifies that, for practitioners other than physicians, serving in a non-primary care setting, such as a nursing home, is allowed so long as the setting is in an underserved area, serve residents or patients in that underserved area, and provide Medicaid services; and
- Provide 25 hours of volunteer primary care services annually in a free clinic or through another specified volunteer program.

Rural Hospital Capital Improvement (RHCI) Grant Program

The Rural Hospital Capital Improvement (RHCI) Grant Program is administered by DOH and is available to rural hospitals[26] to fund projects to acquire, repair, improve, or upgrade systems, facilities and equipment.[27] Subject to appropriations, the RHCI directs a minimum of $100,000 to each rural hospital that applies and is eligible for the grant program. Between fiscal years 2023-2025 the grant program has helped to fund numerous improvement projects at rural hospitals including, but not limited to:

- Adding a third chiller at AdventHealth Palm Coast;
- Purchasing a leased building which houses a rural health clinic by AdventHealth Wauchula;
- Replacing nuclear medicine camera equipment and upgrading and refreshing patient rooms and air conditioning at Ascension Sacred Heart Emerald Coast;
- Replacing the air conditioning system at Doctors' Memorial Hospital in Bonifay; and
- Renovating emergency department space at Doctors' Memorial Hospital in Perry and Ed Fraser Memorial Hospital in Macclenny.[28]

Critical Access Hospitals

A critical access hospital (CAH) is a federal Medicare designation established by Congress to reduce the financial vulnerability of rural hospitals and improve care access. The CAH designation is for hospitals more than 35 miles from another hospital, with 25 or less inpatient beds and an average stay of 96 hours or less. CAH designation generates a greater Medicare payment rate and allows some regulatory flexibility.[29]

CAHs are regulated by the Agency for Health Care Administration as rural hospitals under part III of ch. 395, F.S. and ch. 408, F.S.

Dental Therapy

Dental Services & Oral Health Care

Oral health is the state of a person's mouth, teeth, and related structures that enable a person to eat, breath, and speak. Oral health plays a key role in a person's physical, mental, social, and economic well-being. Poor oral health

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[24] Primary care specialties for physicians are defined as obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties which may be identified by the DOH.
[25] Mental health professionals include licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists.
[26] A rural hospital is defined in s. 395.602, F.S. According to Florida Health Finder, there are 24 rural hospitals in Florida.
[27] S. 395.6061, F.S.
[28] A full list of all projects is on file with Senate Health Policy Committee staff.
[29] *See*, 42 U.S.C 1395i-4, 42 U.S.C. 1395x; see also, Centers for Medicare & Medicaid Services, Critical Access Hospitals (2024). Available at https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals (last visited April 13, 2025).

is associated with a variety of poor health outcomes including diabetes, heart and lung disease, as well as increased stroke risk and adverse birth outcomes including pre-term deliveries and low birth-weight.[30] Additionally, the pain and discomfort of oral disease negatively impacts the academic success of children and employment and workplace productivity in adults.[31]

The primary barriers to good oral health are a lack of access to dental care and the high cost of dental care services. The state of a person's oral health is closely related to whether they have dental insurance and the accessibility of dental prevention and treatment services. Certain populations, including children living in poverty, racial and ethnic minorities, the frail elderly, and rural communities, are significantly more likely to experience oral disease, as well as limited access to the dental care needed to treat and prevent oral disease.[32]

Dental Health Professional Shortage Areas

In the U.S., the dental care workforce is primarily composed of dentists and allied professionals including dental hygienists and dental assistants who provide dental care and oral health education to patients in a variety of settings. Unfortunately, there are not enough dental professionals to serve the needs of the U.S. population, and the majority of dental professionals are disproportionately concentrated in urban and suburban areas.[33]

The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs). 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.[34] 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.[35]

As of December 31, 2024, 5,907,517 Floridians live in one of the 274 dental HPSAs in the state. The state would need 1,256 dentists appropriately distributed throughout the state to eliminate these shortage areas.[36] Florida dentists are disproportionately concentrated in the most populous areas of the state, while rural areas are significantly underserved. Two counties, Dixie and Glades, do not have any licensed dentists, while other counties have more than 80 dentists per 100,000 residents.[37]

Regulation of Dental Professionals

The Florida dental care workforce, including dentists, dental hygienists, and dental assistants, is regulated by the Board of Dentistry (BOD), within DOH.[38] Dentists and dental hygienists must receive specified education and training to be licensed and practice in their respective professions;[39] dental assistants are not a licensed profession

[30] Mayo Clinic, *Oral Health: A Window to Your Overall Health* (2024). Available at https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475 (last visited January 16, 2025).
[31] National Institutes of Health, *Oral Health in America: Advances and Challenges* (2021). Available at https://www.nidcr.nih.gov/sites/default/files/2024-08/oral-health-in-america-advances-and-challenges-full-report.pdf (last visited February 3, 2025).
[32] *Id*.
[33] *Id*.
[34] 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 January 16, 2025).
[35] HRSA, *What is a Shortage Designation?* Available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited January 16, 2025).
[36] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited January 16, 2025). To generate the report, select "Designated HPSA Quarterly Summary."
[37] Department of Health, FL Health Charts: Dentists (DMD, DDS). Available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=0326 (last visited January 16, 2025).
[38] *See*, Ch. 466, F.S., *see also*, s. 466.004, F.S.
[39] Ss. 466.003(2), F.S., and 466.003(5), F.S.

and provide a narrow scope of services as authorized and supervised by a licensed dentist.[40] There are currently 17,529 dentists and 18,439 dental hygienists with active licenses to practice in Florida. There are 45 out-of-state registered telehealth dentists.[41]

The Board of Dentistry

The BOD is responsible for adopting rules to implement provisions of state law regulating the practice of dentists, dental hygienists, and dental assistants. The BOD consists of 11 members including seven licensed dentists actively practicing in the state, two licensed dental hygienists actively practicing in the state, and two laypersons who have never practiced oral health care. Members of the BOD are appointed by the Governor and subject to confirmation by the Senate. The Council on Dental Hygiene and Council on Dental Assisting advise the BOD on rules and policies relating to their respective professions.[42]

Dentist Supervision

Dental care teams are generally comprised of dentists and allied professionals including dental hygienists and dental assistants who are trained to provide specific oral health care services under the supervision of a dentist. There are three levels of supervision that a dental hygienist and dental assistant may be subject to:[43]

Level of Supervision	Requirements
Direct Supervision	A licensed dentist examines the patient, diagnose a condition to be treated, authorize the procedure to be performed, be on the premises while the procedure is performed, and approve the work performed prior to the patient's departure from the premises.
Indirect Supervision	A licensed dentist examines the patient, diagnose a condition to be treated, authorize the procedure to be performed, and be on the premises while the procedure is performed.
General Supervision	A licensed dentist authorizes the procedures to be performed but need not be present when the authorized procedures are performed. The authorized procedures may also be performed at a place other than the dentist's usual place of practice.

