# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 1549 Health Care
**SPONSOR(S):** Health Care Appropriations Subcommittee, Grant
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Select Committee on Health Innovation | 11 Y, 0 N | McElroy | Calamas |
| 2) Health Care Appropriations Subcommittee | 14 Y, 0 N, As CS | Smith | Clark |
| 3) Health & Human Services Committee | | McElroy | Calamas |

## SUMMARY ANALYSIS

CS/HB 1549 revises or creates numerous provisions of Florida law relating to the state's health care workforce, health care services, health care practitioner licensure and regulation, health care facility licensure and regulation, the Medicaid program, and health-care-related education programs. Specifically, the bill revises:

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

The bill amends statutes relating to:

- Licensure by endorsement for health care practitioners;
- Mobile response team standards;
- Licensure for foreign-trained physicians;
- Certification of foreign medical schools;
- Medical faculty certificates;
- Autonomous-practice nurse midwives;
- Developmental research laboratory schools; and
- The Linking Industry to Nursing Education (LINE) Fund.

The bill creates:

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

The bill provides that Florida will enter into the Interstate Medical Licensure Compact, the Audiology and Speech-Language Pathology Interstate Compact, and the Physical Therapy Licensure Compact. The bill contains numerous appropriations related to the programs and revisions listed above, as well as for provider reimbursement in the Medicaid program.

The bill provides various appropriations to implement provisions in the bill. The bill will have no impact on local government. *See* Fiscal Comments.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

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

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and the growth of the U.S. population[3] and the expanded access to health care under the federal Affordable Care Act.[4] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.[5] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

**Health Care Shortage Designations**

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

Health Care Professional Shortage Areas

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

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

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

[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Health Workforce Shortage Areas*, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited January 22, 2024).

[3] The U.S. population is expected to increase by 79 million people by 2060, and average of 1.8 million people each year between 2017 and 2060. *See* U.S. *Census Bureau, Demographic Turning Points for the U.S.; Population Projections for 2020 to 2060* (February 2020), available at https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited January 22, 2024).

[4] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034,* (June 2021), available at https://www.aamc.org/media/54681/download (last visited January 22, 2024).

[5] The nation's 65-and-older population is projected to nearly double in size in coming decades, from 49 million in 2016 to 95 million people in 2060. *See:* U.S. Census Bureau, *U.S. and World Population Clock*, available at https://www.census.gov/popclock/, and U.S. Census Bureau, *U.S. Population Projected to Begin Declining in Second Half of Century* (Nov. 9, 2023), available at https://www.census.gov/newsroom/press-releases/2023/population-projections.html (both sites last visited January 22, 2024).

[6] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, available at https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited January 22, 2024).

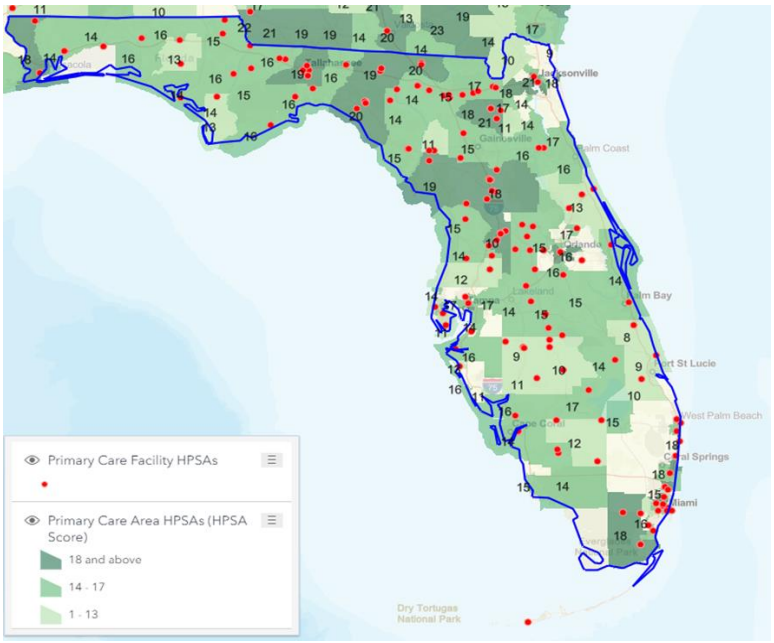
[7] *What is a Shortage Designation?*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas, (last visited January 22, 2024).

[8] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics, Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023), available at https://data.hrsa.gov/topics/health-workforce/health-workforce-shortage-areas?hmpgtile=hmpg-hlth-srvcs (last visited January 22, 2024). To generate the report, select "Designated HPSA Quarterly Summary."

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

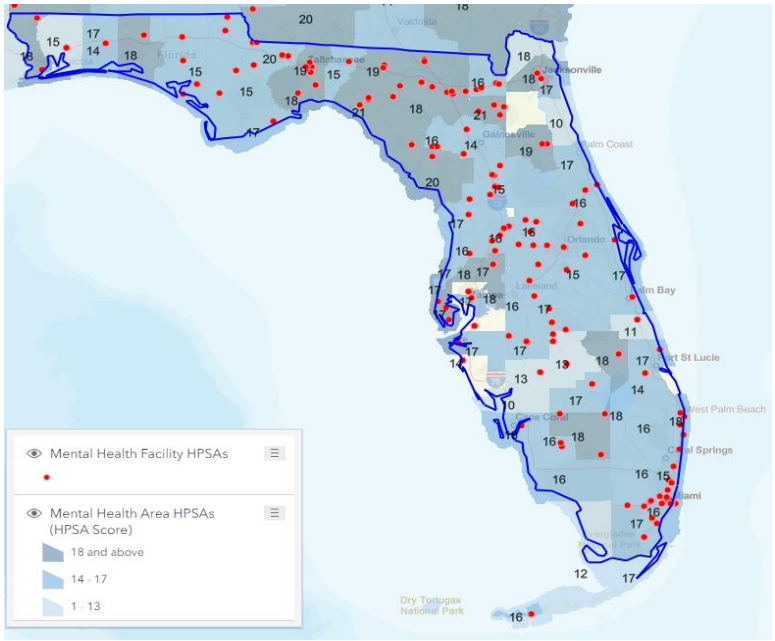
## Primary Care HPSAs

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




## Mental Health HPSAs

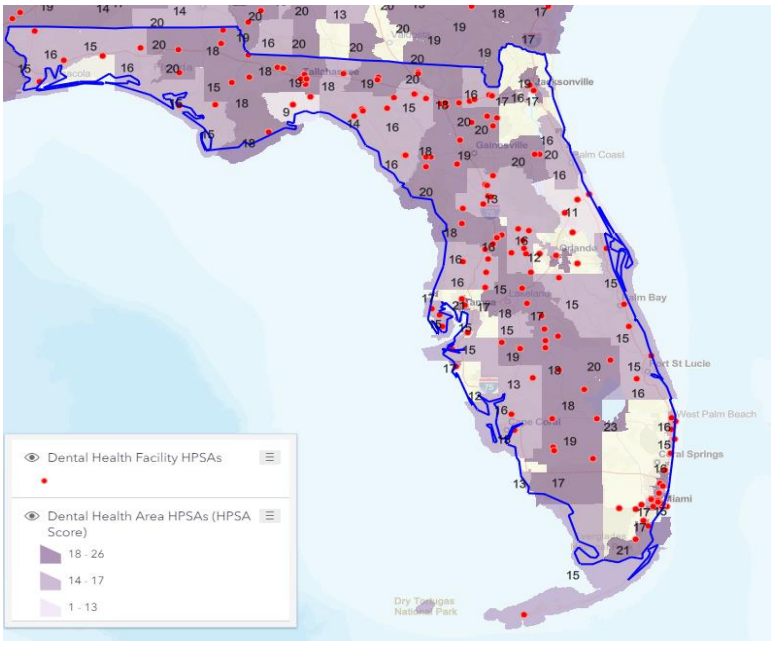
Below is a map of mental health HPSAs in Florida with their associated HPSA scores.




## Dental HPSAs

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

[9] *Scoring Shortage Designations*, HRSA, available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring, (last visited January 22, 2024).
[10] The three maps were generated with HRSAs map tool, available at https://data.hrsa.gov/maps/map-tool/, (last visited January 22, 2024).

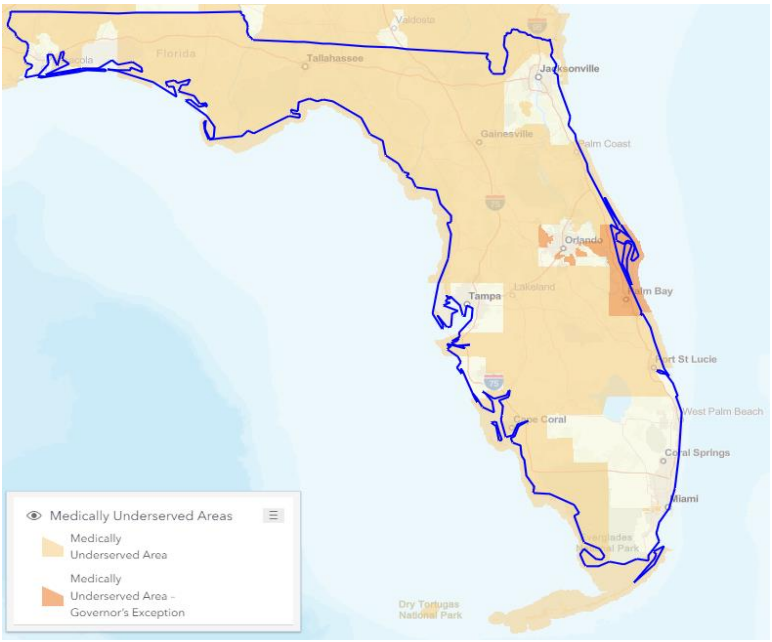



Medically Underserved Areas

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

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

Below is a map of the MUAs in Florida.




[11] *Health Professional Shortage Areas (HPSAs) and Your Site,* National Health Service Corps, available at https://bhw .hrsa.gov/sites/default/files/bureau-health-workforce/workforce-shortage-areas/nhsc-hpsas-practice-sites.pdf, (last visited January 22, 2024).

## The Florida Physician Workforce

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

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

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

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

## IHS Markit Report – Physician Supply and Demand Deficit

In 2021, IHS Markit prepared a report for the Safety Net Hospital Alliance of Florida and the Florida Hospital Association that examined Florida's statewide and regional physician workforce with projections on workforce changes out to 2035.[15] Between 2019 and 2035, the report estimates that while physician supply will increase by six percent overall and by three percent to four percent for primary care, the demand for physician services in Florida will grow by 27 percent.[16] While there is already supply and demand deficits for physician services (estimated by 2019 numbers to be at 1,977 for primary care and 1,650 for non-primary care), the significant growth in the demand for physician services that may outpace the growth in the physician workforce over the next decade is estimated to create a shortfall of 7,872 in primary care physicians by 2035 and an overall decline in the adequacy for all non-primary care specialties from 95 percent in 2019 to 77 percent in 2035.[17]

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[12] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2019 to 2034,* (June 2021), prepared for the AAMC by HIS, Ltd., p. viii, available at https://www.aamc.org/media/54681/download (last visited January 22, 2024). This includes both allopathic and osteopathic physicians.

[13] Department of Health, *2023 Florida Physician Workforce Annual Report*, Nov. 1, 2023, available at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/physician-workforce-development-and-recruitment/2023DOHPhysicianWorkforceAnnualReport-FINAL.pdf (last visited January 22, 2024).

[14] *Id.*

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

[16] *Id.* at V.

[17] *Id.* at VI

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

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

Source: IHS Markit © 2021 IHS Markit

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

## The Florida Nursing Workforce

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

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

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

[18] *Id.* at 10

[19] Florida Center for Nursing, *The State of the Nursing Workforce in Florida, 2023*, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1957&PortalId=0&TabId=151 (last visited January 22, 2024).

[20] *Id.*

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

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

**Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act**

Heath Care Practitioner Licensure and Regulation

The Division of Medical Quality Assurance (MQA), within the DOH, has general regulatory authority over health care practitioners.[25] The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions.[26] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.

The self-stated purpose of the MQA is to protect health care consumers.[27] Regulation of health care licensure broadly aids the consumer in differentiating the trained from the untrained and enhancing public health initiatives.[28] Through licensure regulation, the state is able to establish a minimum standard of education and experience necessary for a person to practice a particular profession and ensure a minimum standard of care through enforcement mechanisms which may result in action against a professional's license.[29]

The MQA is statutorily responsible for the following boards and professions established within the division:[30]

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;

[21] The Department of Economic Opportunity, Bureau of Workforce Statistics and Economic Research, 2020 - 2028 Employment Projections, updated Feb. 9, 2021, *2020 - 2028 College Projections Report,* available at https://lmsresources.labormarketinfo.com/college_projections/index.html (last visited January 22, 2024).
[22] Florida Center for Nursing, *The State of the Nursing Workforce in Florida, 2023*, Tampa, Fl., prepared by Rayna M. Letourneau, PhD, RN, E.D., available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1957&PortalId=0&TabId=151 (last visited January 22, 2024).
[23] Florida Commerce, Bureau of Workforce Statistics and Economic Research, *Occupational Data Search, 29-2061 Licensed Practical or Vocational Nurses*, available at https://floridajobs.org/economic-data/employment-projections/occupational-data-search (last visited January 22, 2024).
[24] Florida Center for Nursing, *Florida Autonomous Practice 2020-2021*, available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1975&PortalId=0&TabId=151 (last visited January 22, 2024).
[25] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[26] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2022-2023*. Available at https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/annual-reports.html (last visited January 22, 2024)
[27] *Id*.
[28] Adams, T.L. (2020). *Health professional regulation in historical context: Canada, the USA and the UK (19th century to present)*. Hum Resour Health 18, 72. https://doi.org/10.1186/s12960-020-00501-y
[29] Section 456.072(2), F.S.; *see also, supra* note **Error! Bookmark not defined.**.
[30] Section 456.001(4), F.S; *see also supra* note **Error! Bookmark not defined.**.

- Nursing assistants, as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;
- Midwifery, as provided under ch. 467, F.S.;
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.;
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.;
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.;
- Respiratory therapy, as provided under part V of ch. 468, F.S.;
- Dietetics and nutrition practice, as provided under part X of ch. 468, F.S.;
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.;
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.;
- Electrolysis, as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part III of ch. 483, F.S.;
- Medical physicists, as provided under part IV of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, created under ch. 490, F.S.;
- School psychologists, as provided under ch. 490, F.S.;
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.; and
- Emergency medical technicians and paramedics, as provided under part III of ch. 401, F.S.

DOH and the practitioner boards have different roles in the regulatory system. Boards establish practice standards by rule, pursuant to statutory authority and directives. DOH receives and investigates complaints about practitioners, and prosecutes cases for disciplinary action against practitioners.[31] The boards determine the course of action and any disciplinary action to take against a practitioner.[32] For professions in which there is no board, DOH determines the action and discipline to take against a practitioner and issues the final orders.[33] DOH is responsible for ensuring that licensees comply with the terms and penalties imposed by the boards.[34]

Pathways to Licensure

Licensure by examination is the most common pathway for individuals seeking initial licensure, particularly among health care professionals educated and trained in Florida. The requirements to qualify for licensure by examination are specified in each profession's respective practice act and vary based on professional standards. However, licensure by examination generally requires, at a minimum, the following from applicants:

- Completion of an approved[35] educational program;
- Completion of an approved[36] licensure or certification examination with a passing score; and
- Submission of an application approved by DOH in conjunction with an application fee.

Licensure by endorsement is the most common alternative to licensure by examination. Licensure by endorsement is an expedited licensure process which allows a health care professional to become licensed in one state based upon holding a substantially equivalent health care professional license in another state.