The level of supervision required is dependent upon on the specific task being performed, the education and training of the dental hygienist or dental assistant, and the discretion of the supervising dentist. Supervisory standards are outlined in current law and rule prescribed by the BOD.[44]

Dentists

A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[45] Dentists may delegate certain tasks[46] to dental hygienists and dental assistants, but a patient's "dentist of record" retains primary responsibility for all dental treatment on the patient.[47]

To be licensed as a dentist in Florida, a person must apply to DOH and meet the following requirements:[48]

- Be at least 18 years of age;

[40] *See*, Rules 64B5-16.002 and 64B5-16.005, F.A.C.
[41] *See*, Department of Health, *License Verification* web search. Available at https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders (last visited January 16, 2025).
[42] s. 466.004(2), F.S.
[43] Rule 64B5-16.001, F.A.C.
[44] S. 466.024, F.S., and Rule 64B5-16, F.A.C.
[45] Ss. 466.003(2), F.S., and 466.003(3), F.S.
[46] S. 466.024, F.S.
[47] S. 466.018, F.S.
[48] S. 466.006, F.S.

- Be a graduate of an accredited dental school;[49] and
- Obtain a passing score on the:
    - American Dental License Examination (ADEX), developed by the American Board of Dental Examiners, Inc.;
    - National Board of Dental Examiners Dental Examination (NBDE), administered by the Joint Commission on National Dental Examinations (JCNDE);[50] and
    - A written examination on Florida laws and rules regulating the practice of dentistry.

Dentists must maintain professional liability insurance or provide proof of professional responsibility. If the dentist obtains professional liability insurance, the coverage must be at least $100,000 per claim, with a minimum annual aggregate of at least $300,000.[51] Alternatively, a dentist may maintain an unexpired, irrevocable letter of credit in the amount of $100,000 per claim, with a minimum aggregate availability of credit of at least $300,000.[52] The professional liability insurance must provide coverage for the actions of any dental hygienist supervised by the dentist.[53] A dentist may be exempt from maintaining professional liability insurance under certain circumstances.[54]

Dentists are required to report any adverse incidents that occur in their office to DOH by certified mail within 48 hours of the incident. Adverse incidents include any mortality relating to a dental procedure, or any incident requiring the hospitalization or emergency room treatment of a dental patient relating to the use of any form of anesthesia.[55]

Dental Hygienists

A dental hygienist provides education, preventive, and delegated therapeutic dental services under varying levels of supervision by a licensed dentist.[56] To be licensed as a dental hygienist, a person must apply to DOH and meet the following requirements:[57]

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school;[58] and
- Obtain a passing score on the:
    - Dental Hygiene National Board Examination;
    - Dental Hygiene Licensing Examination developed by the American Board of Dental Examiners, Inc., which is graded by a Florida-licensed dentist or dental hygienist employed by DOH for such purpose; and
    - A written examination on Florida laws and rules regulating the practice of dental hygiene.

A supervising dentist may delegate certain tasks to a dental hygienist, such as removing calculus deposits, accretions, and stains from exposed surfaces of the teeth and from the gingival sulcus and the task of performing root planning and curettage.[59] A dental hygienist may also expose dental X-ray films, apply topical preventive or prophylactic agents, and delegated remediable tasks.[60] Remediable tasks are intra-oral tasks which do not create

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[49] A dental school must be accredited by the American Dental Association (ADA) Commission on Dental Accreditation (CODA) or its successor entity, if any, or any other dental accrediting entity recognized by the US Department of Education. *See also*, the American Dental Education Association, *Dental School Curriculum*. Available at https://www.adea.org/godental/discover-dentistry/Why-be-a-dentist/dental-school-curriculum (last visited February 4, 2025).
[50] For more information, *see*, American Dental Association, Joint Commission on National Dental Examinations, *Upholding Quality Oral Care For All.* Available at https://jcnde.ada.org/ (last visited March 15, 2024).
[51] Rule 64B5-17.011(1), F.A.C.
[52] Rule 64B5-17.011(2), F.A.C.
[53] Rule 64B5-17.011(4), F.A.C.
[54] *See*, Rule 64B5-17.011(3), F.A.C.
[55] s. 466.017, F.S.; forms of anesthesia include general anesthesia, deep sedation, moderate sedation, pediatric moderate sedation, oral sedation, minimal sedation, nitrous oxide, or local anesthesia.
[56] Ss. 466.003(4), F.S., and 466.003(5), F.S.
[57] S. 466.007, F.S.
[58] If the school is not accredited, the applicant must have completed a minimum of 4 years of postsecondary dental education and received a dental school diploma which is comparable to a D.D.S. or D.M.
[59] S. 466.023, F.S.
[60] Ss. 466.023, F.S., and 466.024, F.S.

an unalterable change in the oral cavity or contiguous structures, are reversible, and do not expose the patient to risk, including but not limited to:

- Fabricating temporary crowns or bridges inter-orally;
- Selecting and pre-sizing orthodontic bands;
- Preparing a tooth service by applying conditioning agents for orthodontic appliances;
- Removing and re-cementing properly contoured and fitting loose bands that are not permanently attached to any appliance;
- Applying bleaching solution, activating light source, and monitoring and removing in-office bleaching solution;
- Placing or removing rubber dams;
- Making impressions for study casts which are not being made for the purpose of fabricating any intra-oral appliances, restorations, or orthodontic appliances;
- Taking impressions for passive appliances, occlusal guards, space maintainers, and protective mouth guards; and
- Cementing temporary crowns and bridges with temporary cement.

A dental hygienist may perform additional remediable tasks as delegated by the supervising dentist if they have received additional training in a pre-licensure course, other formal training, or on-the-job training.[61] Dental hygienists are not authorized to use lasers in the provision of patient care under current law. The BOD considered the use of lasers by dental hygienists as a remedial task in 2021, and ultimately rejected the proposal due to lack of evidence of the efficacy of such laser treatments and patient safety concerns.[62]

A qualified dental hygienist may, under the direct supervision of a dentist, administer local anesthesia to non-sedated, adult patients. In order to be qualified to administer local anesthesia, a dental hygienist must obtain a certificate from DOH which indicates that they are certified in basic or advanced cardiac life support and have completed an accredited or BOD-approved course[63] consisting of a minimum of 60 hours of instruction relating to the administration of local anesthesia. A dental hygienist must display this certificate prominently at the location where the dental hygienist is authorized to administer local anesthesia. Dental hygienists are required to notify the BOD by registered mail within 48 hours after any adverse incident related to the administration of local anesthesia.[64]

Dental hygienists are authorized to perform dental charting without dentist supervision. Dental charting includes the recording of visual observations of clinical conditions of the oral cavity without the use of X-rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets.[65] Dental charting is not a substitute for a comprehensive dental examination, and each patient who receives dental charting by a dental hygienist must be informed of the limitations of dental charting.[66] Dental hygienists performing dental charting without dentist supervision are required to maintain their own medical malpractice insurance or other proof of financial responsibility.[67]

Dental hygienists are not required to maintain professional liability insurance and must be covered by the supervising dentist's liability insurance,[68] unless they are providing services without dental supervision, in which case they must maintain their own medical malpractice insurance or other proof of financial responsibility.[69]

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[61] *See*, ss. 466.023, F.S., 466.0235, F.S., and 466.024, F.S.; and Rule 64B5-16, F.A.C.
[62] See, Board of Dentistry, Rules Hearing Meeting Minutes: May 21, 2021 (2021). Available at https://floridasdentistry.gov/Meetings/Minutes/2021/05-may/05212021-rules-minutes.pdf (last visited April 22, 2025).
[63] *See*, s. 466.017(5), F.S. The course must include at least 30 hours of didactic instruction and 30 hours of clinical instruction and cover the following subjects: the theory of pain control, selection-of-pain-control modalities, anatomy, neurophysiology, pharmacology of local anesthetics, pharmacology of vasoconstrictors, psychological aspects of pain control, systematic complications, techniques of maxillary anesthesia, techniques of mandibular anesthesia, infection control, and medical emergencies involving local anesthesia.
[64] S. 466.017(11), F.S.
[65] S. 466.0235, F.S.; Dental hygienists may only perform periodontal probing as a part of dental charting if the patient has received medical clearance from a physician or dentist.
[66] Rule 64B5-16.0075, F.A.C
[67] Rule 64B5-17.011(4), F.A.C.
[68] Rule 64B5-17.011(4), F.A.C.

Dental Assistants

Dental assistants provide limited dental care services under the supervision and authorization of a licensed dentist.[70] Florida does not license dental assistants; however, dental assistants may choose to receive formal education in dental assisting and obtain a national certification.[71] Dental assistants who have graduated from a BOD-approved dental assisting school are eligible for certification as dental radiographers.[72]

The scope of practice for dental assistants is limited to the delegable tasks determined in Florida law and rule. The specific tasks that may be delegated to a dental assistant are dependent on the formal and on-the-job training the dental assistant has received.[73]

Dental Therapy

Dental therapy is an emerging profession in the U.S.; dental therapists are mid-level dental care providers intended to occupy a role in dentistry similar to that of physician assistants in medicine. Under dentist supervision, dental therapists provide preventative and routine restorative care, such as filling cavities, placing temporary crowns, and extracting badly diseases or loose teeth. Dental therapists provide services as part of a dental care team and, in theory, enable dentists to perform more advanced care and treat a larger number of patients.[74]

Education & Training

In 2015, the Commission on Dental Accreditations (CODA)[75] established accreditation standards for dental therapy education programs.[76] To be accredited programs must, among other things:[77]

- Include at least 3 academic years of full-time instruction or its equivalent at the postsecondary college-level;
- Include content that is integrated with sufficient depth, scope, sequence of instruction, quality and emphasis to ensure achievement of the curriculum's defined competencies in the following three areas: general education, biomedical sciences, and dental sciences (didactic and clinical);
- Have content that includes oral and written communications, psychology, and sociology;
- Include biomedical instruction that ensures an understanding of basic biological principles, consisting of a core of information on the fundamental structures, functions and interrelationships of the body systems in each of the following areas:
    - Head and neck and oral anatomy;
    - Oral embryology and histology;
    - Physiology;
    - Chemistry;
    - Biochemistry;
    - Microbiology;

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[69] *Id.*; *see also*, s. 466.024(5), F.S.
[70] S. 466.003(6), F.S.
[71] *See*, Dental Assisting National Board, *Earn Dental Assistant Certification*. Available at https://www.danb.org/certification/earn-dental-assistant-certification (last visited January 16, 2025).
[72] Rule 64B5-9.011, F.A.C.; A dental assistant may also become eligible for certification as a dental radiographer through three continuous months of on-the-job training under the direct supervision of a dentist.
[73] For more information on the specific tasks which may be delegated to a dental assistant, and the required training for each task, *see*, rules 64B5-16.002 and 64B5-16.005, F.A.C.
[74] American Dental Therapy Association. *Get the Facts*. Available at https://www.americandentaltherapyassociation.org/get-the-facts (last visited January 16, 2025).
[75] The Commission on Dental Accreditation (CODA) accredits dental and dental-related education programs in the U.S.; for more information, *see, About CODA*. Available at https://coda.ada.org/ (last visited April 12, 2025).
[76] Commission on Dental Accreditation, *Accreditation Standards for Dental Therapy Education Programs* (2015). Available at https://coda.ada.org/-/media/project/ada-organization/ada/coda/files/dental_therapy_standards.pdf?rev=814980f6110140e7ba00659703cc3b3c&hash=81A3585FD5B1B478DA7D99065A9B75DE (last visited January 16, 2025).
[77] *Id.*

    - Immunology;
    - General pathology and/or pathophysiology;
    - Nutrition; and
    - Pharmacology;
- Include didactic dental sciences that ensures an understanding of basic dental principles, consisting of a core of information in each of the following areas within the scope of dental therapy:
    - Tooth morphology;
    - Oral pathology;
    - Oral medicine;
    - Radiology;
    - Periodontology;
    - Cariology;
    - Atraumatic restorative treatment;
    - Operative dentistry;
    - Pain management;
    - Dental materials;
    - Dental disease etiology and epidemiology;
    - Preventive counseling and health promotion;
    - Patient management;
    - Pediatric dentistry;
    - Geriatric dentistry;
    - Medical and dental emergencies;
    - Oral surgery;
    - Prosthodontics; and
    - Infection and hazard control management; and
- Ensure that graduates are competent in their use of critical thinking and problem-solving, related to the scope of dental therapy practice.

There are currently three CODA-accredited dental therapy education programs in the U.S.; the CODA-accredited programs are located in Minnesota, Alaska, and Washington state.[78] Oregon, Michigan, Wisconsin, and Vermont are in the process of developing dental therapy education programs.[79]

Dental Therapy in Other US States

There are currently 14 states in the US that authorize the practice of dental therapy. Licensure, scope of practice, supervision, and practice setting requirements for dental therapists vary somewhat in each state that has established the profession. Minnesota was the first state to authorize the practice of dental therapy in 2009 and in 2024, Wisconsin became the most recent state to adopt legislation regulating the practice of dental therapy.[80] There has been some evidence indicating that authorizing the practice of dental therapists has improved access to oral health care.[81] Florida does not currently license dental therapists.

The Sunrise Act and Sunrise Questionnaire

The Sunrise Act (Act), codified in s. 11.62, F.S., requires the Legislature to consider specific factors in determining whether to regulate a new profession or occupation.[82] The legislative intent in the Act provides that:[83]

[78] Commission on Dental Accreditation, *Search for Dental Programs*. Available at https://coda.ada.org/find-a-program/search-dental-programs#sort=%40codastatecitysort%20ascending&f:ProgramType=[Dental%20Therapy] (last visited January 16, 2025). Two of the three programs are fully accredited and operational; the third program is in the initial accreditation phase.
[79] Oral Health Workforce Research Center. *Authorization Status of Dental Therapists by State*. Available at https://oralhealthworkforce.org/authorization-status-of-dental-therapists-by-state/ (last visited April 12, 2025).
[80] *Id*; Vermont, Washington, Michigan, Minnesota, Montana, Nevada, New Mexico, Oregon, Alaska, Arizona, Colorado, Connecticut, Idaho, Maine, and Wisconsin have authorized the practice of dental therapy. Some states only authorize dental therapy in the context of providing services for Native American Tribes. For more information on Tribal Dental Therapy, *see* National Indian Health Board, *Tribal Dental Therapy Legislation in the States*. Available at https://www.nihb.org/oralhealthinitiative/map.php (last visited January 16, 2025).
[81] Mertz, E., Kottek, A., Werts, M., Langelier, M., Surdu, S., & Moore, J. *Dental Therapists in the United States: Health Equity, Advancing*. (2021). Medical care, 59(Suppl 5), S441–S448. https://doi.org/10.1097/MLR.0000000000001608

- No profession or occupation be subject to regulation unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the state's police power be exercised only to the extent necessary for that purpose; and
- No profession or occupation be regulated in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the services to the public.