[31] Section 456.072(2), F.S.
[32] Section 456.072(2), F.S.
[33] *Id.* Professions which do not have a board include naturopathy, nursing assistants, midwifery, respiratory therapy, dietetics and nutrition, electrolysis, medical physicists, and school psychologists.
[34] Department of Health, *Prosecution Services*. Available at http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited January 22, 2024).
[35] The requirements for "approval" of an educational program or examination vary by profession; some practice acts outline specific qualifications such as accreditation with a national board, while others grant the relevant regulatory board discretion in determining such requirements.
[36] *Id.*

Currently, only 20 of the health care professions regulated by DOH and the boards authorize licensure by endorsement.[37]

| Professions With Licensure by Endorsement | Professions Without Licensure by Endorsement |
|---|---|
| Acupuncturist | Anesthesiologist Assistant |
| Allopathic Physician (MD) | Athletic Trainer |
| Audiologist | Chiropractor |
| Certified Nursing Assistant (CNA) | Clinical Laboratory Personnel |
| Mental Health Professions | Dental Hygienist |
| Dietitian | Dentist |
| Electrologist | EMT/Paramedic |
| Licensed Practical Nurse | Genetic Counselor |
| Massage Therapist | Hearing Aid Specialist |
| Midwifery | Medical Physicist |
| Nursing Home Administrator | Optometrist |
| Occupational Therapist | Optician |
| Pharmacist | Orthotist and Prosthetist |
| Physical Therapist | Osteopathic Physician (DO) |
| Physical Therapist Assistant | Physician Assistant |
| Psychologist | Podiatrist |
| Radiation Technician | Registered Pharmacy Technician |
| Registered Nurse (RN/APRN) | |
| Respiratory Therapist | |
| Speech-Language Pathologist | |

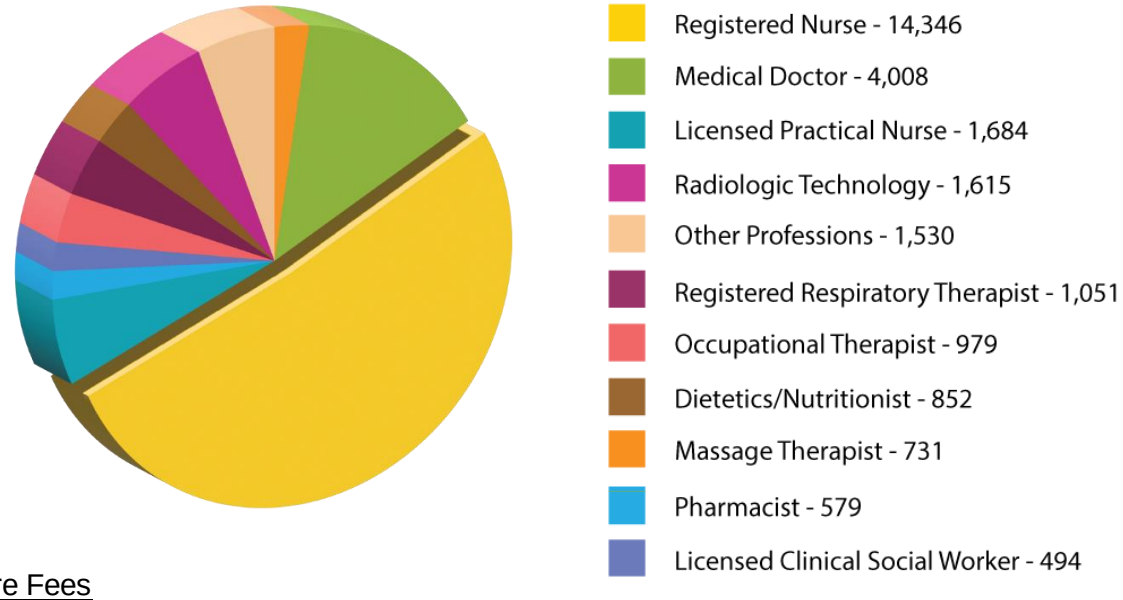
Even amongst the professions which allow licensure by endorsement there are no standard requirements. Rather, requirements to obtain licensure by endorsement vary greatly by profession. For example, some professions require that the applicant submit to a background screening,[38] have a certain amount of prior practice experience,[39] or pass an exam on Florida rules and laws relevant to the profession[40].

[37] Email from Jennifer Wenhold, Division of Medical Quality Assurance Director, Florida Department of Health, RE: Endorsement Info, July 13, 2023. On file with the Health and Human Services Committee.
[38] Allopathic Physicians, Certified Nursing Assistants, Licensed Practice Nurses, Registered Nurses, and Massage Therapists.
[39] Allopathic Physicians, Mental Health Professionals, Licensed Practical Nurses, Registered Nurses, Nursing Home Administrators, Pharmacists, and Psychologists.
[40] Mental Health Professions, Licensed Practical Nurses, Registered Nurses, Nursing Home Administrators, Pharmacists, Psychologists, and Radiology Technicians.

From FY 18-19 to FY 22-23 DOH approved 136,533 licenses by endorsement.[41] During that time DOH reduced the average business days to issue such licenses from 2.5 days to 1.4 days.[42]

| Fiscal Year | Total Licenses by Endorsement | Avg Business Days to Issue License |
|---|---|---|
| FY 18-19 | 21,492 | 2.495 |
| FY 19-20 | 21,841 | 2.091 |
| FY 20-21 | 29,258 | 1.450 |
| FY 21-22 | 36,073 | 1.380 |
| FY 22-23 | 27,869 | 1.379 |
| **Overall** | **136,533** | **1.672** |

In FY 2022-23 DOH approved 27,869 applications for licensure by endorsement for the various professions listed below.[43]




Licensure Fees

Health care practitioner regulation is typically funded through fees paid during the licensure process. Current law expressly states that all costs of regulating health care professions and practitioners are to be borne solely by licensees and licensure applicants.[44] Such fees should be reasonable and not serve as a barrier to licensure.

Section 456.025(3), F.S., directs the regulatory boards, or DOH if there is no board, to establish by rule license fee amounts for the profession it regulates and ensure that such fees are adequate to cover all anticipated expenses relating to the board and maintain a reasonable cash balance. Fees are to be based upon long-range estimates prepared by the Department of the Revenue required to implement laws relating to the regulation of professions by the department and the board.

Current law specifies that licensure renewal fees established by rule must be:[45]

- Based on revenue projections prepared using generally accepted accounting procedures;

[41] Correspondence from Department of Health to Health and Human Services Committee staff dated 8/11/23 on file with the Health and Human Services Staff.
[42] *Id.*
[43] Florida Department of Health presentation to the Health Care Regulation Subcommittee on November 16, 2023.
[44] Section 456.025, F.S.
[45] Section 456.025(1), FS. Such fees are subject to challenge pursuant to Ch. 120, F.S.

- Adequate to cover all expenses relating to that board identified in the department's long-range policy plan;
- Reasonable, fair, and not serve as a barrier to licensure;
- Based on potential earnings from working under the scope of the license; and
- Similar to fees imposed on similar licensure types.

The fees may not be more than 10 percent greater than the actual cost to regulate that profession for the previous biennium.

Effect of bill - Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act

The bill repeals existing licensure by endorsement statutes and establishes a single standardized process for licensure by endorsement for all health care professions regulated by DOH, not just the 20 that currently allow it. The bill requires applicants seeking licensure by endorsement to submit an application and meet the following requirements:

- Hold an active, unencumbered license with a similar scope of practice[46] in a US jurisdiction;
- Have obtained a passing score on a national licensure examination or national certification, if the profession requires such;
- Have actively practiced the profession for two of the last four years;
- Attest that they are not currently subject to a disciplinary hearing for any offense related to the profession for which they are applying for licensure in any US jurisdiction, nor has had disciplinary action taken against their license in the five years preceding application;
- Meet the financial responsibility requirements of s. 456.048 or the applicable practice act, if required for the profession for which the applicant is seeking licensure; and
- Submit a set of fingerprints for a background screening pursuant to s. 456.0135, if required for the profession for which he or she is applying.

Under the bill, a person is ineligible for licensure under this section if they:

- Have a complaint, allegation, or investigation pending before a licensing entity in another state, the District of Columbia, or a possession or territory of the United States;
- Have been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Have had a health care provider license revoked or suspended from another of the United States, the District of Columbia, or a United States territory or has voluntarily surrendered any such license;
- Have been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his or her name removed from the data bank.

The bill gives the regulatory boards, or DOH if there is no board, the authority to revoke a license issued under this section upon a finding that the individual provided false or misleading material information in an application for licensure.

The bill requires that the regulatory board, or DOH if there is no board, issue a license under this section within 7 days after receipt of all required documentation for the application.

The bill authorizes the regulatory board, or DOH if there is no board, to require the applicant complete a jurisprudence exam specific to Florida state laws and rules as a condition of licensure if such an exam is required by ch. 456, F.S., or the relevant practice act.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill requires DOH submit an annual report to the Governor, the President of the Senate, and the Speaker of the House, providing the following information:

[46] The bill defines "scope of practice" to mean the full spectrum of functions, procedures, actions, and services that a health care practitioner is deemed competent and authorized to perform under a license.

- The number of applications for licensure received under this section, distinguished by profession.
- The number of licenses issued under this section.
- The number of applications submitted under this section which were denied and the reason for such denials.
- The number of complaints, investigations, or other disciplinary actions taken against health care practitioners who are licensed under this section.

The bill directs the regulatory boards and DOH to adopt rules necessary to implement these provisions by December 1, 2024.

**Interstate Compacts**

An interstate compact is a legal contractual agreement between two or more states to address common problems or issues, create an independent, multistate governmental authority, or establish uniform guidelines, standards or procedures for the compact's member states.[47] Article 1, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other, without the consent of Congress. However, the case law has provided that not all interstate agreements are subject to congressional approval, but only those that may encroach on the federal government's power.[48]

To join a compact, states must enact compact legislation and meet the requirements of the compact. Florida is a party to multiple interstate health care compacts, including the Nurse Licensure Compact,[49] Professional Counselors Licensure Compact,[50] and the Psychology Interjurisdictional Compact.[51]

Telehealth

A Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[52] or a registered out-of-state-health care provider is authorized to provide health care services to Florida patients via telehealth.[53] Current law sets the standard of care for telehealth providers at the same level as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

Under current law, in-state and out-of-state licensed or registered health care practitioners may use telehealth to provide health care services to patients physically located in Florida.[54] The law does not allow health care practitioners to use telehealth to provide services to out-of-state patients.

Sovereign Immunity

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through an enactment of general law. [55]

Current law partially waives sovereign immunity, allowing individuals to sue state government and its subdivisions.[56] Individuals may sue the government under circumstances where a private person "would be liable to the claimant, in accordance with the general laws of [the] state . . . . " Section 768.28(5), F.S., imposes a $200,000 limit on the government's liability to a single person, and a $300,000 total limit on liability for claims arising out of a single incident.

[47] National Center for Interstate Compacts, *What Are Interstate Compacts?,* https://compacts.csg.org/compacts/ (Last visited January 22, 2024).
[48] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[49] Section 464.0095, F.S.
[50] Section 491.017, F.S.
[51] Section 490.0075, F.S.
[52] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[53] Section 456.47(4), F.S.
[54] Section 456.47(1) and (4), F.S.
[55] Fla. Const. art. X, s. 13.
[56] Section 768.28, F.S.

Impaired Practitioner Program

The impaired practitioner treatment program was created to provide resources to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or both, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety.[57] For a profession that does not have a program established within its individual practice act, the DOH is required to designate an approved program by rule.[58] By rule, DOH designates the approved program by contract with a consultant to initiate intervention, recommend evaluation, refer impaired practitioners to treatment providers, and monitor the progress of impaired practitioners. The impaired practitioner program may not provide medical services.[59]

Audiology and Speech-Language Pathology Interstate Compact

*Speech-Language Pathology and Audiology Licensure in Florida*

The Board of Speech-Language Pathology and Audiology (SLPA Board) within the DOH oversees the licensure and regulation of speech-language pathologist and audiologist in Florida.[60] DOH must issue a license to any applicant whom the Board certifies is qualified to practice speech-language pathology or audiology and who has paid the initial licensure fee.[61]

To receive license to practice speech-language pathology, an individual must meet the following requirements:[62]

- Received a master's or doctoral degree with a major emphasis in speech-language pathology from an institution accredited by:
  - An agency recognized by the Council for Higher Education Accreditation;
  - The U.S. Department of Education or its successor;
  - An institution that is a member in good standing with the Association of Universities and Colleges of Canada; or
  - From an institution outside of the U.S. or Canada that has been determined to be equivalent to an accredited U.S. institution;
- Completed 300 clock hours of supervised clinical experience with at least 200 hours in the area of speech-language pathology;
- Completed nine months of professional employment experience, or its part-time equivalent; and
- Passage of the national examination (Praxis Exam) within three years prior to the date of application.

To receive license to practice audiology, an individual must meet the following requirements:[63]

- Received a doctoral degree with a major emphasis in audiology from an institution accredited by;
  - An agency recognized by the Council for Higher Education Accreditation or its successor;
  - The U.S. Department of Education;
  - An institution that is a member in good standing with the Association of Universities and Colleges of Canada; or
  - From an institution outside of the U.S. or Canada that has been determined to be equivalent to an accredited U.S. institution;
- Completed 300 clock hours of supervised clinical experience with at least 200 hours in the area of audiology;

[57] Section 456.076, F.S. The provisions of s. 456.076, also apply to veterinarians under s. 474.221, F.S. and radiological personnel under s. 486.315, F.S.
[58] Section 456.076(1), F.S.
[59] Rule 64B31-10.001(1)(a), F.A.C.
[60] Section 468.1135, F.S.
[61] *Id.*
[62] Section 468.1185. F.S., and Florida Board of Speech-Language Pathology & Audiology, *Speech-Language Pathologist*, at https://floridasspeechaudiology.gov/licensing/speech-language-pathologist/, (last visited January 22, 2024).
[63] Section 468.1185. F.S., and Florida Board of Speech-Language Pathology & Audiology, *Audiologist*, at https://floridasspeechaudiology.gov/licensing/audiologist/, (last visited January 22, 2024).

- Completed eleven months of clinical experience or one-year clinical work experience within the doctoral program; and
- Passage of the Praxis exam within the three years prior to the date of application.

*Audiology and Speech-Language Pathology Interstate Compact*

The Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC or compact) is mutual recognition licensure compact that allows an audiologist or speech-language pathologists who holds a license in their home state to apply for a "compact privilege" to practice in another state.[64] Compact privilege also authorizes an audiologist or speech-language pathologist licensed by a home state to practice telehealth in member states. To exercise compact privilege under the ASLP-IC, the audiologist or speech-language pathologist must:

- Hold an active license in the home state (for purposes of compact privilege, the licensee may only hold one home state license at a time);
- Be eligible for compact privilege in any member state;
- Have no encumbrance on any state license;
- Have no adverse actions taken against the license or compact privilege within the previous two (2) years;
- Pay any applicable fees, including any state fee, for the compact privilege;
- Function within the laws and regulations of the remote state when providing services in such state; and
- Report to the ASLP-IC Commission any adverse action taken against his or her license by any non-member state within 30 days from the date the adverse action is taken.

If the home state license is encumbered, the licensee shall lose the compact privilege in all remote states until the home state is no longer encumber and two (2) years have passed since the adverse action.

Under the compact, the privilege to practice is renewable upon the renewal of the home state license.

*State Participation in the Audiology and Speech-Language Pathology Interstate Compact*

To participate in the ASLP-IC states must implement procedures for considering the criminal history records (background screening) of applicants for the initial privilege to practice.[65] These procedures must include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information.

Each member state must require an applicant to obtain or retain a license in the home state and meet the home state's qualifications for licensure or renewal of licensure, as well as, all other applicable state laws. Applicants for licensure to meet the following requirements:

For licensure as an audiologist the applicant must:

- Have graduated with a master's or doctoral degree (on or before December 31, 2007) or with a doctoral degree (on or after January 1, 2008) in audiology, or an equivalent degree regardless of degree name, from a program that is accredited by an accrediting agency recognized by the Council for Higher Education Accreditation, or its successor, or by the U.S Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or
    - Have graduated from an audiology program that is housed in an institution of higher education outside of the United States and:

[64] The ASLP-IC defines "compact privilege" as the authorization granted by a remote state to allow a licensee from another member state to practice as an audiologist or speech-language pathologist in the remote state under its laws and rules. *Id.*

[65] Under the compact, the initial privilege to practice is granted when a licensed audiologist or speech-language pathologist completes the necessary steps to gain eligibility to apply for the privileges to practice under the compact. These steps are completed by the licensee's home state, and include verifying the applicant's education, examination record, and criminal history record. ASLP-IC, Frequently Asked Questions, at https://aslpcompact.com/wp-content/uploads/2023/10/ASLP-IC-Frequently-Asked-Questions-10-7-23.pdf, (last visited January 22, 2024).

        - For which the program and institution have been approved by the authorized accrediting body in the applicable country; and
        - The degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.
- Have completed supervised clinical practicum experience from an accredited educational institution or its cooperating programs as required by the board;
- Passed a national examination approved by the compact's commission;
- Hold an active, unencumbered license;
- Have not be convicted or found guilty, or have entered into an agreed disposition, of a felony related to the practice of audiology, under applicable state or federal criminal law; and
- Have a valid United States Social Security or National Practitioner Identification number.