The Legislature must review all legislation proposing regulation of a previously unregulated profession or occupation and make a determination for regulation based on consideration of the following:[84]

- Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- Whether the public is or can be effectively protected by other means; and
- Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.

The Act requires the proponents of legislation for the regulation of a profession or occupation to provide specific information in writing to the state agency that is proposed to have jurisdiction over the regulation and to the legislative committees of reference.[85] This required information is traditionally compiled in a "Sunrise Questionnaire."

Dental Therapist Sunrise Questionnaire

As a not-yet-regulated profession, proponents of dental therapy are required to complete the Sunrise Questionnaire. The Sunrise Questionnaire was completed on behalf of several national and Florida-based organizations seeking to advance the practice act for dental therapy. They include: The National Partnership for Dental Therapy, the National Coalition of Dentists for Health Equity, the American Dental Therapy Association, and Floridians for Dental Access.[86]

The submitted questionnaire indicates that the licensure and regulation of dental therapists is being sought to address oral health access challenges. Per the questionnaire, existing law regulating the practice of dentistry in Florida,[87] prohibits anyone, other than dentists, from performing certain procedures that would be within the scope of practice for a dental therapist, thus prohibiting the practice of dental therapy. The proposed legislation would authorize a dental therapist to practice dental therapy in Florida without violating the dental practice act. This would allow a mid-level practitioner to provide some dental services that currently may only be provided by a dentist.[88]

Since dental therapist are not yet licensed, the public is already protected by the existing dental practice act. By licensing dental therapists, it will exclude unqualified practitioners from providing services, give official

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[82] *Id.*
[83] S. 11.62(2), F.S.
[84] S. 11.62(3), F.S.
[85] S. 11.62(4), F.S.
[86] FLORIDA SENATE SUNRISE QUESTIONNAIRE, Submitted January 22, 2024. On file with the Health & Human Services Committee.
[87] Chapter 466, F.S.
[88] *Supra*, note 86.

recognition to the field's scope of practice, extend professional opportunities for dental care professionals, and expand access to dental care.[89]

Mobile Dental Units

Mobile dental units use portable dental equipment to provide dental care in nontraditional settings, generally with a focus on underserved communities. Mobile dental units most commonly provide services through the use of either:[90]

- A mobile van that serves as a self-contained dental clinic configured with all of the essential tools and equipment. Mobile dental vans may travel to different locations to serve patients; or
- Portable dental equipment that is transported and set up at a community site such as schools, community centers, or nursing homes. Such programs may move from location to location after the provision of care is complete.

Through the use of mobile dental units, dental care professionals provide preventative and basic restorative services in the community while also conducting risk assessments and referring patients for treatment for more complex conditions. Mobile dental units have most commonly been used to provide oral health care to children in schools and related programs, but the model has also been used to provide care to underserved adults and the elderly, especially those in nursing homes or with unstable housing, those with developmental disabilities or other special needs, or other barriers to accessing traditional private dental practices.[91]

Florida Medicaid – Dental Services

Medicaid is the health insurance safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including DOH, the Department of Children and Families, the Agency for Persons with Disabilities, and the Department of Elderly Affairs.

Each state operates its own Medicaid program, but many parameters are set by the federal government as a condition of receiving federal funds.[92] Among other requirements, federal law sets the amount, scope, and duration of services offered by Medicaid. The federal government also determines the minimum mandatory populations, as well as the minimum mandatory benefits to be covered in every state Medicaid program. Mandatory benefits include physician services, hospital services, home health services, and family planning.[93] States may choose to add benefits, with federal approval; Florida has added many optional benefits, including adult dental services.[94]

While most Medicaid services are provided by comprehensive, integrated, managed care plans, dental services are provided by separate, dental-only plans. Medicaid covers dental benefits for both children[95] and adults. Medicaid covers full dental services for children.[96] Adult dental benefits are limited to emergency treatment and dentures,

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[89] *Id.*[90] Lehnert, L. & Thakur, Y. (2024) *Alternative Pathways in Dentistry: Mobile Dental Clinics, Illustration of Implementation in San Mateo and Santa Clara County through Federally Qualified Health Center*. Journal of the California Dental Association, 52:1, 2320945, DOI: 10.1080/19424396.2024.2320945

[90] Lehnert, L. & Thakur, Y. (2024) *Alternative Pathways in Dentistry: Mobile Dental Clinics, Illustration of Implementation in San Mateo and Santa Clara County through Federally Qualified Health Center*. Journal of the California Dental Association, 52:1, 2320945, DOI: 10.1080/19424396.2024.2320945

[91] Oral Health Workforce Research Center. *An Assessment of Mobile and Portable Dentistry Programs to Improve Population Oral Health* (2017). Available at https://www.oralhealthworkforce.org/wp-content/uploads/2017/11/OHWRC_Mobile_and_Portable_Dentistry_Programs_2017.pdf (last visited February 4, 2025). *See also*, National Institutes of Health, *Oral Health in America: Advances and Challenges* (2021). Available at https://www.nidcr.nih.gov/sites/default/files/2024-08/oral-health-in-america-advances-and-challenges-full-report.pdf (last visited February 3, 2025).

[92] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).

[93] S. 409.905, F.S.

[94] S. 409.906, F.S.

[95] Under the age of 21.

[96] S. 409.906(6), F.S.

and do not include preventive services.[97] However, Medicaid dental plans provide expanded dental benefits to adults, including preventive and restorative dental services, at no cost to the state.[98]

Medicaid Covered Dental Services[99]		
Children		**Adults**
Ambulatory Surgical Center or Hospital-based Services	Orthodontics	Dental Exams (emergencies and dentures only)
Dental Exams	Periodontics	Dental X-rays (limited)
Dental Screenings	Prosthodontics (dentures)	Prosthodontics (dentures)
Dental X-rays	Root Canals	Extractions
Extractions	Sealants	Sedation
Fillings and Crowns	Sedation	Ambulatory Surgical Center or Hospital-based Services
Fluoride	Space Maintainers	
Oral Health Instructions	Teeth Cleanings	

Mobile Dental Units

Current law prohibits Medicaid reimbursement for dental services provided in a mobile dental unit except under specified circumstances. Medicaid may reimburse services provided in a mobile dental unit owned or operated by, or under contract with, a county health department, FQHC, state-approved dental educational institution, or a mobile dental unit providing adult dental services at a nursing home.[100] Current law does not authorize the reimbursement for dental services provided in a mobile dental unit owned by, operated by, or having a contractual agreement with a health access setting.[101]

Dental services under Medicaid may be provided by a:[102]

- Practitioners licensed under Ch. 466, F.S., such as dentists and dental hygienists;
- County health department administered by DOH;[103]
- Federally qualified health center (FQHC);[104] or a
- Dental intern or a dental graduate temporarily certified to practice in a state operated hospital or a state or county government facility.[105] in accordance with s. 466.025, F.S.

Out-of-Network Providers

Health Insurance Networks

[97] S. 409.906(1), F.S.
[98] Agency for Healthcare Administration, *Agency Analysis of HB 1177 (2023).* On file with the Health & Human Services Committee.
[99] Florida Medicaid, *Dental Services Coverage Policy* (August 2018). Available at https://ahca.myflorida.com/content/download/5945/file/59G-4.060_Dental_Coverage_Policy.pdf (last visited January 16, 2025).
[100] S. 409.906, F.S.
[101] *See*, s. 466.003(15), F.S. ; a "health access setting" is a program or institution of the Department of Children and Families, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start Center, a federally qualified health center or look-alike program, a school-based prevention program, a clinic operated by an accredited college or dentistry or dental hygiene program which adheres to requirements to report certain violations to the BOD.
[102] *Id.*
[103] *See*, s. 154.01, F.S., for information on county health departments.
[104] A federally qualified health center is a federally funded nonprofit health center or clinic that serves medically underserved areas and populations regardless of an individual's ability to pay. *See* Federally Qualified Health Center, HealthCare.gov. Available at https://www.healthcare.gov/glossary/federally-qualified-health-center-fqhc/ (last visited January 16, 2025).
[105] *See*, s. 466.025, F.S., for information on the temporary certificate program.

Health insurers contract with a limited number of providers to serve their enrollees, called a provider network. Insurers may encourage patients to use in-network providers by imposing higher cost-sharing, such as co-payments, for out-of-network provider treatment, and may not apply any patient expenditure to the patient's deductible[106] or out-of-pocket maximum.[107]

Preferred Providers

A Preferred Provider Organization (PPO)[108] is a health plan that contracts with providers, such as hospitals and doctors, to create a network of providers who participate for an alternative or reduced rate of payment. Generally, the patient, or member, is only responsible for the policy co-payment, deductible, or co-insurance amounts if covered services are obtained from network providers.

However, if a member chooses to obtain services from an out-of-network provider, those out-of-pocket costs likely will be higher. In addition, the terms of the policy may prohibit the patient from receiving credit for out-of-pocket (cash) expenditures for such services toward the patient's out-of-pocket maximum or deductible obligations. In addition, because a non-participating provider does not have a contract with the insurer delineating the reimbursement rates, the provider may bill the patient for the difference between what the provider bills the insurer and what the insurer chooses to pay – called balance-billing. Current law requires insurers to include an express warning to enrollees in the policy, advising them of the possible financial consequences of using a non-participating provider.

Current law requires each health insurer that uses a preferred provider model to give the policy-holder a list of the participating providers and publish that list on its website.[109]

Health Care Price Finder

Current law requires the Agency for Health Care Administration (AHCA) to maintain a Florida Center for Health Care Information and Transparency to collect, analyze and disseminate health care information data and statistics (s. 408.05, F.S.). As part of its functions, the agency administers a website of health care paid-claims data to assist consumers identify the costs of care. The Florida Health Price Finder[110] website accesses national paid-claims data for at least 15 billion claim lines from multiple payers, and current law requires all authorized insurers in Florida to provide claims data to the AHCA vender managing the website. The site allows a consumer to search for prices health care providers were paid by insurers, expressed as a range of averages, for providers in the consumer's geographic location. Prices are searchable by specific service or as a bundle of all the corollary services part of a major service.

Health Price Finder includes data on most hospitals in Florida, although AHCA limits data on hospitals in some geographic areas with little competition or few payers to avoid the possibility that specific reimbursement amounts might be identified. The payment information available on the website is limited; for example, a patient cannot search by specific facility or provider, so it has limited usefulness for a patient searching for a provider based on cost or comparing providers based on cost.

Health Care Practitioners

Health care practitioners are regulated by DOH under ch. 456, F.S., and individual practice acts for each profession. Many practitioners are regulated by profession-specific boards or councils of members of the profession appointed by the Governor and administered by DOH; some are regulated directly by DOH without a board or council.

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[106] A deductible is the amount of money a patient must pay before an insurer begins paying for covered services, in a given plan year or other policy term.
[107] An out-of-pocket maximum is a limit set on the amount a patient much pay for services covered by an insurance policy in a given plan year or other policy term.
[108] *See*, s. 627.6471, F.S.
[109] S. 627.6471, F.S.
[110] Available at https://price.healthfinder.fl.gov/#.

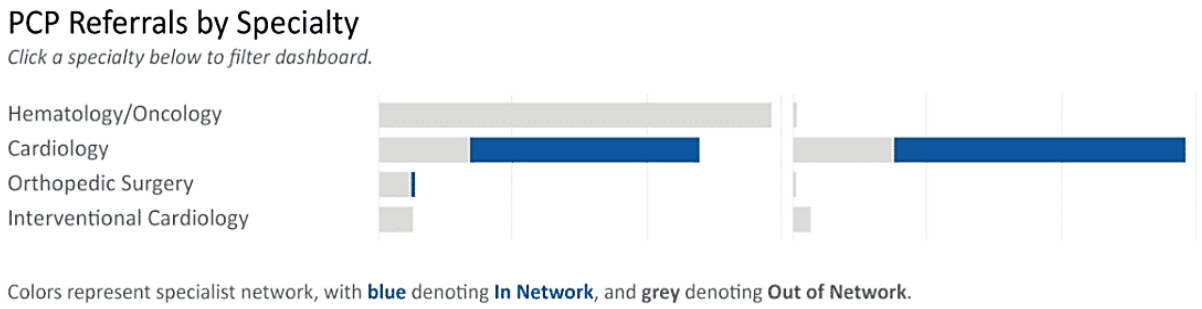
Chapter 456 and individual practice acts delineate standards of licensure and practice, and the boards, or department if there is no board, enforce violations of those standards under the Administrative Procedures Act. Boards and the department may issue a reprimand or letter of concern, assess fines, suspend or restrict licenses, or revoke licenses, among other penalties, based on the nature of the violation.[111]

Out-of-Network Referrals

Health care practitioners may refer patients to other health care practitioners for the patient to obtain additional, possibly more specialized diagnosis or treatment. Sometimes, the referred practitioner does not participate in the patient's insurer's provider network, which may result in increased costs for the patient – or delays in care while the patient goes back to the referring provider for an alternative referral. However, this is common practice. For example, one survey of primary care providers (PCPs)[112] found:

- 79% refer patients out-of-network.
- 34% of out-of-network referrals could be avoided if providers had more information on other providers' specialties and areas of focus.
- 72% refer to the same provider for a specialty, rather than determining whether another provider has more specific expertise or earlier appointment time.
- 60% of PCPs did not always know whether their patient required re-referral.

An analysis of PCP referrals in the Washington, D.C. area found significant out-of-network referral, as indicated by graphic below.[113]



That analysis, showed significant variation in referral patterns by PCPs, with some making non-participating providers 100% of their referrals; others referring out-of-network at much lower rates.

Current law does not obligate practitioners to inform patients when referring them to other providers who are not in the patient's insurance network, or the possible financial consequences of treatment by out-of-network providers.