For licensure as a speech-language pathologist the applicant must:

- Have graduated with a master's degree from a speech-language pathology program that is accredited by an organization recognized by the U.S. Department of Education and operated by a college or university accredited by a regional or national accrediting organization recognized by the board; or
    - Have graduated from a speech-language pathology program that is housed in an institution of higher education outside of the United States and;
        - For which the program and institution have been approved by the authorized accrediting body in the applicable country; and
        - The degree program has been verified by an independent credentials review agency to be comparable to a state licensing board-approved program.
- Have completed a supervised clinical practicum experience from an educational institution or its cooperating programs as required by the ASLP-IC commission;
- Have completed supervised postgraduate professional experience as required by the ASLP-IC commission;
- Passed a national examination approved by the compact's commission;
- Hold an active, unencumbered license;
- Have not be convicted or found guilty, or have entered into an agreed disposition, of a felony related to the practice of speech-language pathology, under applicable state or federal criminal law;
- Have a valid United States Social Security or National Practitioner Identification number.

*Audiology and Speech-Language Pathology Compact Commission*

The compact establishes the Audiology and Speech-Language Compact Commission (Commission) which is responsible for establishing rules and enforcing the compact. Commission membership consist of compact member states. The licensing board of each member state must delegate two (2) members, one audiologist and one speech-language pathologist, to serve on the Commission. Delegates must be current members of the state licensing board. Each delegate is granted one vote in regard to the promulgation of rules and creation of bylaws and must have the opportunity to participate in the business and affairs of the Commission. The compact requires the Commission to establish and elect an executive committee to act on behalf of, and within the powers granted to them by the Commission.

All Commission and executive committee meetings must be open to the public and public notice of the meeting must be provided. However, the Commission or the executive committee or other committees of the Commission may convene in a closed, non-public meeting if confidential or privileged information must be discussed. Nothing in the compact shall be construed to be a waiver of sovereign immunity.

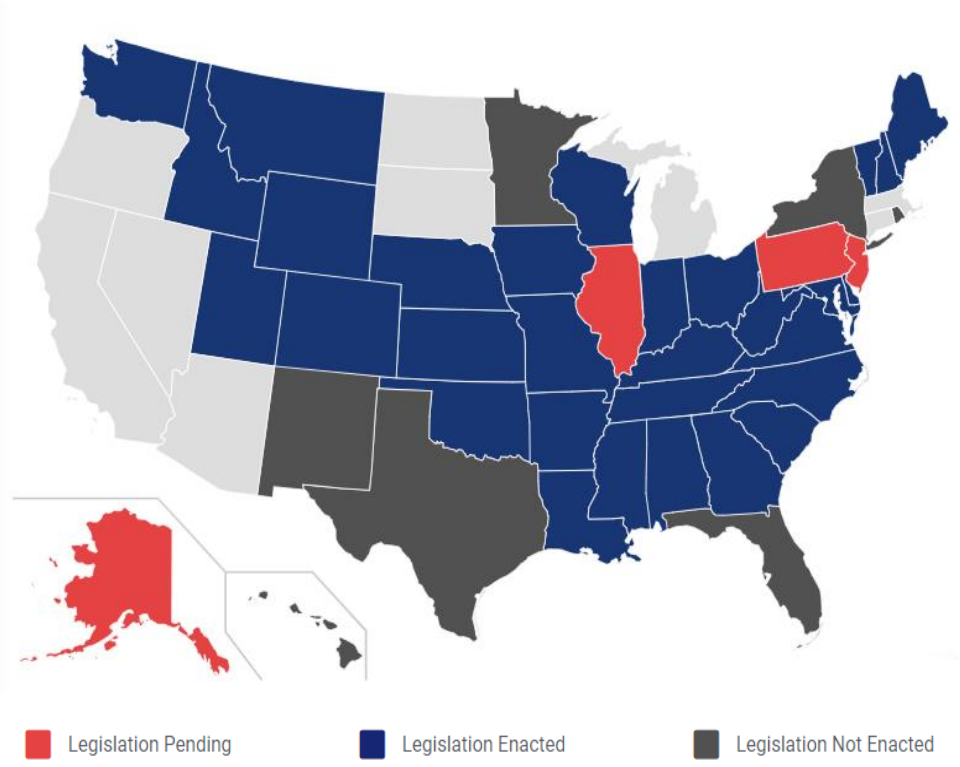
*Shared Data System*

The compact requires the Commission to develop and maintain a coordinated database and reporting system containing certain information on all licensed individuals in member states. Member states must submit licensure information to the data system for all audiologists and speech-language pathologists to whom the compact applies, including, identifying information, licensure data, and any adverse actions taken against the provider's license. The shared data system will allow for the expedited sharing of adverse action against the license of compact audiologists and speech-language

pathologists.[66] A member state contributing information to the data system may designate information that may not be shared with the public without the express permission of that member state.

*Enactment of the Compact*

The compact became effective on the date of enactment in the tenth compact state which occurred on April 1, 2021.[67] ASLP-IP currently has 29-member states. The compact is in the process of establishing the commission and operationalizing the compact. The compact anticipate it will begin accepting applications for compact privilege in early 2024.




Effect of the bill - Audiology and Speech-Language Pathology Interstate Compact

The bill requires Florida to join the Audiology and Speech-Language Pathology Interstate Compact. The bill authorizes eligible licensed Florida audiologists and speech-language pathologists to obtain a compact privilege to provide services to out-of-state patients in person or through telehealth in compact member states. It also allows out-of-state licensed audiologists and speech-language pathologists in member states with a Florida compact privilege to provide services to Floridians via telehealth and in-person.

The bill amends current law to allow compact implementation. The bill requires the SLPA Board to implement procedures for background screening, including the submission of fingerprints or other biometric-based information, of applicants applying for licensure for the purpose of obtaining the applicant's criminal history information. The bill also requires the SLPA Board to submit certain specified information on all licensed audiologists and speech-language pathologists practicing under the compact to a shared data system, including, identifying information, licensure data, and any adverse actions taken against the audiologist or speech-language pathologist's license. It requires audiologists and speech-language pathologists to withdraw from all practice under the compact if the audiologist or speech-language pathologist is in an impaired practitioner program. The bill also exempts out-of-state licensed audiologists and speech-language pathologists who practice under the compact

[66] ASLP-IC, *Section-by-Section Overview*, at https://aslpcompact.com/wp-content/uploads/2019/09/90792-ASLP-IC-Section-Flyer_Final.pdf, (last visited January 22, 2024).
[67] American Speech-Language-Hearing Association, *Nebraska Becomes the Critical 10th State to Adopt the Interstate Compact,* at https://www.asha.org/news/2021/nebraska-becomes-10th-state-to-adopt-compact/, (last visited January 22, 2024).

from licensure requirements in this state. Further, the bill authorizes the SLPA Board to take adverse action against a licensed audiologist or speech-language pathologist's privilege to practice under the compact and impose disciplinary actions for violation of prohibited acts.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill preserves the regulatory authority of the state's current system of state licensure and does not require changes to Florida's licensure and license renewal requirements.

Interstate Medical Licensure Compact

*Licensure of Florida Physicians*

The regulation of the practices of medicine and osteopathic medicine in Florida fall under chapters 458 and 459, F.S., respectively. The practice acts for both professions establish the regulatory boards, a variety of licenses, the application process with eligibility requirements, and financial responsibilities for the practicing physicians. The boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[68] Such standards may include education and training, medication including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[69]

Licensure by Examination

The general requirements for licensure under both practice acts are very similar with the obvious differences found in the educational backgrounds of the applicants. Where the practice acts share the most similarities are the qualifications for licensure. Both the Board of Medicine and the Board of Osteopathic Medicine require their respective applicants to meet these minimum qualifications:[70]

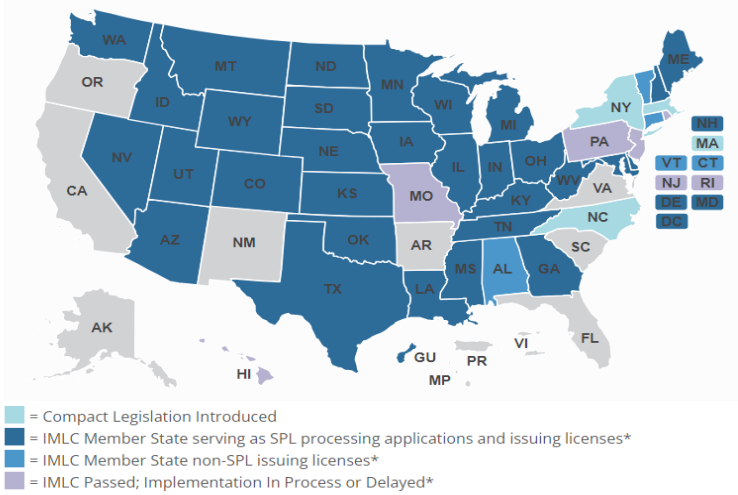
- Complete an application form as designated by the appropriate regulatory board.
- Be at least 21 years of age.
- Be of good moral character.
- Have completed at least two years (medical) or three years (osteopathic) of pre-professional post-secondary education.
- Have not previously committed any act that would constitute a violation of this chapter or lead to regulatory discipline.
- Have not had an application for a license to practice medicine or osteopathic medicine denied or a license revoked, suspended or otherwise acted upon in another jurisdiction by another licensing authority.
- Must submit a set of fingerprints to DOH for a criminal background check.
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the applicant's respective professional association.
- Demonstrate that she or he has successfully completed an internship or residency (osteopathic) or supervised clinical training (medical) of not less than 12 months in an accredited program (osteopathic) or hospital (medical) approved for this purpose by the applicant's respective professional association.
- Demonstrate that he or she has obtained a passing score, as established by the applicant's appropriate regulatory board, on all parts of the designated professional examination conducted by the regulatory board's approved medical examiners no more than five years before making application to this state; or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than five years after the applicant obtained a passing score on the required examination.

[68] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[69] *Id.*
[70] Sections 458.311 and 459.0055, F.S.

The current licensure application fee for a medical doctor is $350 and is non-refundable.[71] Applications must be completed within one year. If a license is approved, the initial license fee is $355. For osteopathic physicians, the current application fee is non-refundable $200, and if approved, the initial licensure fee is $305.[72] The same application validity provision of one year applies and the processing time of two to six months is the range of time that applicants should anticipate for a decision.[73]

*The Interstate Medical Licensure Compact*

The Interstate Medical Licensure Compact (Medical Licensure Compact or compact) creates an expedited path to licensure by setting qualifications for licensure and outlining a process for physicians to apply and receive licenses in states where they are not currently licensed.[74] Thirty-seven states, the District of Columbia, and the Territory of Guam have adopted the compact.[75]

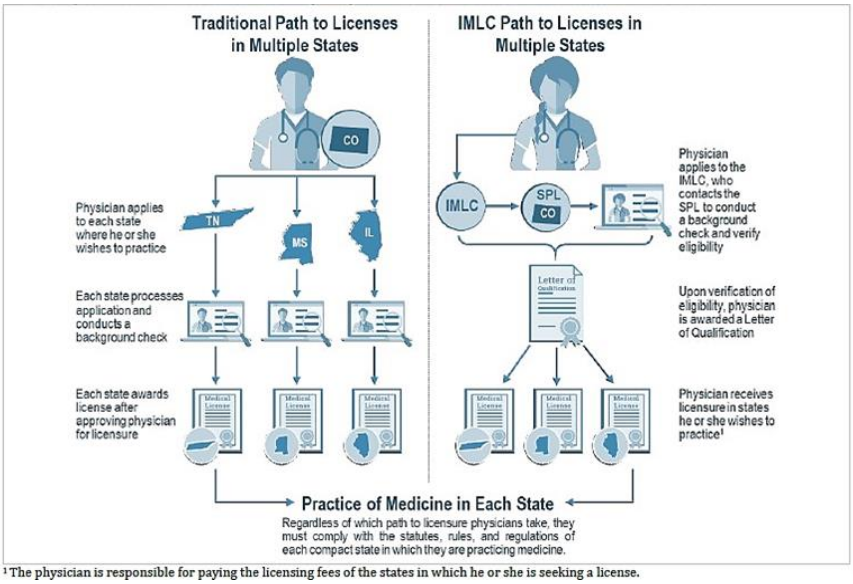



Physician Licensure under the Compact

Typically, if a physician wishes to be licensed in more than one state, the physician must separately apply to each state. The physician must submit documentation to verify qualification for licensure prior to the state issuing a license. However, under the compact the physician must designate a member state as his or her home state or state of principal licensure (SPL)[76] and file an application for an expediated license[77] with the member board (state licensing agency) of the SPL. The SPL verifies the physician's qualifications for licensure by collecting and reviewing all required documents related to training and education and performing a background screening.[78] If the physician meets the required compact qualifications, the SPL will issue a Letter of Qualification. The physician may then submit the Letter of Qualification, along with applicable fees, to the states in which the physicians wishes to be licensed.[79] The Letter of Qualification is valid for 365 days.[80]

[71] Florida Board of Medicine, *Medical Doctor - Fees,* available at https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited January 22, 2024).
[72] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees,* available at https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/#tab-fees, (last visited January 22, 2024).
[73] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process,* available at https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/#tab-process, (last visited January 22, 2024).
[74] *Id.*
[75] Interstate Medical Licensure Compact, *The IMLC*, available at https://www.imlcc.org/participating-states/, (last visited January 22, 2024).
[76] The compact defines the "state of principal license" as a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.
[77] The compact defines "expediated license" as a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact.
[78] Interstate Medical Licensure Compact, *About*, available at https://www.imlcc.org/a-faster-pathway-to-physician-licensure/, (last visited January 22, 2024).
[79] *Id.*
[80] Rule 5.6 of the IMLCC Rules, available at https://www.imlcc.org/wp-content/uploads/2023/11/IMLCC-Rule-Chapter-5-Expedited-Licensure-Amended-November-14-2023-FINAL.pdf, (last visited January 22, 2024).

**Licensure under the Compact**[81]




[1] The physician is responsible for paying the licensing fees of the states in which he or she is seeking a license.

To be eligible to receive a license under the compact, a physician must hold a full unrestricted medical license in a compact member state that can be declared the physician's SPL. To designate a state as a SPL, the physician must ensure that at least one of the following apply:

- The physician's primary residence is in the SPL;
- At least 25% of the physician's practice of medicine occurs in the SPL;
- The physician is employed to practice medicine by a person, business or organization located in the SPL; or
- The physician uses the SPL as his or her state of residence for U.S. Federal Income Tax purposes.

The physician must also meet the following requirements to be licensed under the compact:

- Have graduated from a medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;
- Have passed each component of the United States Medical Licensing Exam (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMPLEX-USA) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;
- Have successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;
- Hold a specialty certification or time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Board of Osteopathic Specialties; however, the times unlimited specialty certificate does not have to be maintained once the physician is initially determined through the expedited Compact process;
- Possess a full and unrestricted license to engage in the practice of medicine issued by a member board;[82]
- Have never been convicted received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

[81] Office of Program Policy Analysis and Gov't Accountability, Florida Legislature, *Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts*, Report No. 19-07, (Oct. 1, 2019) available at https://oppaga.fl.gov/Documents/Reports/19-07.pdf, (last visited January 22, 2024).

[82] The compact defines "member board" as the state agency in the member state that acts in the sovereign interest for the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government. Under the compact, DOH would be the member board in Florida.

- Have never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license;
- Have never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and
- Not be under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

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

Upon completion of eligibility verification process by the compact member state, applicants suitable for an expedited license are directed to complete the registration process with the Interstate Medical Licensure Compact Commission (Commission), including the payment of any fees. After completing the registration process and paying the appropriate fees, the member board will issue an expedited license to the physician. The license authorizes the physician to practice medicine in the issuing state consistent with the laws and regulations of the issuing member board and member state.

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

The compact authorizes the Commission to adopt rules regarding the application process, including the payment of any applicable fees, and the issuance of an expedited license. The compact also gives states issuing an expediated license authorizing physicians to practice in the compact the discretion to impose fees for licensure or renewal through the compact. However, the compact does not authorize DOH to collect a fee, but rather states that fees of this kind are allowable under the compact.

License Renewal and Continued Compact Participation

The compact requires the member board to notify a physician at least 90 days prior to the expiration of a license issued through the compact.[83] To renew a compact license the physician must:

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

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

The Commission collects any renewal fees charged for the renewal of a license and distribute the fees to the appropriate member board. Upon payment of fees, a physician's license may be renewed. Any information collected during the renewal process shall also be shared with all member boards.

Interstate Medical Licensure Compact Commission

The compact establishes the Interstate Medical Licensure Compact Commission to oversee and maintain the administration of the compact. The Commission has all the duties, powers, and responsibilities set forth in the compact, plus any other powers conferred upon it by the member states

[83] Rule 5.8 of the IMLCC Rules, available at https://www.imlcc.org/wp-content/uploads/2023/11/IMLCC-Rule-Chapter-5-Expedited-Licensure-Amended-November-14-2023-FINAL.pdf, (last visited January 22, 2024).

through the compact. Each member state has two voting representatives appointed by each member state to serve as Commissioners. For states with separate regulatory boards for allopathic and osteopathic regulatory boards, such as Florida, the member appoints one representative from each member board. A Commissioner must be:

- An allopathic or osteopathic physician appointed to a member board.
- An executive director, executive secretary, or similar executive or a member board, or
- A member of the public appointed to a member board.

The compact requires the Commission to establish an executive committee, which shall have the power to act on behalf of the Commission. All Commission and executive committee meetings must be open to the public and public notice must be provided. However, a meeting may be closed to the public, in full or in portion, when it is determined by a two-thirds vote of the Commissioners present, that an issue or matter to be discussed is confidential or privileged as designated in the compact. The Commission must make its information and official records, to the extent, not otherwise designated in the compact or by its rules, available to the public for inspection.

Coordinated Information System

The compact requires the Commission to establish a database of all physicians licensed, or who have applied for licensure under the compact. Member boards are required to report any public action or complaints against a licensed physician who has applied or received an expedited license through the compact and any disciplinary or investigatory information as required by Commission rule. Member boards may also report any non-public complaint, disciplinary, or investigatory information not required to be reported to the Commission.

Each member board must report the name, National Provider Identifier (NPI) number, and all necessary and proper disciplinary or investigatory information of a public complaint or action on a form provided by the Commission within 10 business days after a public complaint or action has been entered.[84] Member boards must submit updated reports to the Commission upon changes to the status of any reported action.

All information provided to the Commission or distributed by the member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters. Upon request, member boards may share complaint or disciplinary information about physicians to another member board.

Effect of the bill - Interstate Medical Licensure Compact

The bill requires Florida to join the Interstate Medical Licensure Compact by adopting the entirety of the compact terms into state law. Florida physicians will be able to obtain an expedited licensure in compact member states. Likewise, eligible physicians in compact member states will be able to obtain expedited licensure in Florida.

The bill also requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

Physical Therapy Licensure Compact

*Physical Therapy Licensure in Florida*

The Physical Therapy Practice Act is codified in chapter 486, F.S. Licensed physical therapist are regulated by the Board of Physical Therapy Practice (Board) within in DOH.[85] A physical therapist must

[84] Rule 6.3 of the IMLCC Rules, available at https://imlcc.org/wp-content/uploads/2018/12/IMLCC-Rule-Chapter-6-Coordinated-Information-System-Joint-Investigations-and-Disciplinary-Actions-Adopted-November-16-2018.pdf (last visited January 22, 2024). "Necessary and proper disciplinary and investigatory information" includes type of action, date action was taken, whether the action results in removal of the physician's Compact license, whether the action is to initiate a joint investigation, name of Board or entity that took action, and current status and changes in status of any action.
[85] Section 486.023, F.S.

practice physical therapy in accordance with the provisions of the practice act and Board rules.[86] The practice of physical therapy includes:[87]

- The performance of physical therapy assessments;
- The treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other health condition, and the rehabilitation of such disability, injury, disease, or other health condition by alleviating impairments, functional movement limitations, and disabilities by designing, implementing, and modifying treatment interventions through use of:
    - Therapeutic exercise;
    - Functional movement training in self-management and in-home, community, or work integration or reintegration;
    - Manual therapy;
    - Massage;
    - Airway clearance techniques;
    - Maintaining and restoring the integumentary system and wound care;
    - Physical agent or modality;
    - Mechanical or electrotherapeutic modality;
    - Patient-related instruction;
    - The use of apparatus and equipment in the application of the above;
- The performance of tests of neuromuscular functions as an aid to the diagnosis or treatment of any human condition; or
- The performance of electromyography as an aid to the diagnosis of any human condition only upon compliance with the criteria set forth by the Board of Medicine.

To be eligible for licensure as a physical therapist (PT), an applicant must:[88]

Be 18 years of age;
Be of good moral character; and
Satisfy the following educational requirements:

- Have graduated from a school of physical therapy which has been approved for the educational preparation of physical therapists by the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation or the U.S. Department of Education at the time of her or his graduation and have passed, to the satisfaction of the Board, the American Registry Examination prior to 1971 or a national examination approved by the Board to determine her or his fitness for practice as a physical therapist;
- Have received a diploma from a program in physical therapy in a foreign country and have educational credentials deemed equivalent to those required for the educational preparation of physical therapists in this country, as recognized by the appropriate agency as identified by the Board, and have passed to the satisfaction of the Board an examination to determine her or his fitness for practice as a physical therapist;[89] or
- Be entitled to licensure without examination.

*Physical Therapist Assistant Licensure*

A physical therapist assistant (PTA) is an individual who performs patient-related activities, including the use of physical agents, under the direction of a physical therapist.[90] To be licensed as a PTA an applicant must:[91]

- Be at least 18 years old;
- Be of good moral character; and

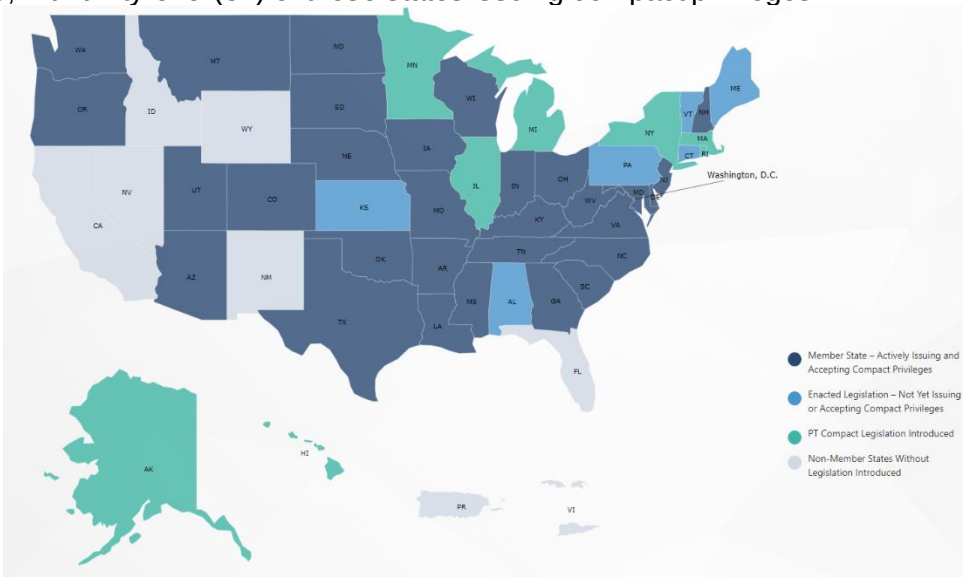
[86] Sections 486.031 and 486.102, F.S.
[87] Section 486.021(11), F.S.
[88] Section 486.031, F.S.
[89] Section 486.081, F.S.
[90] Section 486.021(6), F.S.
[91] Section 486.102, F.S.

- Have graduated from a school that provides at least a two-year course of study for the preparation of physical therapist assistants and is recognized by the appropriate accrediting agency recognized by the Commission on Recognition of Postsecondary Accreditation or the U.S. Department of Education at the time of graduation and have passed a board-approved examination to determine his or her fitness to practice; or
- Have graduated from a school that provides a course for physical therapist assistants in a foreign country that has educational credentials that have been deemed equivalent to the requirements in this country, as recognized by the agency, as identified by the board, and have passed a board-approved examination to determine his or her fitness to practice;
- Be entitled to licensure without examination as provided in section 486.107, F.S., or
- Have been enrolled between July 1, 2014, and July 1, 2016, in a physical therapist assistant school in this state which was accredited at the time of enrollment; and have graduated or is eligible to graduate from such school by July 1, 2018, and have passed a board-approved examination to determine his or her fitness to practice.

The board may issue a PTA license to an applicant who presents evidence to the board, under oath, of licensure in another state, the District of Columbia, or a territory, if the board determines that standards for registering or licensing of a physical therapist assistant in such other state are as high as the standards of this state.[92]

*Physical Therapy Licensure Compact*

The Physical Therapy Licensure Compact (PT Compact or compact) is a mutual recognition licensure compact that allows a physical therapist who holds a license in their home state to apply for a "compact privilege" to practice in another state. Compact privilege also authorizes a physical therapist licensed by a home state to practice telehealth in member states. Currently, there are thirty-seven (37) compact member states, with thirty-one (31) of those states issuing compact privileges.[93]




To exercise compact privilege under the PT Compact, PTs and PTAs must meet all of the following requirements:

- Hold a license in the home state;
- Have no encumbrance on any state license;
- Be eligible for compact privilege in all member states;
- Have no adverse actions taken against the license or compact privilege within the preceding two (2) years;
- Notify the Physical Therapy Compact Commission that the licensee is seeking compact privilege within a remote state;

[92] Section 486.107, F.S.
[93] PT Compact, *Compact Map*, available at https://ptcompact.org/ptc-states, (last visited January 22, 2024).

- Pay any applicable fees, including any state fee, for the compact privilege;
- Meet any jurisprudence requirement established by the remote state in which the licensee is seeking compact privilege; and
- Report any adverse action taken by any nonmember state to the Physical Therapy Compact Commission within 30 days after the action is taken.

To maintain compact privilege, the licensee must continue to meet all of the requirements above in the remote state. A licensee providing physical therapy in a remote state must also comply with the laws and rules of that state and are subject to that state's regulatory authority.

Compact privilege is valid until the expiration date for the home license and is renewable upon renewal of the home state license. If the home state license is encumbered, the licensee shall lose compact privilege to practice in all remote states until the home state license is no longer encumbered and two (2) years have passed since the adverse action.

*State Participation in the Physical Therapy Licensure Compact*

Under the PT Compact, a member state must grant compact privilege to a licensee holding a valid unencumbered license in another member state. To participate in PT Compact, states must meet all of the following requirements:

- Participate fully in the Physical Therapy Compact Commission (Commission) data system, including using the Commission's unique identifier;
- Have a mechanism in place for receiving and investigating complaints about licensees;[94]
- Notify the commission of any adverse action or the availability of investigative information regarding a licensee;
- Require a criminal background check, including the submission of fingerprints or other biometric-based information, as condition of licensure;
- Comply with Commission rules;
- Require the licensee to pass a recognized national examination as a requirement for licensure;
- Have continuing competence requirements as a condition for license renewal;

*Physical Therapy Compact Commission*

The PT Compact establishes the Physical Therapy Compact Commission as the governing body and the entity responsible for creating and enforcing the rules and regulations of the compact. Each member state may delegate one member, selected by that member state's physical therapy licensing board, to serve on the Commission. The compact requires the Commission to establish and elect an executive board to act on behalf of, and within the powers granted to them by, the Commission.

All Commission meetings must be open to the public and public notice must be given. However, the Commission or the executive committee or other committees of the Commission may convene in a closed non-public meeting if confidential or privileged information must be discussed. Nothing in the compact shall be construed to be a waiver of sovereign immunity.

*Shared Data System*

The PT Compact requires the Commission to develop and maintain a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensees in member states. Compact member states must submit certain licensure information to the data system on all PTs and PTAs to whom the compact applies, including identifying information, licensure data, and any adverse actions taken against the PT or PTA's license or compact privilege. Investigative information pertaining to a licensee in any member state must be available to other member states. A member state may designate information submitted to the data system that may not be shared with the public without the express permission of that member state.

[94] Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations, including physical therapist and physical therapist assistants under the Division of Medical Quality Assurance in DOH. Section 456.072, F.S., specifies acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Section 486.125, F.S., identifies acts that constitute grounds for w hich disciplinary actions may be taken against a physical therapist or a physical therapist.

Effect of the bill - Physical Therapy Licensure Compact

The bill requires Florida to join the Physical Therapy Licensure Compact. The bill authorizes eligible licensed Florida PTs and PTAs to obtain a compact privilege to provide services to out-of-state patients in person or through telehealth in compact member states. It also allows out-of-state licensed PTs and PTAs in member states with a Florida compact privilege to provide services to Floridians via telehealth and in-person.

The bill amends current law to allow compact implementation. The bill also requires the Board of Physical Therapy Practice to submit certain specified information on all licensed PTs and PTAs under the compact to a shared data system, including, identifying information, licensure data, and any adverse actions taken against the PT or PTA's license. It requires PTs and PTAs to withdraw from all practice under the compact if the PT or PTA is in an impaired practitioner program. The bill also exempts out-of-state licensed PTs and PTAs who practice under the compact from licensure requirements in this state. The bill authorizes the Board to take adverse action against a licensed PT or PTA's compact privilege and impose disciplinary actions for violation of prohibited acts.

The bill requires DOH and the boards to comply with the licensure fee requirements of s. 456.025, F.S.

The bill preserves the regulatory authority of the state's current system of state licensure.

**Licensure of Physicians of Foreign-Trained Physicians**

Chapter 458, F.S., provides for the licensure and regulation of the practice of allopathic medicine by the Florida Board of Medicine within the DOH. The chapter imposes requirements for licensure examination and licensure by endorsement.[95]

Licensure by Examination

An individual seeking to be licensed by examination as a physician must meet the following requirements:[96]

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

[95] An individual who holds an active license to practice medicine in another jurisdiction may seek licensure by endorsement to practice medicine in Florida in lieu of examination. The applicant must meet the same requirements for licensure by examination. To qualify for licensure by endorsement, the applicant must also submit evidence of the licensed active practice of medicine in another jurisdiction for at least 2 of the preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure. S. 458.313(1)(c), F.S.

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

Licensure by Examination – Foreign-Trained Applicant

Foreign-trained applicants must meet the same requirements as U.S.-trained applicants related to age, character, background checks, prior disciplinary action, completion of post-secondary education and obtaining a passing score on the USMLE, FLEX or SPEX, as applicable. Applicants who graduated from an allopathic foreign medical school registered with the World Health Organization and certified pursuant to statute as meeting the standards required to accredit U.S. medical schools, are required to have completed at least one year of an approved residency training.[97] Applicants who graduated from an allopathic foreign medical school that has not been certified pursuant to statute must have:

- An active, valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG);
- Passed the ECFMG's examination; and
- Completed an approved residency or fellowship of at least 2 years in one specialty area.

Residency Programs

A residency, also called graduate medical education, is a training program that medical students and international medical school graduates must complete at a postgraduate hospital. The duration of the program varies in length from three to eight years depending on the specialty.[98] While in a residency program, residents train in a specialty or core program (e.g., general surgery, pediatrics, or internal medicine). The residency placement occurs during the final year of medical school. Residents are matched to a program based on certain criteria including resident preference for a particular specialty, aptitude based on medical school grades and performance in rotations, and available residency positions or slots.[99]

In Florida an approved one-year residency consists of a course of study and training in a single program for a period of at least 12 months by a medical school graduate (resident).[100] The hospital and the program in which the resident is participating must be accredited for the training and teaching of physicians by the Accreditation Council for Graduate Medical Education (ACGME), College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC) and the resident must be assigned an allocated position or slot[101] approved by the ACGME, CFPC or RCPSC.[102]

Similarly, an approved two-year residency in one specialty area consists of two progressive years in a course of study and training as long as each year is accepted by the American Board of Medical Specialties in that specialty for at least twenty-four months by a medical school graduate. The hospital and the program in which the resident is participating must meet the same accreditation and slot assignment requirements as an approved one-year residency.[103]

As noted above, foreign-trained applicants are required to complete a 1-year or 2-year approved residency to become licensed in Florida. The Florida Board of Medicine (BOM) limits the approved residencies to those accredited by the ACGME, CFPC and the RCPSC. These entities only accredit U.S. and Canadian medical residencies. Thus, a foreign-trained physician who did not complete a U.S. or Canadian residency is required to complete an additional residency irrespective of how long they may have practiced medicine and whether they previously completed a residency in another country.

Certification of Foreign Educational Institutions

[97] *Id.*
[98] USMLE Courses, *Residency & Match,* at https://www.usmle-courses.eu/residency-match/ (last visited January 22, 2024).
[99] OPPGA, *Florida's Graduate Medical Education System,* Report No. 14.08, February 2014 at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/HealthResourcesandAccess/_physician-workforce-development-and-recruitment/additional-council-resources/OPPAGAGMERepor14-08February2014.pdf (last visited January 22, 2024).
[100] 64B8-4.004 F.A.C.
[101] A residency position or slot refers to federally supported residency training slots. These slots are typically funded through Medicare Graduate Medical Education Payments, which cover Medicare's share of the costs of a hospital's approved medical residency program. These costs include direct costs of operating a residency program, such as resident stipends, supervisory physician salaries, and administrative costs. In fiscal year 2020, Medicare paid $16.2 billion for medical residency training. See Congressional Research Service, *Medicare Graduate Medical Education Payments: An Overview.,* September 29, 2022 at https://crsreports.congress.gov/product/pdf/IF/IF10960, (last visited January 22, 2024).
[102] Rule 64B8-4.004, F.A.C.
[103] *Id.*

Section 458.314, F.S., allows for the evaluation and certification of foreign medical schools that provide an education that is reasonably comparable to that of similar accredited institutions in the U.S. and which adequately prepares its students for the practice of medicine. Foreign medical schools are certified by DOH. To be considered for certification a foreign medical school must submit an application to DOH and complete the certification process outlined in Rule 64B8-14.003, F.A.C.