Electronic Prescribing

Electronic prescribing (e-prescribing) is the use of an electronic device such as a computer or tablet to enter and securely transmit prescriptions to pharmacies using special software and connectivity to a transmission network,

[111] *See*, s. 456.072, F.S.
[112] Kyruus Health, *2018 Referral Trends Report* (2018). Available at https://kyruushealth.com/new-physician-referral-report-identifies-top-barriers-to-patient-retention-and-care-coordination-within-health-system-networks/ (last visited March 15, 2025).
[113] CareJourney, *Using Healthcare Analytics to Understand & Optimize Physician Referrals at the Point of Care* (2021). Available at https://carejourney.com/healthcare-analytics-to-optimize-physician-referrals-at-point-of-care/ (last visited March 15, 2025).

rather than writing a prescription on paper.[114] Numerous benefits have been attributed to e-prescribing including, improved prescription accuracy, increase patient safety, reduction of opportunities for fraud, and cost reduction.[115]

Patient Safety

An adverse drug event (ADE) is harm experienced by the patient as a result of exposure to medicine.[116] Each year, ADEs account for approximately 700,000 emergency department visits and 100,000 hospitalizations.[117] Some ADEs occur unrelated to hospital care, such as overdoses of opioid medications.[118] Medication errors most commonly occur during the prescribing, ordering, and administration stage; approximately 50% of medication errors occur when a medication is prescribed or ordered.[119] It is estimated that about half of ADEs are preventable.[120] E-prescribing can help reduce errors due to illegible handwriting, lost paper scripts, and incomplete or inaccurate instructions.[121]

Fraud

Individuals may illegally obtain prescription medication by using fraudulent, forged, or altered written prescriptions. In an effort to reduce fraud related to the use or misuse of controlled substances, Florida law requires prescribers to use counterfeit-proof prescription pads purchased from an authorized supplier for written prescriptions for controlled substances.[122] A counterfeit-proof prescription pad must include the following features:[123]

- A background color that is blue or green and resists reproduction;
- Printed on artificial watermarked paper;
- Resists erasures and alterations; and
- The word "void" or "illegal" must appear on any photocopy or reproduction;

Health care practitioners and health care facilities must return unused counterfeit-proof prescription to the vendor to be destroyed.[124] Even with these precautions, there is still the danger of a legitimate prescription pad being stolen from a health care practitioner's office or a health care facility and fraudulent prescriptions written.[125]

E-prescribing eliminates the risk of stolen prescription pads and, with the two-factor authentication required by the U.S. Drug Enforcement Administration (DEA), may further reduce unauthorized or altered prescriptions.[126]

Efficiency

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[114] The Office of the National Coordinator for Health Information Technology, *What is Electronic Prescribing?* Available at https://www.healthit.gov/faq/what-electronic-prescribing (last visited March 17, 2025).
[115] Agency for Health Care Administration, *Florida Electronic Prescribing Annual Report for 2023*. Available at https://ahca.myflorida.com/content/download/25388/file/2023eRxAnnualReport_Final.pdf (last visited March 17, 2025).
[116] U.S. Department of Health and Human Services, *Agency for Healthcare Research and Quality, Medication Errors and Adverse Drug Events* (last rev. Sep. 2019). Available at https://psnet.ahrq.gov/primer/medication-errors-and-adverse-drug-events (last visited March 17, 2025).
[117] *Id.*
[118] *Id.*
[119] Rayhan A. Tariq, Rishik Vashisht, Ankur Sinha, et al., *Medication Dispensing Errors and Prevention*, (2024). Available at https://www.ncbi.nlm.nih.gov/books/NBK519065/ (last visited March 17, 2025).
[120] *Id.*
[121] Matthew E. Hirschtritt, M.D., M.P.H., Steven Chan, M.D., M.B.A, and Wilson O.Ly, Pharm.D,M.Sc, *Realizing E-Prescribing's Potential to Reduce Outpatient Psychiatric Medication Errors*, (2017). Available at https://psychiatryonline.org/doi/10.1176/appi.ps.201700269 (last visited March 17, 2025).
[122] S. 456.42, F.S.
[123] Rule 64B-3.005, F.A.C.
[124] *Id.*
[125] U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division, *A Pharmacist's Guide to Prescription Fraud*, (2000). Available at https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-002R1)(EO-DEA009R1)_RPH_Guide_to_RX_Fraud_Trifold_(Final).pdf (last visited March 17, 2025).
[126] National Association of Chain Drug Stores, *Opioid Abuse Epidemic: Solutions from the Front Lines of Care*, (last rev. May 2019). Available at https://www.nacds.org/pdfs/government/2017/Opioid-Policy-Oct-2017.pdf (last visited March 17, 2025).

E-prescribing creates efficiencies for prescribers, patients, and pharmacies. For prescribers, e-prescribing can be integrated into electronic health records, which includes patient information such as clinical notes, laboratory results, and clinical decision support functions.[127] E-prescribing also improves the accuracy of prescriptions and helps guide clinical decision-making by checking the appropriateness of a prescription and connecting to a patient's health insurance for its formulary.[128] Prescribers have also indicated that less time is spent resolving issues with pharmacies, including prior authorizations and refill requests, allowing more time to be spent on patient care.[129] The software also automates certain tasks which allows staff to perform other functions. Such efficiencies may ultimately lower overall operating costs.

Patients may also benefit from e-prescribing efficiencies due to the ability of the prescriber to check for drug interactions, drug allergies, and whether a particular drug is covered by their insurance. This may enable patients to reduce copayment expenses or inconvenience associated with requesting an alternate medication from the prescriber if the drug prescribed is not covered or too expensive.[130]

Finally, pharmacies will likely benefit from e-prescribing efficiencies because it reduces the time spent on interpreting a prescription. Pharmacists must contact prescribers if a prescription is illegible or inconsistent, which affords the pharmacist more time to counsel patients.[131]

As noted above, ADEs result in many emergency room visits and hospitalizations, as well as additional visits to the prescriber's office. Although e-prescribing will not prevent all ADEs,[132] they may reduce the number of ADEs due to improved prescribing and the assistance of decision support systems.[133] The efficiencies noted above may also lead to a reduction to overall operating costs.

Electronic Prescribing for Controlled Substances Application Requirements

E-prescribing relies on specialized software to securely generate and transmit sensitive information between the health care provider and pharmacy. All applications used for electronically prescribing controlled substances (EPCS) must meet standards established by the DEA.[134] All prescriptions issued electronically for controlled substances must meet these requirements regardless of whether the patient is under Medicare Part D. EPCS software must be capable of authenticating prescriber and patient identities, detecting irregularities, and preventing duplication, among other technical security standards.[135]

The DEA implements the Comprehensive Drug Abuse Prevention and Control Act of 1970, often referred to as the Controlled Substances Act.[136] In 2010, the DEA adopted a rule authorizing prescriber to issue electronic prescriptions for controlled substances and permitted pharmacies to receive, dispense, and archive these electronic prescriptions.[137] To e-prescribe controlled substances, a prescriber must:[138]

- Purchase or use DEA-compliant software that supports e-prescribing;

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[127] Amber Porterfield, et. al., *Electronic Prescribing: Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting*, Perspect. Health Inf. Manage. 2014 Spring: 11 (Apr. 2014). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3995494/ (last visited March 17, 2025).
[128] Academy of Managed Care Pharmacy, *Concept Series Paper on Electronic Prescribing*. Available at https://amcp.org/sites/default/files/2019-03/Electronic%20Prescribing.pdf (last visited March 17, 2025).
[129] *Supra,* note 127.
[130] *Id.*
[131] Amina Hareem, Joshua Lee, et al., Benefits and Barriers Associated with E-prescribing in Community Pharmacy—A systemic Review. Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10746557/ (last visited March 17, 2025).
[132] Some ADEs are unavoidable even if the medication is properly prescribed and administers. These are often known side effects of a medication. *See supra,* note 116.
[133] *Supra,* note 116.
[134] The DEA establishes these requirements according to the agency's responsibilities under the Controlled Substances Act. *See*, 21 U.S.C. 829 (a) and 871(b).
[135] 21 CFR 1311.120
[136] 21 U.S.C. 801–971.
[137] 21 C.F.R. s. 1306.08 and 21 C.F.R. Part 1311.
[138] *Id.*

- Complete the identity-proofing process to acquire a two-factor authentication credential or digital certificate;
- Attach the authentication credential to his or her identity;
- Set access controls so that only individuals who may legally prescribe a controlled substance are allowed to do so; and
- Access the e-prescribing or electronic health record platform.