Effect of the bill - Licensure of Physicians of Foreign-Trained Physicians

The bill removes the current law requirement for foreign-trained physicians to complete an approved residency program in the U.S. to obtain a license to practice medicine in Florida and creates an alternative licensing requirement for graduates of a foreign medical school. Specifically, the bill allows a graduate of a foreign-trained medical school to forgo completion of an approved residency if the applicant meets all meets all of the following criteria:

- Holds an active, unencumbered license to practice medicine in a foreign country;
- Has actively practiced medicine in the four years preceding the date in which the foreign graduate submitted an application to obtain licensure;
- Has completed a residency or substantially similar postgraduate medical training in a country recognized by his or her licensing jurisdiction; or
- Has an offer for full-time employment as a physician from a health care provider that operates in Florida, and maintains employment with the employer, or another health care provider in Florida, for two consecutive years after licensure. The physician must notify the board within five days after any change of employer.

The foreign-trained applicant must still meet all other statutory requirements for licensure, including having graduated from a foreign medical school that provides an educational program reasonably comparable to that of similarly accredited institutions in the U.S.

For foreign medical schools that do not complete the certification process, the bill authorizes the Board of Medicine to exclude the foreign medical school from being considered an institution that provides medical education that is reasonably comparable to similar accredited institutions in the U.S.

**Temporary Certificates for Practice in Areas of Critical Need**

Areas of Critical Need

The Surgeon General is responsible for determining areas of critical need in the state.[104] The determination by the Surgeon General defines the areas of the state wherein a physician may be issued a temporary certificate to practice in areas of critical need. The determination also includes a provision which allows physicians with an active temporary certificate for practice in an area of critical need to continue to practice under the certificate until it is due for renewal, regardless if the location where the physician practices loses its HPSA designation.[105] In August 2022, the Surgeon General determined that all mental health and primary care Health Professional Shortage Areas (HPSA),[106] Volunteer Health Care Provider participants,[107] and free clinics are areas of critical need.[108]

Temporary Certificates for Practice in Areas of Critical Need

A temporary certificate allows a qualified physician to provide services in certain settings in areas of critical need without undergoing the process of obtaining full licensure to practice in Florida.

[104] Sections. 458.315(3)(a) and 459.0076(3)(a), F.S.
[105] *Supra*, note **Error! Bookmark not defined.**.
[106] HRSA, *What is Shortage Designation?* (2023). Available at https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas (last visited January 22, 2024).
[107] S. 766.1115, F.S. *See also*, Florida Department of Health, *The Volunteer Healthcare Provider Program Online Listing of Participating Providers*. Available at https://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-provider-listing/index.html (last visited January 22, 2024).
[108] Florida Department of Health, Determination of Areas of Critical Need Pursuant to Sections 458.315 and 459.0076, Florida Statutes (2022). Available at https://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/DeterminationofAreasofCriticalNeed-8-10-22.pdf (last visited January 22, 2024).

The Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) may issue a temporary certificate to practice in an area of critical need to a physician[109] with an active license to practice in any United States jurisdiction[110] who will:[111]

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

The BOM and the BOOM are authorized to administer an abbreviated oral examination to determine a physician's competency. A written examination is not required.[112] The boards must review the application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification within 60 days after the receipt of the application.[113] The boards may not issue a temporary certificate to a physician who is under investigation in any jurisdiction in the US for an act which would constitute a violation of the relevant practice act.[114]

A temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.[115] However, the boards must review the temporary certificate holder at least annually to ensure that he or she is in compliance with the practice act and rules adopted thereunder.[116] A board may revoke or restrict the temporary certificate for practice in areas of critical need if noncompliance is found.[117]

There are currently 934 physicians with active temporary certificates to practice in areas of critical need.[118] The BOM and the BOOM are not authorized under current law to issue temporary certificate for practice in areas of critical need to physician assistants.[119] Likewise, the Board of Nursing (BON) is not authorized to issue temporary certificates to practice in areas of critical need to advanced practice registered nurses (APRNs).

Physician Assistants and APRNs

Physicians assistants (PA) and APRNs are non-physician advanced practice providers, sometimes considered "physician extenders."[120] PAs and APRNs are able to complement the physician workforce in a manner that expands the capacity of a health care system while ensuring safe and efficient patient care.[121] The role of PAs and APRNs is especially important in areas experiencing a shortage of health care providers.

PA is a health care practitioner who practices under the direct or indirect supervision of an allopathic or osteopathic physician. PAs may provide a number of medical services including:[122]

[109] Allopathic physicians are licensed and regulated by the Board of Medicine (BOM), pursuant to Ch. 458, F.S. Osteopathic physicians are licensed and regulated by the Board of Osteopathic Medicine (BOOM), pursuant to Ch. 459, F.S.
[110] Sections 458.315 and 459.0076, F.S.
[111] Sections 458.315(2) and 459.0076(2), F.S.
[112] Sections 458.315(3)(d) and 459.0076(3)(d), F.S.
[113] *Id.*
[114] Sections 458.315(2) and 459.0076(2), F.S.
[115] Sections 458.315(3) and 459.0076(3), F.S.
[116] *Id.*
[117] *Id.*
[118] Correspondence from the Department of Health to Health and Human Services Committee staff dated December 14, 2023. On file with the Health and Human Services Committee.
[119] In Florida, PAs are governed by the respective physician practice act governing the physician under which they practice. As such, PAs are governed by either ch. 458, F.S., if they practice under an allopathic physician, or by ch. 459, F.S., if they practice under an osteopathic physician.
[120] Milewski, M.D., Coene, R.P., Flynn, J.M., Imrie, M.N., Annabell, L., Shore, B.J., Dekis, J.C., Sink, E.L. (2022). *Better Patient Care Through Physician Extenders and Advanced Practice Providers*. Journal of Pediatric Orthopaedics 42, 18-S24. DOI: 10.1097/BPO.0000000000002125
[121] Johal, J., & Dodd, A. (2017). Physician extenders on surgical services: a systematic review. Canadian journal of surgery. Journal canadien de chirurgie, 60(3), 172–178. https://doi.org/10.1503/cjs.001516
[122] Florida Academy of Physician Assistants, *What is a PA*? Available at https://www.fapaonline.org/page/whatisapa (last visited January 22, 2024).

- Physical examinations;
- Diagnosis and treatment of illness;
- Counsel on preventative health care;
- Assistance in surgery; and
- Prescribing of medication.

PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.[123] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[124] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than ten PAs at any time.[125]

An APRN is a licensed professional nurse who is additionally licensed in an advanced nursing practice, including certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric nurses.[126] In addition to the practice of professional nursing,[127] APRNs perform advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[128] APRNs are also authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[129]

Effect of the bill - Temporary Certificates for Practice in Areas of Critical Need

The bill authorizes the BOM and BOOM to issue temporary certificates to practice in areas of critical need to physician assistants under the same specified criteria as required for physicians to practice in those areas under a temporary certificate.

The bill authorizes the BON to issue temporary certificates to practice in areas of critical need to APRNs who hold a valid license in any U.S. jurisdiction and meets the educational and training requirements established by the BON. To be eligible for a temporary certificate an APRN must practice in one of the following settings:

- An area of critical need;
- A county health department; correctional facility;
- A Department of Veterans' Affairs clinic;
- A community health center funded by s. 329, s. 330, or s. 340 of the United States Public Health Services Act; or other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of underserved populations in this state.

The bill requires the BON to review an application and issue the temporary certificate, notify the applicant of denial, or notify the applicant that the board recommends additional assessment, training, education, or other requirements as a condition of certification within 60 days after the receipt of the application. The BON may administer an abbreviated oral examination to determine an applicant's competency, but may not require a regular, written examination.

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

[123] Sections 458.347(2)(f), F.S., and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.
[124] Rules 64B8-30.012, F.A.C., and 64B15-6.010, F.A.C.
[125] Sections 458.347(15), F.S., and 459.022(15), F.S.
[126] Section 464.003(3), F.S. In 2018, the Florida Legislature enacted a law which changed the occupational title from "Advanced Registered Nurse Practitioner (APRN)" to "Advanced Practice Registered Nurse (APRN)," and also reclassified a Clinical Nurse Specialist as a type of APRN instead of a stand-alone occupation (*see* ch. 2018-106, Laws of Fla.).
[127] "Practice of professional nursing" means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences. *See* s. 464.003(19), F.S.
[128] Section 464.012(3)-(4), F.S.
[129] Section 464.003, F.S., and s. 464.012, F.S.

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

An APRN must notify the BON of all approved institutions in which the APRN practices within 30 days of accepting employment. A certificate holder may work for any approved entity in an area of critical need or as authorized by the State Surgeon General.

**Graduate Assistant Physician Licensure**

Limited Licenses

Both the BOM and the BOOM are authorized to issue limited licenses. Licensed allopathic physicians are issued limited licenses to practice in areas of critical need, and licensed osteopathic physicians are issued limited licenses to practice in areas of critical need or medically underserved areas, though the process and authorizations for each are slightly different.[130]

An allopathic physician wishing to obtain a limited license to practice in the employ of a public or private 501(c)(3) non-profit[131] agency or institution located in a BOM determined area of critical medical need, must submit an application and fee, unless the applicant includes an employer's statement that the position is uncompensated, in which case all fees are waives, and demonstrates that the applicant:

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

If it has been more than three years since the limited license applicant has been in active practice, the full-time director of the county health department, or a BOM approved licensed physician, must supervise the applicant for six months after licensure, unless the BOM determines that a shorter period will be sufficient. Procedures for such supervision shall be established by the BOM.

The BOOM is also authorized to issue limited licenses to certain osteopathic physicians who will only practice in areas of critical need or in medically underserved areas. A limited license may be issued to an osteopathic physician who:[132]

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

If it has been more than three years since the osteopathic limited license applicant has actively practiced medicine, the full-time director of the local county health department must supervise the applicant for at least six months after the issuance of the limited license unless the BOOM determines a shorter period will be sufficient.[133]

The BOOM must review the practice of each osteopathic physician who holds a limited license at least biennially to ensure that he or she is in compliance with the practice act and rules adopted thereunder.[134]

[130] Sections 458.317 and 459.0075, F.S.
[131] Section 501(c)(3) of the Internal Revenue Code.
[132] Section 459.0075, F.S., and Fla. Admin. Code R. 64B15-12.005 (2023).
[133] Section 459.0075(2), F.S.
[134] Section 459.0075(5), F.S.

Graduate Medical Education

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.[135] Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.[136]

The National Residency Matching Program (NRMP) matches allopathic and osteopathic medical school graduates to GME programs. The GME application process is competitive and graduates typically apply for more than one residency.[137] In 2023, the residency match had a 99% position fill rate.[138] Despite this success rate there are still a significant number of graduates that fail to match. For example, in 2023, there were 3,000 medical school graduates nationwide that failed to match with a GME program.[139] These graduates are unable to provide care to patients until they are matched with a GME program which may take multiple application cycles.

Currently, neither the BOM nor the BOOM are authorized to issue limited licenses to allopathic and osteopathic school graduates who fail to match with a GME program.

Effect of the bill - Graduate Assistant Physician Licensure

The bill authorizes the BOM and BOOM to issue a graduate assistant physician (GAP) license to a graduate of an allopathic or osteopathic medical school who has not matched with a GME program. The BOM and the BOOM, respectively, must issue a GAP license for a duration of two years to an applicant who meet all of the following:

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

The bill prohibits the DOH from issuing a limited license, or the BOM or the BOOM from certifying any applicant for a limited licensure, who is under investigation in another jurisdiction for an offense which

[135] *Graduate Medical Education That Meets the Nation's Health Needs*, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited January 22, 2024).
[136] *Id.*
[137] *Graduate Medical Education in Florida*, Office of Program Analysis and Government Accountability, December 2023, available at https://oppaga.fl.gov/Products/ReportDetail?rn=23-GME (Last visited January 22, 2024).
[138] *Id.*
[139] *Medical Students Show Leadership in Call for More GME Slots*, American Medical Association, April 17, 2023 (available at https://www.ama-assn.org/education/gme-funding/medical-students-show-leadership-call-more-gme-slots, Last visited January 22, 2024).

would constitute a violation of ch. 456, F.S., orch. 458 and 459, F.S., as applicable; and the applicant is subject to disciplinary action under ss. 458.331 and 459.015. F.S., as appropriate. If a board finds that an individual has committed an act or offense in any jurisdiction which would constitute the basis for disciplining a physician under ss. 458.331 or 459.015, F.S, as applicable, the board may enter an order imposing one of the following terms:

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

The bill authorizes a one-time renewal for one additional year of the limited license provided licensee submits to the appropriate board documentation of:

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

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

- May supervise no more than two GAP licensees;
- Must be physical presence at the location where the services are rendered; and
- Must draft the protocol to specify the duties and responsibilities of the limited licensed GAP as specified by board rule.

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

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

**Medical Faculty Certificates**

The BOM may issue medical faculty certificates. Medical faculty certificates allow physicians to practice medicine in Florida without the prerequisite of sitting for and successfully passing a national examination. While they have the same rights and responsibilities as other licensed physicians,[140] physicians issued medical faculty certificates may only practice in conjunction with a full-time faculty position at an accredited medical school and its affiliated clinical facilities or teaching hospitals.[141]

A physician is eligible to receive a medical faculty certificate without examination if they fulfill all of the following prerequisites:[142]

- A graduate of an accredited medical school or its equivalent, or a graduate of a foreign medical school listed with the World Health Organization.
- Hold a valid, current license to practice medicine in another jurisdiction.
- Complete an application form and remit a nonrefundable application fee not to exceed $500.[143]
- Complete an approved residency or fellowship of at least one year or equivalent training.
- Are at least 21 years of age.
- Are of good moral character.

[140] Section 458.3145(3), F.S.
[141] Section 458.3145(2), F.S.
[142] Section 458.3145(1), F.S.
[143] BOM's nonrefundable application fee for medical faculty certificates is $350. If the application is for an initial license, an initial license fee adds another $355 to the total. In addition, BOM charges a Neurological Injury Compensation Association (NICA) Fund fee between $0 and $5,000 depending on practitioner status. For medical faculty certificate applicants who seek authorization to dispense pharmaceuticals, there is a $100 dispensing practitioner fee. Board of Medicine, *Application for Medical Faculty Certificate for Allopathic Physicians*, p. 4 (revised Dec. 2020) https://flboardofmedicine.gov/apps/app-medical-faculty-certificate.pdf (last visited Dec. 13, 2023).

- Have not committed any act in Florida or any other jurisdiction which would constitute the basis for disciplining a physician.
- Complete, before medical school, the equivalent of 2 academic years of preprofessional, postsecondary education, as determined by BOM.[144]
- Accept a full-time faculty appointment to teach in a program of medicine at one of the following schools:
    - The University of Florida.
    - The University of Miami.
    - The University of South Florida.
    - The Florida State University.
    - The Florida International University.
    - The University of Central Florida.
    - The Mayo Clinic College of Medicine and Science (Jacksonville).
    - The Florida Atlantic University.
    - The Johns Hopkins All Children's Hospital (St. Petersburg).
    - Nova Southeastern University.
    - Lake Erie College of Osteopathic Medicine.

Medical faculty certificates automatically expire when the physician's relationship with the medical school terminates or after a period of 24 months.[145] Medical faculty certificates are renewable every 2 years, but the physician must apply for the renewal and provide certification by the dean of the medical school that the physician is a distinguished medical scholar and an outstanding practicing physician.[146] An annual review of each medical faculty certificate recipient is made by the dean of the certificate recipient's accredited 4-year medical school and reported to BOM.[147]

In any year, the maximum number of extended medical faculty certificate holders may not exceed 30 persons at each medical school.[148] The exception is The Mayo Clinic College of Medicine and Science in Jacksonville where the maximum number of extended medical faculty certificate holders may not exceed 10 persons.[149]

As of August 17, 2023, BOM oversees 58 active number of certificate holders at the following institutions:[150]

| Medical School of Teaching Institution | Medical Faculty Certificate Holders |
|---|---|
| H. Lee Moffitt Cancer Center and Research Institute (USF)[151] | 0 |
| Florida Atlantic University | 0 |
| Florida International University | 2 |
| Florida State University | 1 |
| Lake Erie College of Osteopathic Medicine | 0 |
| Nova Southeastern University | 1 |
| The Johns Hopkins All Children's Hospital (St. Petersburg) | 0 |
| The Mayo Clinic College of Medicine and Science (Jacksonville) | 2 |
| University of Central Florida | 0 |
| University of Florida | 32 |
| University of Miami | 18 |
| University of South Florida | 2 |

[144] This education requirement is only applicable to applicants who graduated medical school after October 1, 1992. s. 458.3145(1)(h), F.S.
[145] Section 458.3145(2), F.S.
[146] *Id*.
[147] Section 458.3145(5), F.S.
[148] Section 458.3145(4), F.S.
[149] *Id*.
[150] Correspondence from Department of Health to Health and Human Services Committee dated December 14, 2023 (on file with the Health and Human Services Committee). Data reflects the number of medical certificate holders employed full-time on August 17, 2023. Thus, this number for any day of the year could be different than the number (70) published in MQA's Annual Report and Long-Range Plan FY 22-23.
[151] Sections 458.1345(4), 1004.43, F.S.

For FY 22-23, a total of 29 initial medical faculty certificates were issued out of 45 initial applications received.[152] Out of the total 45,352 complaints and 5,246 investigations that MQA's Bureau of Enforcement handled during FY 22-23, none involved medical faculty certificates.[153]

Effect of the bill - Medical Faculty Certificates

The bill eliminates the cap on the maximum number of medical faculty certificates that the BOM may issue to eligible physicians.

**Restricted Licenses For Certain Experienced Foreign-Trained Physicians**

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

Effect of the bill - Restricted Licenses For Certain Experienced Foreign-Trained Physicians

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

**Autonomous APRN Practice**

Current law authorizes an APRN who meets certain eligibility criteria to engage in autonomous practice only in primary care, which includes family practices, general pediatrics and general internal medicine, as defined by BON rule and midwifery, without a supervising physician or written protocol with a physician.[154] The BON has defined primary care by rule to include the "physical and mental health promotion, assessment, evaluation, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, inclusive of behavioral and mental health conditions."[155]

To engage in autonomous practice, an APRN must hold active and unencumbered Florida or multi-state license and have:

- Completed at least 3,000 clinical practice hours or clinical instructional hours[156] supervised by a physician with an active license within the five-year period immediately preceding the registration request;
- Not have been subject to any disciplinary action during the five years immediately preceding the application;
- Completed three graduate-level semester hours, *or the equivalent*, in pharmacology and three graduate-level semester hours, *or the equivalent,* in differential diagnosis within the five-year period preceding the registration request;[157] and
- Any other registration requirements provided by BON rule.

An autonomous APRN registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN and RN. To maintain autonomous APRN registration, an

[152] *See footnote 150*.
[153] *Id*.
[154] Section 464.0123(3)(a)1., F.S.
[155] Fla. Admin. Code R. 64B9-4.001(12), (2023).
[156] The bill defines "clinical instruction" as education provided by faculty in a clinical setting in a graduate program leading to a master's or doctoral degree in a clinical nursing specialty area.
[157] *See* Fla. Admin. Code R. 64B9-4.020(3),(2023) where the BON defined, by rule, *the equivalent of* three graduate-level semester hours in pharmacology and *the equivalent of* three graduate-level semester hours in differential diagnosis as equal to forty-five (45) Continuing Education credits offered in those areas by the entities set forth in Section 464.013(3)(b), F.S. and Fla. Admin. Code R. 64B9-4.002(2), (2023).

autonomous APRN must complete at least 10 hours of BON approved CE for each biennial renewal in addition to the 30 hours of CE required for renewal of the APRN license.[158]

Autonomous Practice by Certified Nurse Midwives (CNM)

CNMs is an APRN who has a specialty certification in midwifery. A CNM provides care during pregnancy, childbirth, and the postpartum period, as well as sexual and reproductive health care, gynecologic health care, and family planning services.[159]

A CNM may perform the following procedures to the extent authorized by the established protocol approved by the health care facility in which they are operating, or by the supervising physician if performing a delivery in a patient's home:[160]

- Perform superficial minor surgical procedures.
- Manage the patient during labor and delivery to include amniotomy, episiotomy, and repair.
- Order, initiate, and perform appropriate anesthetic procedures.
- Perform postpartum examination.
- Order appropriate medications.
- Provide family-planning services and well-woman care.
- Manage the medical care of the normal obstetrical patient and the initial care of a newborn patient.

A CNM who is registered to practice autonomously may only perform midwifery services[161] if they have a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician.[162] CNMs have encountered difficulty obtain written referral agreements from physicians. Currently, only 83 of the 1,202 licensed CNMs in Florida are registered for autonomous practice.[163]

Effect of the bill - Autonomous Practice by Certified Nurse Midwives (CNM)

The bill revises the requirements under which an autonomous CNM may provide out-of-hospital intrapartum care. The bill outlines specific safety procedures that must be in place before an autonomous CNM may provide out-of-hospital intrapartum care, and eliminates the existing requirement that an autonomous CNM have a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician to do so.

As a condition precedent to providing out-of-hospital intrapartum care, a CNM engaged in autonomous practice must maintain a written policy for the transfer of patients needing a higher acuity of care or emergency services. The written policy must include an emergency plan-of-care form to be signed by the patient before admission. The plan-of-care form must contain:

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

When an emergency transfer of care is required, the bill requires an autonomous CNM provide the receiving provider with the patient's emergency plan-of-care form, and the patient's prenatal records

[158] Current law provides an exception to the 10 hours of CE in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.
[159] American College of Nurse-Midwives, *Definition of Midwife and Scope of Practice of Certified Nurse-Midwives and Certified Midwives*. Available at https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007476/Definition%20Midwifery%20Scope%20of%20Practice_2021.pdf (last visited January 22, 2024).
[160] S. 464.012(4)d), F.S.
[161] *See* s. 464.012(4)(c), F.S.
[162] S. 464.0123(3)(b), F.S.

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

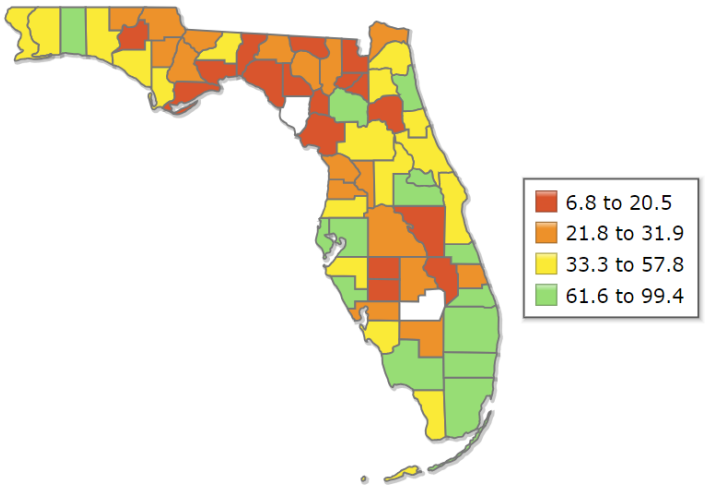
The bill authorizes the BON to adopt rules to prescribe transfer-of-care conditions, monitor for excessive transfers, conduct reviews of adverse maternal and neonatal outcomes, and monitor the licensure CNMs engaged in autonomous practice.

**Dental Student Loan Repayment Program**

Access to Dental Care and Dental Workforce in Florida

There are 7,651 dental HSPAs in the U.S., 266 of which are in Florida.[164] In 2022, there were approximately 59 licensed dentists per 100,000 people in Florida; however, this ratio varies greatly across the state. Most dentists are disproportionately concentrated in the more populous areas of the state. Two counties, Dixie and Glades, do not have any licensed dentists.[165]

**Licensed Dentists per 100,000 Floridians FY 2021-2022[166]**




There is a noticeable shortage of dentists in certain parts of the state, especially the central Panhandle counties and interior counties of south Florida.[167] Lower patient densities, rural income disparities, and lower dental care reimbursement levels make it difficult to recruit and retain dentists in rural communities of the state.[168] Lack of access to dental care can lead to poor oral health and poor overall health.[169] Research has shown a link between poor oral health and diabetes, heart and lung disease, stroke, respiratory illnesses, and adverse birth outcomes including the delivery of pre-term and low birth weight infants.[170]

Dental Student Loan Repayment Program

In 2019, the Legislature created the Dental Student Loan Repayment Program under DOH. Under the program, a Florida-licensed dentist is eligible to participate if he or she maintains active employment in

[164] Florida Department of Health, FL Health Charts, available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=NonVitalIndNoGrp.Dataviewer&cid=326 (last visited January 22, 2024)
[165] *Id.*
[166] *Id.*
[167] *Id.*
[168] Chris Collins, MSW, *Challenges of Recruitment and Retention in Rural Areas*, North Carolina Medical Journal, Vol. 77 no. 2, (March-April 2016), http://www.ncmedicaljournal.com/content/77/2/99.full (last visited January 22, 2024).
[169] Florida Department of Health, *Florida's Burden of Oral Disease Surveillance Report*, (Aug, 2016), p. 5, *available at*, http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/floridas-burden-oral-disease-surveillance-report.pdf (last visited January 22, 2024).
[170] *Id.*

a public health program[171] that serves Medicaid recipients and other low-income patients and is located in a dental HSPA or a MUA.[172]

A dentist is no longer eligible to receive funds under the Loan Program if the dentist:[173]

- Is no longer employed by a public health program that is located in a dental HSPA or a MUA and serves Medicaid recipients and other low-income patients;
- Ceases to participate in the Florida Medicaid program; or
- Has disciplinary action taken against his or her license by the Board of Dentistry for a violation of the dental practice act.

DOH is authorized to award each eligible dentist up to $50,000 in student loan repayments per year for up to five years, for a maximum of $250,000. DOH may approve up to 10 new dentists each fiscal year to participate in the Loan Program, in addition to those dentists already participating in the Loan Program.[174]

The Loan Program may only cover loans to pay the costs of tuition, books, dental equipment and supplies, uniforms, and living expenses and must be made directly to the holder of the loan. All repayments are contingent upon continued proof of eligibility and the state is not responsible for the collection of any interest charges or other remaining loan balances.[175]

Currently, there is no reporting requirement and no requirement to perform an evaluation on the effectiveness of the program.

Effect of the bill - Dental Student Loan Repayment Program

The bill expands eligibility for the Dental Student Loan Repayment Program to include dental hygienists and to include dentists who practice in private dental practices that are located in dental health professional shortage areas. The annual award for a qualifying dentists or dental hygienist is 20 percent of his or her principal loan amount at the time that he or she applies for the program, but may not be more than $50,000 per year for dentists or $7,500 per year for dental hygienists.

The bill requires practitioners to provide 25 hours of volunteer primary care or dental services in a free clinic, as defined in s. 766.1115, F.S., that is located in an underserved area or through another volunteer program operated by the state pursuant to part IV of ch. 110, F.S.

Additionally, the bill requires AHCA to seek federal authority to use Title XIX[176] matching funds for the Dental Student Loan Repayment Program and provides a sunset date for the program of July 1, 2034.

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

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

The bill also requires DOH to contract with an independent third party to develop and conduct a study to evaluate the effectiveness the DSLR Program. The bill requires DOH to begin collecting the data needed by January 1, 2025, and submit the study to the Governor and the Legislature by January 1,

[171] Section 381.4019 defines a "public health program" as a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by DOH.
[172] Section 381.4019, F.S.
[173] *Id.*
[174] *Id.*
[175] *Id.*
[176] Title XIX of the federal Social Security Act creates the Medicaid program and provides federal matching funds for states that participate in Medicaid.

2030. Practitioners who receive payments under the DSLR Program must furnish any information requested by DOH for the study or DOH's annual reporting requirements.

**The Florida Reimbursement Assistance for Medical Education Program (FRAME)**

In 2002, the Legislature created the Medical Education Reimbursement and Loan Repayment Program (program) within DOH, to encourage health care professionals to practice in underserved areas where there are shortages of such personnel.[177] The program makes payments to offset loans and educational expenses incurred in nursing or medical studies or licensure. Health care professionals eligible to participate in the program include:[178]

- Allopathic physicians with primary care specialties;
- Osteopathic physicians with primary care specialties;
- Physician assistants;
- Autonomous APRNs with primary care specialties;
- Licensed practical nurses;
- Registered nurses; and
- APRNs.

As funds are available, DOH may award up to:[179]

- $20,000 per year for allopathic and osteopathic physicians with primary care specialties;
- $15,000 per year for autonomous APRNs with primary care specialties;
- $10,000 per year for APRNs and physician assistants; and
- $4,000 per year for licensed practical nurses and registered nurses.

To qualify for reimbursement, a health care practitioner must:[180]

- Be a U.S. citizen;
- Possess a clear active Florida health care professional license;
- Provide in-person services to persons in an underserved location;[181]
- Not have received an award from any other State of Florida-funded student loan repayment program since July 1 of the previous year; and
- Have a qualified loan.[182]

An autonomous APRN, in addition to the requirements above, must specifically have active employment providing primary care services in a practice or public health program that serves Medicaid and other low-income patients and practice in a location that has a primary care Health Professional Shortage Area (HPSA)[183] score of at least 18.[184]

During the 2022-2023 fiscal year, 3,702 applications were submitted for loan reimbursement. Of the 3,702 applicants, 1,407 met the program requirements, representing $40.8 million in requested loan forgiveness, which is more than twice the available funding for the program—$16 million. Of the 1,407 applicants who met the program requirements, 1,097 received loan reimbursement awards.[185]

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[177] Section 1009.65(1), F.S.
[178] *Id.* Primary care specialties for physicians include obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties identified by DOH.
[179] Section 1009.65(1), F.S.
[180] Rule 64W-4.002(1)(a), F.A.C.
[181] Rule 64W-4.001, F.A.C., defines an "underserved location" as a public health program; a correctional facility; a Health Professional Shortage Area as designated by Federal Health Resources and Services Administration in a primary care discipline; a rural area as identified by the Federal Office of Rural Health Policy; a rural hospital as defined in s. 395.602(2)(b), F.S.; a state hospital; or other state institutions that employ medical personnel.
[182] Rule 64W-4.001, F.A.C., defines a "qualified loan" as a federal and/or private student loan with a US-based lender that has a verified balance remaining which loan proceeds were used to pay educational expenses.
[183] S. 1009.65(1)(b)1., F.S., defines "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration or a rural area as defined by the Federal Office of Rural Health Policy.
[184] Rule 64W-4.002(1)(b), F.A.C.
[185] Presentation by Emma Spencer, PhD, MPH, Department of Health, on Student Loan Repayment Programs, Florida House of Representatives, Healthcare Regulation Subcommittee, November 16, 2023, at pgs.7-9, available at

Physicians received 81% of the available funding.[186] In determining which applicants receive awards, DOH computes a Frame Prioritization Score using an adjusted HPSA score for the practice location of the provider and the length of employment for the provider.[187]

Currently, there is no reporting requirement and no requirement to perform an evaluation on the effectiveness of the program.

Effect of the bill - The Florida Reimbursement Assistance for Medical Education Program (FRAME)

The bill expands the list of eligible practitioners to include mental health professionals, such as licensed clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists. The bill consolidates autonomous APRNs with the other practitioner types and eliminates specific requirements for such APRNs to qualify for the program. The bill allows reimbursement awards to be provided over a four-year period, instead of on a yearly basis and increases the maximum award amounts for each type of practitioner to up to:

- $150,000 for physicians;
- $90,000 for Autonomous APRNs;
- $75,000 for APRNs and PAs;
- $75,000 for mental health professionals; and
- $45,000 for LPNs and RNs.

A practitioner may only receive an award for one four-year period. At the end of each year that a practitioner participates in the program, DOH must award 25 percent of the practitioner's principal loan amount at the time he or she applied for the program.

The bill requires practitioners to provide 25 hours of volunteer primary care in a free clinic that is located in an underserved area or through another volunteer program operated by the state.

The bill requires AHCA to seek federal authority to use Title XIX matching funds for FRAME, and provides a sunset date of July 1, 2034.

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

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

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

https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3246&Session=2024&DocumentType=Meeting+Packets&FileName=hrs+11-16-23.pdf (last visited January 22, 2024).

[186] *Id.* Physicians received $12,897,865, APRNs received $1,763,773, physician assistants received $512,249, registered nurses received $449,971, autonomous APRNs received $302,079, and licensed practical nurses received $73,950.

[187] Rule 64W-4.005(2), F.A.C.