Cost of Implementation

According to an industry analysis of e-prescribing software costs, the cost of a stand-alone e-prescribing system that meets the DEA's requirements for EPCS ranges from $170 to $650, annually.[139] The fee for initial set-up of the software may be included; however, some vendors may charge additional fees for set-up and for a token for the two-factor authentication required by the DEA.[140] In 2018, a health IT management consulting company identified the estimated cost of adding on EPCS functionality to the most widely used EHR systems, as indicated by the table below.[141]

EHR	EPCS Setup (One-time fee)	Annual Ongoing Cost
Allscripts Professional	$340 per provider	$150 per provider
Allscripts Touchworks	$6,000 per practice	$150 per provider
Amazing Charts	$0	$250 per provider
Aetna	$0	$0 per provider
Cerner	Varies based upon # of providers	
DrFirst	$90 per provider	$75 per provider
eClinicalWorks	$250 per provider	$0 per provider
E-MDs	$225 per provider	$120 per provider
Epic	Varies based upon # of providers	
GE Centricity	$0	$5,988 per provider
Greenway Intergy	$150 per provider	$90 per provider
Greenway PrimeSuite	$150 per provider	$90 per provider
NewCrop	$150 per provider	$150 per provider
NextGen	$0	included in ePrescribing
Practice Fusion	$0	included in ePrescribing

Federal Requirements and Incentives

The Health Information Technology for Economic and Clinical Health Act of 2009, authorized incentive payments through Medicare and Medicaid to health care practitioners and hospitals for meaningfully using EHRs to help offset some of the costs related to the adoption of electronic health record systems.[142] The incentive program consists of two stages. Stage one required the electronic capture of clinical data, including transmitting at least 40

[139] Eclinicworks, *E-prescribing of Controlled Substances*,. Available at https://www.eclinicalworks.com/wp-content/uploads/2016/11/ePrescribing-of-Controlled-Substances-Slick.pdf; RxNT, *ERX*. Available at https://www.rxnt.com/eprescribing/ (last visited March 17, 2025). *See also*, RxNT, *ERX*, https://www.rxnt.com/software/electronic-prescribing/ (last visited March 30, 2025).
[140] 21 C.F.R. 1311. The U.S. Drug Enforcement Administration requires electronic prescribing software for controlled substances to have two-factor authentication to verify the identity of the prescriber and protect such credentials from misuse.
[141] Point of Care Partners, *HIT Perspectives: The Impact of Cost on EPCS Adoption*, (2018). Available at https://www.pocp.com/hit-perspectives-cost-EPCS-Adoption (last visited March 30, 2025).
[142] Medscape, *EHR Incentive Programs: Achieving Meaningful Use*. Available at https://www.medscape.org/viewarticle/770841#content=0_0 (last visited March 17, 2025).

percent of eligible prescriptions electronically.[143] In stage two, health care providers must demonstrate meaningful use for a full year; stage two retains the objective that eligible prescriptions be transmitted electronically.[144] Participants could choose to participate under Medicare or Medicaid, but could only participate in one of the programs. The maximum incentive available under Medicare was $44,000 across five years and under Medicaid, $63,750 across six years.[145]

Incentive payments for the Medicare program ended in 2016, and the Medicaid program ended in 2021.[146] The Centers for Medicare and Medicaid Services subsequently launched the Promoting Interoperability Program and implemented a merit-based incentive program to reward value and outcomes.[147] The focus of the program is on interoperability, improved flexibility, and placing emphasis on the use of electronic exchange of health information between patients and providers.[148] Promoting interoperability objectives, which includes the use of e-prescribing and EHRs, may account for up to 25 percent of the final score for the merit-based incentive.[149]

According to the Office of the National Coordinator for Health Information Technology, approximately 80 percent of office-based physicians in Florida have adopted EHRs that meet the criteria for meaningful use.[150] The ONC also found that, as of June 2017, 97 percent of hospitals of Florida hospitals had adopted EHRs that meet the criteria for meaningful use.[151]

Federal Electronic Prescribing Requirements

Federal policy does not broadly mandate the use of e-prescribing for prescriptions generally, nor controlled substances specifically. Federal policy establishes requirements for e-prescribing applications used in prescribing controlled substances in order to ensure secure and fraud-free transmissions. The only circumstance where the government mandates the use of e-prescribing is for controlled substances prescribed under a Medicare Part D drug plan.

Medicare Part D Mandatory e-Prescribing

Federal law requires all Schedule II-V controlled substances prescribed under a Medicare Part D drug plan to be prescribed electronically unless an exemption applies.[152] Currently, there are three exemptions:

- The prescriber has obtained a CMS-approved waiver because the prescriber cannot meet the requirements due to circumstances beyond the prescriber's control;
- The prescriber issues 100 or fewer relevant prescriptions per year; or

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[143] *Id.*
[144] Centers for Medicare and Medicaid Services, *Stage 2 Overview Tipsheet* (2012). Available at https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/stage2overview_tipsheet.pdf (last visited March 17, 2025). For the initial year of stage 2, CMS required providers to demonstrate meaningful use for 90 days, but in subsequent year the requirement is for a full year.
[145] Centers for Medicare and Medicaid Services, *An Introduction to the Medicare EHR Incentive Program for Eligible Professionals*. Available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Medicare_Stg1_BegGuide.pdf (last visited March 17, 2025).
[146] Centers for Medicare and Medicaid Services, *Medicare and Medicaid Promoting Interoperability Program Basics*, (last rev. Aug. 2019). Available at https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/basics.html (last visited March 17, 2025). Participants must have enrolled to participate in the Medicaid program before 2016 to be eligible for incentive payments.
[147] *Id.*
[148] *Id.*
[149] Centers for Medicare and Medicaid Services, *Quality Payment Program*. Available at https://qpp.cms.gov/participation-lookup/about?py=2019 (last visited March 17, 2025), Centers for Medicare and Medicaid Services, *Merit-based Incentive Payment System: Promoting Interoperability Requirements*. Available at https://qpp.cms.gov/mips/promoting-interoperability?py=2019 (last visited March 17, 2025), and Centers for Medicare and Medicaid Services, *Quality Payment Program: Explore Measures*, available at https://www.cms.gov/medicare/quality/measures (last visited March 17, 2025).
[150] U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *Florida Health IT Summary*. Available at https://dashboard.healthit.gov/apps/health-information-technology-data-summaries.php?state=Florida&cat9=all+data (last visited March 17, 2025).
[151] *Id.*
[152] P.L. 115-271, Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).

- The prescriber is in the geographic area of an emergency or disaster declared by a Federal, State, or local government entity.

CMS monitors prescriber compliance through the EPCS Program. Prescribers who use e-prescribing for less than 70 percent of annual prescribing for controlled substances under Medicare Part D are notified of their noncompliance which may be considered by CMS during the assessment for potential fraud, waste, and abuse.[153]

Florida Electronic Prescribing Requirements

Current Florida law requires prescribers to prescribe electronically, but this requirement only applies to prescribers who have an electronic health record system. In addition, Florida law exempts prescribers from this requirement if:

- The practitioner and the dispenser are the same entity;
- The prescription cannot be transmitted electronically under the current national standard;
- The practitioner has been issued a waiver by the Department of Health;[154]
- The practitioner determines that the use of e-prescribing would delay a patient's access to a drug thus adversely impacting the patient's medical condition;
- The drug is being prescribed under a research protocol;
- The prescription is for a drug which the federal Food and Drug Administration requires the prescription contain elements that may not be included in e-prescribing;
- The prescription is for an individual receiving hospice care or a resident of a nursing home facility; or
- The practitioner determines that it is in the best interest of the patient, or the patient determines that it is in his or her own best interest, to compare prescription drug prices among area pharmacies. The practitioner must document such determination in the patient's medical record.

Current law requires prescriptions that are electronically generated and transmitted to contain the following: [155]

- The name of the prescriber;
- The name and strength of the drug prescribed;
- The quantity of the drug prescribed in numerical format;
- Directions for use;
  Date and electronic signature of the prescriber.

Under current law, e-prescribing software may not interfere with a patient's choice of pharmacy or use any means, such as pop-up ads, advertising, or instant messaging, to influence or attempt to influence the prescribing decision of the prescriber at the point of care.[156] E-prescribing software may provide formulary information, as long as nothing makes it more difficult or precludes a prescriber from selecting a specific pharmacy or drug.[157]

E-Prescribing Requirements and Exemptions: Federal[158] vs State			
Exemptions	**Federal: Medicare Part D Patients**	**Florida: All Patients**	**Florida: HB 1297**
	Controlled Substances	All Drugs	All Drugs

[153] Centers for Medicare & Medicaid (2024). *CMS Electronic Prescribing for Controlled Substances (EPCS) Program*. Available at https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program (last visited Mar. 17, 2025).
[154] Waivers are not to exceed one year, and may be issued due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or another exceptional circumstance demonstrated by the practitioner.
[155] S. 456.42, F.S.
[156] S. 456.43, F.S.
[157] *Id.*
[158] The shaded cells were federal exemptions at the time the Florida e-prescribing exemptions became law but the federal government subsequently repealed them.

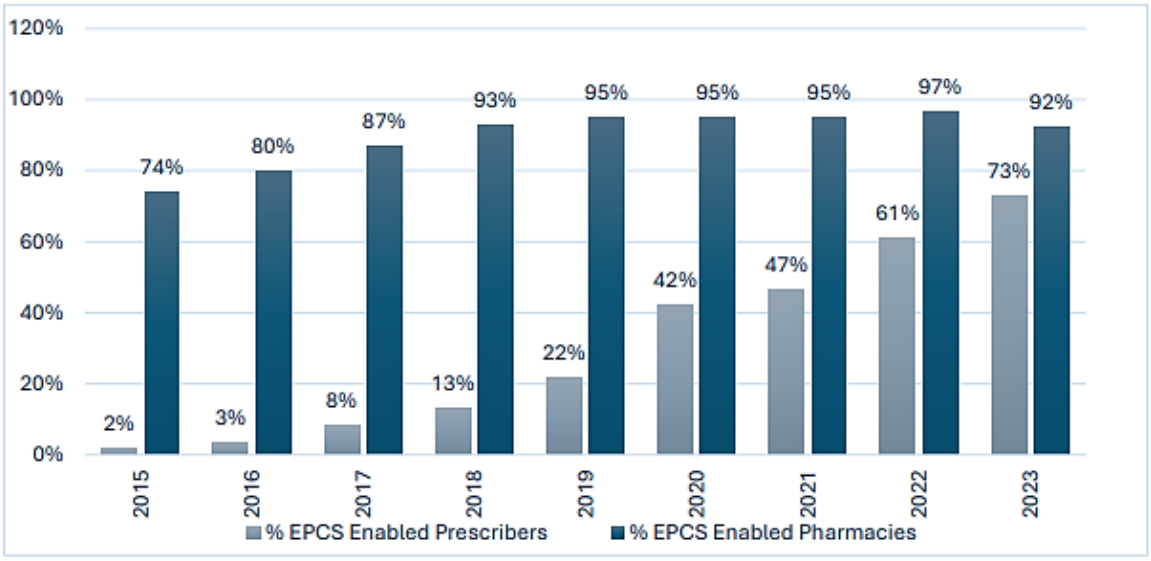
1. Prescriber and dispenser are the same entity		X	
2. Prescriber issues fewer than 100 relevant prescriptions annually	X		X
3. Prescriber is located in a declared emergency or disaster area	X		X
4. Prescriber issued a waiver due to circumstances outside the prescriber's control	X	X	X
5. Prescriber does not maintain an electronic health record system		X	
6. Prescription cannot be eRx under the most recent National Council for Prescription Drug Programs SCRIPT Standard		X	
7. Prescriber determines it is impractical to obtain an eRx drug in a timely manner and such delay would adversely impact patient's medical condition		X	
8. Drug is being prescribed under a research protocol		X	
9. FDA requires prescription elements not available in eRx		X	
10. Patient is receiving hospice care or is a resident of a nursing home		X	
11. Prescriber or patient determines it is in the patient's best interest to compare drug prices among pharmacies		X	

E-Prescribing Data

The Agency for Health Care Administration (AHCA) maintains a clearinghouse of information on electronic prescribing, including trends on the adoption and use of e-prescribing in the state.[159] AHCA annually publishes a report on its website on the implementation of electronic prescribing by health care practitioners, facilities, and pharmacies.[160] The reports provide metrics on e-prescribing in Florida based on data provided by national e-prescribing networks and Florida Medicaid.

In its 2024 annual report, AHCA reported that the average number of e-prescriptions per month increased from 372,085 in 2008 to 17,472,000 in 2023. The report also states that e-prescribers in the state increased by 106% with 73% of prescribers and 92% of pharmacies now capable of e-prescribing. The graph below indicates that growth.[161]

[159] S. 408.0611, F.S.
[160] *Id.*, and Agency for Health Care Administration, Florida Center for Health Information and Transparency, *Florida Electronic Prescribing Annual Report for 2023* (2024). Available at https://ahca.myflorida.com/content/download/25388/file/2023eRxAnnualReport_Final.pdf (last visited March 17, 2024).
[161] Agency for Health Care Administration, Florida Center for Health Information and Transparency, *Florida Electronic Prescribing Annual Report for 2023*, (Nov. 2024). Available at https://ahca.myflorida.com/content/download/25388/file/2023eRxAnnualReport_Final.pdf (last visited March 17, 2025).



BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health & Human Services Committee	17 Y, 6 N, As CS	4/21/2025	Calamas	Osborne
THE CHANGES ADOPTED BY THE COMMITTEE:	• Expanded the scope of practice for dental hygienists to allow for the use of lasers under the general supervision of a dentist. • Required a dental hygienist to complete board-approved continuing education before a hygienist may use lasers for non-diagnostic purposes.			

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.