## Clinical Psychologists' and Psychiatric Nurses' Authority Under the Baker Act

### The Florida Mental Health Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws.[188] The Baker Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[189] Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[190]

### Involuntary Examination

An involuntary examination is required if there is reason to believe that the person has a mental illness and, because of his or her mental illness, has refused voluntary examination, is likely to refuse to care for himself or herself to the extent that such refusal threatens to cause substantial harm to his or her well-being and such harm is unavoidable through help of willing family members or friends, or will cause serious bodily harm to himself or herself or others in the near future based on recent behavior.[191]

An involuntary examination may be initiated by:

- A court entering an ex parte order stating that a person appears to meet the criteria for involuntary examination, based on sworn testimony;[192]
- A law enforcement officer taking a person who appears to meet the criteria for involuntary examination into custody and delivering the person or having him or her delivered to a receiving facility for examination;[193] or
- A physician, clinical psychologist,[194] psychiatric nurse,[195] an autonomous advanced practice registered nurse, mental health counselor, marriage and family therapist, or clinical social worker executing a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination, including a statement of the practitioner's observations supporting such conclusion.[196]

Involuntary patients must be taken to either a public or private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold, or refer, as appropriate, involuntary patients under emergency conditions for psychiatric evaluation and to provide short-term treatment or transportation to the appropriate service provider.[197]

The patient must be examined by a physician, clinical psychologist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist to determine if the patient meets the criteria for involuntary services within 72 hours of the initiation of the involuntary examination.[198] A patient may be released only upon the documented approval of a psychiatrist or clinical psychologist. If the receiving facility is owned or operated by a hospital, health system, or nationally accredited community health center, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist.

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[188] Sections 394.451-394.47892, F.S.
[189] Section 394.459, F.S.
[190] Sections 394.4625, 394.463, and 394.4655, F.S.
[191] Section 394.463(1), F.S.
[192] Section 394.463(2)(a)1., F.S. The order of the court must be made a part of the patient's clinical record.
[193] Section 394.463(2)(a)2., F.S. The officer must execute a written report detailing the circumstances under which the person was taken into custody, and the report must be made a part of the patient's clinical record.
[194] Section 394.455(5), F.S., defines a "clinical psychologist" as a Florida-licensed psychologist with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the U.S. Department of Veterans Affairs that qualifies as a receiving or treatment facility.
[195] Section 394.455(36), F.S., defines a "psychiatric nurse" as a Florida-licensed advanced practice registered nurse who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.
[196] Section 394.463(2)(a)3., F.S. The report and certificate shall be made a part of the patient's clinical record.
[197] Section 394.455(40), F.S.
[198] Section 394.463(2)(f)-(g), F.S.

Involuntary Placement

If an individual continues to be in need of services, a treatment facility may petition the court to order either involuntary inpatient treatment or involuntary outpatient treatment for the individual.[199] Any petition for continued involuntary treatment, whether inpatient or outpatient, must be supported by the opinion of a psychiatrist, and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours and determined that the criteria for involuntary services are met.[200] In a hearing on such petitions, a court may issue an order for involuntary outpatient services, involuntary inpatient services, or an involuntary assessment, appoint a guardian, or order the patient's discharge.[201]

Voluntary Admissions

Baker Act receiving facilities may also admit any person 18 years of age or older making application by express and informed consent for admission, or any person age 17 or younger for whom such application is made by his or her guardian.[202] If found to show evidence of mental illness, to be competent to provide express and informed consent, and to be suitable for treatment, a person 18 years of age or older may be admitted to the facility.[203] A person 17 years of age or younger may only be admitted after a clinical review to verify the voluntariness of the minor's assent.

Psychologists

The practice of psychology is the observations, description, evaluation, interpretation, and modification of human behavior, by the use of scientific and applied psychological principles, methods, and procedures, for the purpose of describing, preventing, alleviating, or eliminating symptomatic, maladaptive, or undesired behavior and of enhancing interpersonal behavioral health and mental or psychological health.[204] Psychological services may be rendered to individuals, couples, families, groups, and the public without regard to place of service.

The Board of Psychology within DOH oversees the licensure and regulation of psychologists in Florida.[205] To be licensed as a psychologist the applicant must:

For licensure by examination:

- Hold a doctoral degree from a program accredited by the American Psychological Association;[206]
- Have at least two years or 4,000 hours of supervised experience in the field of psychology;
- Pass the Examination for Professional Practice in Psychology; and
- Pass an examination on Florida laws and rules.[207]

For licensure by endorsement:

- Be a diplomate in good standing with the American Board of Professional Psychology and pass an examination on Florida laws and rules; or
- Hold a doctoral degree in psychology and have at least 10 years' experience as a licensed psychologist in any U.S. jurisdiction within the preceding 25 years.[208]

Under current law, a "clinical psychologist" is a Florida-licensed psychologist with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for

[199] *See* ss. 394.4655 and 394.467, F.S.
[200] Sections 394.4655(3)-(4), F.S., for involuntary outpatient services, and ss. 394.467(2)-(4), F.S., for involuntary inpatient services.
[201] Section 394.4655(7), F.S., for involuntary outpatient services, and ss. 394.467(6), F.S., for involuntary inpatient services.
[202] Section 394.4625(1)(a), F.S.
[203] *Id*.
[204] Section 490.003(4), F.S.
[205] Section 490.004, F.S.
[206] Alternatively, the applicant may have received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology. The burden is on the applicant to establish that this requirement has been met.
[207] Section 490.005, F.S., and r. 64B19-11.001, F.A.C.
[208] Section 490.006, F.S.

licensure, or a psychologist employed by a facility operated by the U.S. Department of Veterans Affairs that qualifies as a receiving or treatment facility.[209]

Psychiatric Nurses

Psychiatric nurses are licensed as advanced practice registered nurse who has a master's or doctoral degree in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advanced practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.[210] The Board of Nursing within DOH oversees the licensure and regulation of advanced practice registered nurses. To obtain license as an advanced practice registered nurse in Florida, the nurse must submit an application and provide proof that he or she; [211]

- Holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing under the Nurse Licensure Compact;
- Is certified by the appropriate specialty board; and
- Has a master's degree in a clinical nursing specialty area with preparation in specialized practitioner skills.

For licensure as a psychiatric nurse, the applicant must hold one of the following certifications recognized by the Board of Nursing: [212]

- Psychiatric Mental Health Nurse Practitioner Certification;
- Family Psychiatric and Mental Health Nurse Practitioner;
- Adult Psychiatric and Mental Health Nurse Practitioner; or
- Psychiatric Adult Clinical Nurse Specialist (CNS).

In order to be recognized by the Board of Nursing, each specialty board must attest to the competency of nurses in the clinical specialty area, identify standards or scope of practice statements as appropriate for the specialty, require a written examination for certification, and require completion of a formal program prior to eligibility of examination.[213]

Effect of the bill - Clinical Psychologists' and Psychiatric Nurses' Authority Under the Baker Act

Clinical Psychologists

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

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

The bill retains a three-year clinical experience requirement for a clinical psychologist to:

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

[209] Section 394.455, F.S.
[210] Section 394.455, F.S.
[211] Section 464.012(1), F.S.
[212] Rule 64B9-4.002, F.A.C.
[213] *Id*.

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

Psychiatric Nurses

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

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

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

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

**Behavioral Health Acute Care System - Mobile Response Teams**

DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. The behavioral health acute care system is a complex system that includes a variety of entities and integrated components that are essential for providing a public health safety net and comprehensive crisis response system for those with mental health and substance use disorders.

Crisis Response System

A crisis response system is a coordinated set of structures, processes and services put in place to respond to urgent and emerging mental health crisis. The system is designed to connect an individual experiencing a crisis to the appropriate level of care based on the assessed need of the individual. Key components of an effective crisis response system include regional or statewide crisis call centers coordinating in real time, centrally deployed 24/7 mobile crisis response teams, and readily available

crisis receiving and stabilization programs.[214] Florida has various crisis support services that address the different components, including mobile response teams.

Mobile Response Teams

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him or her. It can be caused by a variety of factors and occur at any hour of the day.[215] Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals.[216] Law enforcement or EMTs may be called to respond to mental health crises, and may lack the training and experience to effectively handle the situation.[217] Mobile response teams (MRT) can be beneficial in such instances.

MRTs support the behavioral health crisis response system as these teams travel to the acute situation or crisis to provide assistance. MRTs provide on-demand, community-based crisis intervention services 24 hours a day, seven days per week, in any setting in which a behavioral health crisis is occurring.[218] Mobile response services are typically provided by a team of crisis-intervention trained professionals and paraprofessionals who use face-to-face professional and peer intervention. MRTs are deployed in real time to the location of the person in crisis in order to achieve the best outcomes necessary for that individual, ensuring timely access to assessment, evaluation, support, and other services.[219] MRTs provide a warm handoff to other services, coordinate care, and ensure that the individual is engaged in services. MRTs are required to remained engaged for a minimum of 72 hours to ensure that the individual is actively connected to another service provider.[220]

In 1996, the Legislature integrated mobile crisis response services into Part I of ch. 394, F.S., the Florida Mental Health Act and authorized DCF to adopt rules establishing the minimum standards for services provided and for the personnel employed by a mobile crisis response service.[221] Under Part 1 of ch. 394, F.S., mobile crisis response services, such as MRTs, are contracted through DCF and provide general onsite behavioral health crisis services to persons of all ages in various capacities throughout the state.

DCF rules lists the minimum standards that authorized mobile crisis response service providers must adhere to.[222] The minimum standards list broad requirements and serve as a guideline for providers to use when establishing policy and procedures for operation of mobile crisis response services. Authorized service providers are required to establish and enforce a DCF-approved policy and procedures manual for the specific service being provided. The manual must be consistent with the provisions of Part I of ch. 394, F.S., and include processes and procedures to address the minimum standards specified in rule.[223] A few of the standards that must be included in the manual are:[224]

- A description of the services offered, eligibility criteria, how eligible recipients are informed of service availability, criteria for response, hours of operation, staffing with staff qualifications and supervision, and organizational line of authority to the operating entity;
- Procedures for mechanisms to monitor and evaluate service quality and the outcomes attained by individuals served;
- Procedures to determine whether the individual being served has a case manager from a mental health center or clinic, and procedures requiring notification and coordination of activities with the case manager;
- Procedures to implement voluntary admissions provisions; and

[214] Substance Abuse and Mental Health Services (SAMHSA), *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*, available at https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf, (last visited January 22, 2024)
[215] Department of Children and Families, *Mobile Response Teams Framework*, (August 29, 2018), p. 4 https://myflfamilies.com/sites/default/files/2022-12/Mobile%20Response%20Framework.pdf (last visited January 22, 2024).
[216] *Id.*
[217] *Id.*
[218] *Id.*
[219] *Id.*
[220] DCF correspondence to House Children, Families, & Seniors Subcommittee staff (Email dated December 4, 2023, on file with House Children, Families, & Seniors Subcommittee).
[221] Chapter 1996-169, Laws of Florida and s. 394.457, F.S.
[222] Rule 65E-5.400(6), F.A.C.
[223] *Id.*
[224] *Id.*

- Procedures for transporting individuals subject to involuntary examination.

In 2020, the Legislature required crisis response services be provided through MRTs under Part III of ch. 394, F.S., (Comprehensive Child and Adolescent Mental Health Services).[225] This requires DCF to contract with the managing entities[226] to procure mobile response teams throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18-25, inclusive, who:[227]

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

Part III of ch. 394, F.S., lists specific and detailed requirements for MRTs. Under Part III of ch. 394, F.S., MRTs are required to:

- Triage new requests to determine the level of severity and prioritize new requests that meet the clinical threshold for an in-person response and provide in-person responses to such calls meeting the clinical level of response within 60 minutes after prioritization;
- Respond to a crisis in the location where the crisis is occurring;
- Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family;
- Provide evidence-based practices to children, adolescents, young adults, and families to enable them to de-escalate and respond to behavioral challenges that they are facing and to reduce the potential for future crises;
- Provide screening, standardized assessments, early identification, and referrals to community services;
- Provide care coordination by facilitating the transition to ongoing services;
- Ensure there is a process in place for informed consent and confidentiality compliance measures;
- Promote information sharing and the use of innovative technology; and
- Coordinate with the applicable managing entity to establish informal partnerships with key entities providing behavioral health services and supports to children, adolescents, or young adults and their families to facilitate continuity of care.

In Fiscal Year (FY) 2022-23, DCF received additional funding for MRTs under Part III of ch. 394, F.S., allowing for the implementation of 12 new MRTs and the expansion of 30 existing children's teams. Currently there are 51 MRTs serving all 67 counties in Florida.[228] During FY 2022-23, the MRTs received a total of 28,294 calls and served 22,435 individuals.[229] A recent review of MRT data from 2019 through 2022 shows that approximately 82 percent of MRT engagements resulted in community stabilization rather than involuntary admission or deeper penetration into the behavioral health system.[230]

[225] See Chapter 2020-107, L.O.F.
[226] DCF contracts for behavioral health services through regional systems of care called Managing Entities (MEs). These entities do not provide direct services; rather, they allow the department's funding to be tailored to the specific behavioral health needs in the various regions of the state. Currently, the DCF contracts with seven MEs. *See* Department of Children and Families, *Managing Entities, available at* https://www.myflfamilies.com/services/samh/providers/managing-entities (last visited January 22, 2024).
[227] S. 394.495(7)(a), F.S.
[228] DCF, Agency *Legislative Budget Request for Fiscal Year 2024-2025*, available at http://floridafiscalportal.state.fl.us/Document.aspx?ID=26122&DocType=PDF , (last visited January 22, 2024).
[229] DCF correspondence to House Children, Families, & Seniors Subcommittee staff (Email dated December 4, 2023, on file with House Children, Families, & Seniors Subcommittee).
[230] Department of Children and Families, *Triennial Plan for the Delivery of Mental Health and Substance Abuse Services: State Fiscal Years 2023-2024 and 2025-2026, pg. 6, available at* https://www.google.com/url?client=internal-element-cse&cx=b5f7422ffe5734ed7&q=https://www.myflfamilies.com/sites/default/files/2023-06/Substance%2520Abuse%2520%2526%2520Mental%2520Health%2520Services%2520Triennial%2520State%2520and%2520Regional%2520Master%2520Plan%2520%25202023-2025.pdf (last visited Nov. 28, 2023).

Effect of the bill - Behavioral Health Acute Care System - Mobile Response Teams

The bill requires the minimum standards for the general mobile crisis response services under Part I of ch. 394, F.S., to include the mobile crisis response service and MRT standards established under Part III of ch. 394, F.S., for children, adolescents, and young adults. The bill also requires the minimum standards for general MRTs under Part 1 of ch. 394, F.S., to ensure coverage for adults over age 25 in all counties and to focus on rapid crisis intervention, emergency room diversion, the provision of and referral to services that are responsive to the needs of the individuals in crisis and his or her family. Further the bill implements follow-up procedures requiring MRTs to follow-up with the individual at 90 and 180 days to gather outcome data on the mobile crisis response encounter to determine the effectiveness of the mobile crisis response services that were provided.

While the mobile crisis response service and MRT provisions under Parts I and III of ch. 394, are not in conflict, the bill aligns the requirements and performance expectations between the two types of MRTs, while preserving the focus of MRTs serving children, adolescents, and young adults under Part III of ch. 394. The alignment of these standards will require changes to existing DCF rules to include the MRT standards under Part III of ch. 394, F.S., and implement the additional MRT minimum standard provisions of the bill.

The terms "mobile crisis response service" and "mobile response teams" are used interchangeably throughout Parts I and III. The bill amends s. 394.455, F.S. to make it clear that the terms "mobile crisis response service" and "mobile response team" have the same meaning.

**Graduate Medical Education**

The continuum of formal physician education begins with undergraduate medical education in an allopathic or osteopathic medical school. U.S. medical schools confer the M.D. or D.O. degree. U.S. graduates with these degrees combine with some of the graduates of non-U.S. medical schools in competing for residency program slots. Graduate medical education, or GME, is the post-graduate period often called residency training. GME has evolved from an apprenticeship model to a curriculum-based education program. Learning is still predominantly based on resident participation in patient care, under supervision, with increasing independence through the course of training.[231] Most residency programs are sponsored by and take place in large teaching hospitals and academic health centers. However, as health care services are increasingly provided in ambulatory and community-based settings, residency training is beginning to expand to non-hospital sites.[232]

Every U.S. state requires at least one year of residency training to receive an unrestricted license to practice medicine, and some require two or three years. However, most physicians train beyond the minimum licensure requirement in order to become board certified in a "pipeline" specialty (i.e., those that lead to initial board certification). The number of pipeline training positions determines the total number of physicians that the entire continuum can produce. For many years, the number of U.S. residency slots has been larger than the number of U.S. medical graduates, so residency programs were filled in part by graduates of non-U.S. medical schools (including both U.S. and non-U.S. citizens). Now, with growth in the number and size of medical schools, the number of U.S. medical graduates is beginning to more closely approximate the current number of residency slots. In a recent survey conducted by the Association of American Medical Colleges (AAMC), 122 of 130 responding medical school deans reported some concern about the number of post-graduate training opportunities for their students.[233]

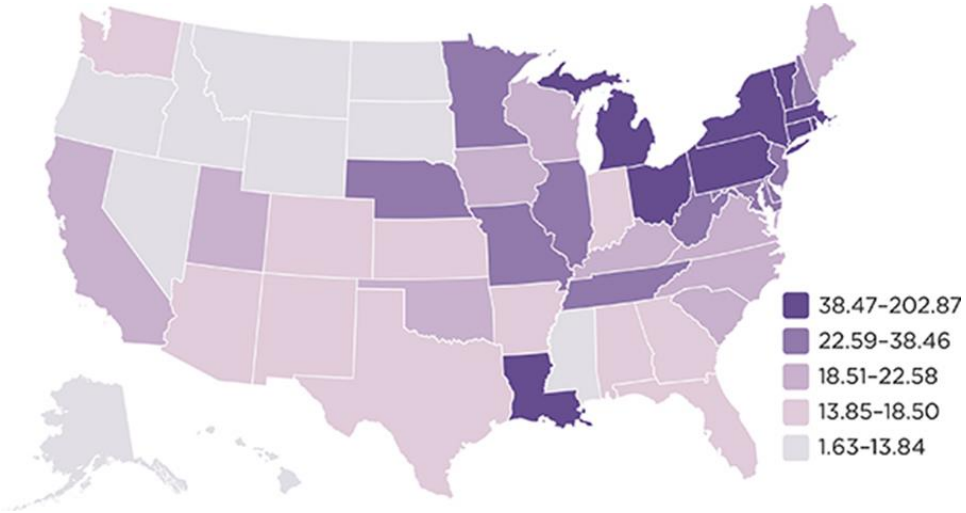
Medicare Funding of GME

GME is largely funded through both the Medicare and the Medicaid programs. Until the enactment of the Balanced Budget Act (BBA) of 1997, Medicare support of GME was open-ended. Before the BBA, hospitals had a strong financial incentive to add new residency slots because each new position generated additional Medicare per-resident amount and indirect medical education revenues. In

[231] *Graduate Medical Education That Meets the Nation's Health Needs*, Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Washington (DC): National Academies Press (US); 2014 Sep 30. 1, Introduction. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248032/, (last visited January 22, 2024).
[232] *Id.*
[233] *Id.*

response to concerns about an oversupply of physicians and increasing Medicare costs, the BBA capped the number of Medicare-supported physician training slots.[234]

Hospitals are free to add residents beyond their cap, but these trainees do not generate additional Medicare revenues. The cap on Medicare funding was set at each hospital's resident count in the cost report period ending on or before December 31, 1996. With this step, the geographic distribution of Medicare-supported residencies was essentially frozen in place without regard for future changes in local or regional health workforce priorities or the geography or demography of the U.S. population. As can be seen by the following chart (showing the number of Medicare-funded training positions per 100,000 population), Medicare-supported slots are most highly concentrated in the Northeastern states, as is most of Medicare GME funding.[235]




Medicaid Funding of GME

GME is an approved component of Medicaid inpatient and outpatient hospital services.[236] If a state Medicaid program opts to cover GME costs, the federal government provides matching funds.[237] Florida opts to fund GME through the Statewide Medicaid Residency Program (SMRP).[238] For fiscal year 2023-2024, the SMRP funded 6,176 residents at 83 location.[239]

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

*Startup Bonus Program (SBP)*[240]

The SBP was established to provide resources for the education and training of physicians in specialties which are in a statewide supply-and-demand deficit. The program allocates a $100,000 startup bonus for each newly created resident position that is authorized by the Accreditation Council for Graduate Medical Education or Osteopathic Postdoctoral Training Institution in an initial or established accredited training program that is in a physician specialty in statewide supply-and-demand deficit. For the purposes of the program, physician specialties in statewide supply-and-demand deficit are identified in the General Appropriations Act (GAA).[241]

[234] *Id.*
[235] *Id.*
[236] *Id.*
[237] *Id.*
[238] Section 409.909, F.S.
[239] SFY 2023-24 Statewide Medicaid Residency Program Distribution, AHCA, available at https://ahca.myflorida.com/content/download/23217/file/SFY%2023-24%20GME%20SMRP%20Calculation%20Clean.pdf, (last visited January 22, 2024).
[240] Section 409.909(5), F.S.
[241] Chapter 2023-239, Laws of Florida

*The Slots for Doctors Program (SDP)*

The SDP requires the AHCA to annually allocate $100,000 to hospitals and qualifying institutions for each newly created slot that is first filled on or after June 1, 2023, and remains filled thereafter.[242] The new slot must be accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit. The sections specify that the program is designed to generate matching funds under the Medicaid program and distribute those funds to participating hospitals and qualifying institutions and that specialties and sub-specialties are those that are identified in the GAA.

Specialties and Sub-Specialties in Supply and Demand Deficit

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

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

**Ohio's Primary Care Workforce Initiatives (OPCWI)**

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

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

Health centers may host students in the following disciplines: medicine, dentistry, advanced practice nursing, physician assisting, and behavioral health. These structured clinical experiences are designed to increase primary care capacity in some of the most underserved neighborhoods in Ohio. Located throughout the state, Ohio's FQHCs serve over 850,000 Ohioans each year. Participating health centers have, or commit to obtaining, national recognition as PCMHs so that students can experience an advanced primary care practice model.[243]

The OPCWI pays quarterly at an hourly rate determined by the type of provider:[244]

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

Effect of the bill - Graduate Medical Education

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

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

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

*Reporting Requirements*

The bill amends s. 409.909, F.S., to require any hospital or qualifying institution[245] that receives state funds under the SMRP, including, but not limited to intergovernmental transfers, to annually report data to the AHCA.

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

- The sponsoring institution for the resident position. As used in this section, the term "sponsoring institution" means an organization that oversees, supports, and administers one or more resident positions.
- The year the position was created and the current program year of the resident who is filling the position.
- Whether the position is currently filled and whether there has been any period of time when it was not filled.
- The specialty or subspecialty for which the position is accredited and whether the position is a fellowship position.

[243] Y8 Ohio Primary Care Workforce Initiative (OPCWI) User Manual, Ohio Association of Community Health Centers, available at Y8_OPCWI_User_Manual.pdf (ymaws.com), (last visited January 22, 2024).
[244] *Id.* at p. 6.
[245] A qualifying institution is defined in s. 409.909, F.S., as a federally Qualified Health Center holding an Accreditation Council for Graduate Medical Education institutional accreditation.

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

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

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

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

*Residency Exit Survey*

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

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

*Graduate Medical Education Committee (GMEC)*

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

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

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

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

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

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

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

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

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

The bill defines the following terms:

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

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

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

- Agree to provide appropriate supervision or precepting for one or more of:
    - Allopathic or osteopathic residents pursuing a primary care specialty.
    - Advanced practice registered nursing students pursuing a primary care specialty.
    - Nursing students.
    - Allopathic or osteopathic medical students.
    - Dental students.
    - Physician assistant students.
    - Behavioral health students, including students studying psychology, clinical social work, marriage and family therapy, or mental health counseling.

- Meet and maintain all requirements to operate on accredited residency program if the qualified facility operates a residency program.
- Obtain and maintain accreditation from an accreditation body approved by the AHCA if the qualified facility provides clinical rotations.
- Ensure that clinical preceptors meet AHCA standards for precepting students, including any required training.
- Provide preference for residents and students enrolled in Florida schools or whose state of legal residence is Florida.
- Submit quarterly reports to the AHCA by the first day of the second month following each quarter which must, at a minimum, include:
- The type of residency or clinical rotation offered by the qualified facility, the number of residents or students participating in each type of clinical rotation or residency, and the number of hours worked by each resident or student each month.
- Evaluations by the residents and student participants of the clinical experience on an evaluation form developed by the agency.
- An itemized list of administrative costs associated with the operation of the clinical training program, including accreditation costs and other costs relating to the creation, implementation, and maintenance of the program.
- A calculation of lost revenue associated with operating the clinical training program.

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

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

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

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

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

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

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

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

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

**Offshore Usage of Clinical Training Opportunities**

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

More than 70 percent of surveyed deans worried about having enough qualified specialty preceptors, and the response jumped to 87 percent for primary care preceptors. One reason for this is an increase in competition for clinical training opportunities from offshore medical schools. Such offshore medical schools may not be able to offer core clinical experiences where they are located. Instead they rely on training sites within the United States. In order to secure these sites, offshore medical schools will often pay the clinical locations such as hospitals in order to place their students there. Although most U.S. medical schools do not pay hospitals or other settings for clinical training, the AAMC survey of deans found that 44 percent of respondents felt moderate to severe pressure to do so.[246]

Effect of the bill - Offshore Usage of Clinical Training Opportunities

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

**The Florida Medicaid Program**

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[247] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[248]

Medicaid Provider Enrollment

Federal exceptions excluded, to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time the service is rendered. Practices must be fully operational before they can be enrolled as Medicaid providers. Every entity that provides Medicaid services to enrollees and all third-party software vendors offering services of any kind to providers must enroll as a Medicaid provider.[249]

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[246] *So Many Medical Students, so Few Clerkship Sites*, AAMCNEWS, Sep. 10, 2020, available at https://www.aamc.org/news/so-many-medical-students-so-few-clerkship-sites#:~:text=According%20to%20a%20new%20AAMC,sites%20even%20before%20the%20pandemic., (last visited January 22, 2024).
[247] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited January 22, 2024).
[248] Section 20.42, F.S.
[249] Florida Agency for Health Care Administration & Gainwell Technologies, *Florida Medicaid Provider Enrollment Application Guide, available at* https://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/Public%20Misc%20Files/Florida%20Medicaid%20Provider%20Enrollment%20App%20Guide.pdf (last visited January 22, 2024).

The AHCA and its fiscal agent, Gainwell Technologies, develop comprehensive education materials, including reference guides, to assist applicants with the enrollment process, as well as answer the questions of any providers interested in Medicaid enrollment, published on their respective websites.[250]

Statewide Medicaid Managed Care

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. In Florida, the majority of Medicaid enrollees receive their services through a managed care plan contracted with the AHCA under SMMC.[251]

SMMC has three components: MMA, Long-Term Care (LTC), and Dental. Florida's SMMC benefits are authorized through federal waivers and are specifically required by the Florida Legislature in s. 409.973, F.S., and s. 409.98, F.S.[252] MMA plans provide preventive, acute, behavioral, therapeutic pharmacy, and transportation services to eligible recipients.[253]

Qualifying Community-Based Mobile Crisis Intervention Services

Section 9813 of the federal American Rescue Plan Act of 2021 (ARPA) amended Title XIX of the Social Security Act (Act) to add a new section 1947, authorizing states to provide qualifying community-based mobile crisis intervention services during the period beginning April 1, 2022, and ending March 31, 2027. States with approved coverage and reimbursement authority can receive 85 percent federal match for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period during which they meet the federally outlined conditions. States are permitted to disregard the provider agreement requirements at s. 1902(a)(27) of the Act that obligate states to enter into provider agreements with "every person or institution providing services under the State plan."[254]

The Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration both describe mobile crisis services as readily available 24 hours a day, and seven days a week services that can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call to respond. The team may be composed of professionals and paraprofessionals, including trained peer support providers, who are educated in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis.[255]

Primary Care Initiative Program

At present, plans operating in the MMA component of SMMC must establish a program to encourage enrollees to establish a relationship with their primary care provider. Each plan is required to:[256]

- Provide information to each enrollee on the importance of and procedure for selecting a primary care provider, and thereafter automatically assign to a primary care provider any enrollee who fails to choose a primary care provider;
- Assist new Medicaid enrollees in scheduling an appointment with a primary care provider within 30 days after enrollment in the plan, if possible;

[250] *Id.*
[251] Section 20.42, F.S.
[252] Florida Agency for Health Care Administration, *Statewide Medicaid Managed Care, available at* https://ahca.myflorida.com/medicaid/statewide-medicaid-managed-care (last visited January 22, 2024).
[253] Florida Agency for Health Care Administration, *A Snapshot of the Florida Statewide Medicaid Managed Care Program, available at* https://ahca.myflorida.com/content/download/9126/file/SMMC_Snapshot.pdf (last visited January 22, 2024).
[254] *Centers for Medicare & Medicaid Services, SHO # 21-008: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services, available at* https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf (last visited January 22, 2024).
[255] *Id.*
[256] Section 409.973(4), F.S.

- Report to the AHCA the number of enrollees assigned to each primary care provider within the plan's network;
- Report to the AHCA the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment; and
- Report to the AHCA the number of emergency room visits by enrollees who have not had at least one appointment with their primary care provider.

Medicaid Encounter Data System

Currently, the AHCA operates a Medicaid Encounter Data System to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in a managed care plan. Each plan must comply with the AHCA's reporting requirements for the Medicaid Encounter Data System, submit encounter data electronically in a format that complies with the Health Insurance Portability and Accountability Act (HIPAA) provisions for electronic claims, and submit encounter data in accordance with deadlines established by the AHCA. The managed care plans must certify the reported data is accurate and complete.[257]

The AHCA is responsible for validating the data submitted by the plans and has developed methods and protocols for ongoing analysis of the encounter data that adjusts for differences in characteristics of SMMC enrollees to allow comparison of service utilization among plans and against expected levels of use. Presently, the analysis is used to identify possible cases of inappropriate service utilization, such as higher-than-expected emergency department encounters[258] or PPEs, to improve access to quality health care services while also reducing expenditures.[259]

**Florida's Health Information Exchange Program**

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

The FHIE electronically makes patient health information available to doctors, nurses, hospitals, and health care organizations when needed for patient care. The exchange of patient information is protected through strict medical privacy and confidential procedures. The FHIE is designed to improve the speed, quality, safety, and cost of patient care.[260]

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

- 95 percent of Licensed Acute Care Hospitals
- 225 Skilled Nursing Facilities
- 64 Urgent Care Centers
- 22 Hospice Providers
- 5 Crisis Stabilization Units
- Statewide Emergency Medical Services Treat-and-Release Providers
- All 67 County Health Departments.[261]

[257] Section 409.967(2)(e), F.S.
[258] *Id.*
[259] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[260] AHCA analysis document, on file with Senate Health Policy Committee staff.
[261] *Id.*

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

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

Although data sharing has grown and improved over time, there are several providers not sharing complete data sets due to various reasons such as workflow issues or turnover of staff that is familiar with FHIE needs. The incomplete data limits the ability for subscribers of ENS to have a complete picture of patient care. The incomplete data negatively impacts the AHCA's public health partners who are receiving data through the Florida HIE Services.[262]

Effect of the bill - Florida's Health Information Exchange Program

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

**Emergency Department (ED) Diversion**

*Emergency Department Diversion*

Hospitals are licensed and regulated by the Agency for Health Care Administration (AHCA) under part I of ch. 395, F.S. In Florida, emergency departments (EDs) are either located in a hospital or on separate premises of a licensed hospital. Any licensed hospital which has a dedicated ED may provide emergency services in a location separate from the hospital's main premises, known as a hospital-based off-campus emergency department.[263] Current law requires each hospital with an ED to screen, examine, and evaluate a patient who presents to the ED to determine if an emergency medical condition exists and, if it does, provide care, treatment, or surgery to relieve or eliminate the emergency medical condition.[264]

Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition.[265] CMS can issue civil monetary penalties to hospitals and physicians for each violation of this provision and can exclude a physician from participation in any federal health care program.[266] The penalty amounts are adjusted annually for inflation. Penalty amounts for the 2023 calendar year are as follows:

- $129,232 for a hospital or responsible physician in a hospital with more than 100 beds; and
- $64,618 for a hospital or responsible physician in a hospital with fewer than 100 beds.[267]

Pursuant to CMS guidance on EMTALA regulations, hospitals should not delay providing a medical screening examination or necessary stabilizing treatment by inquiring about an individual's ability to pay for care.[268] However, hospitals may follow reasonable registration processes for individuals presenting

[262] *Id.*
[263] Section 395.002(13), F.S.
[264] Section 395.1041, F.S.
[265] 42 U.S.C. §1395dd and 42 C.F.R, § 489.24.
[266] 42 C.F.R., § 1003.510
[267] 42 C.F.R., § 102.3
[268] CMS State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases, Interpretive Guidelines for §489.24(d)(4)(i),(ii),(iii) and (iv), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_v_emerg.pdf (last visited January 22, 2024).

with an emergency medical condition. Reasonable registration processes may include asking whether an individual is insured and, if so, what the insurance is, as long as the inquiry does not delay screening, treatment or unduly discourage the individual from remaining for further evaluation.

Avoidable emergency department visits put a significant strain on the health care system by increasing overall costs and leading to ED overcrowding.[269] A large proportion of all ED visits in the U.S. are for non-urgent conditions,[270] potentially as high as 37 percent.[271] A study estimated that annual savings of $4.4 billion could be achieved if non-urgent ED visits were cared for in retail clinics or urgent care centers.[272] Some of the known drivers attributed to ED overuse are indigent populations, such as Medicaid enrollees, as well as others who may lack health insurance and access to timely and quality care, leaving hospitals with the financial and legal obligation to stabilize all patients who arrive in the ED.[273]

Florida has attempted to address the problem of inappropriate ED use in the past.[274] For example, the insurance code requires insurers and health maintenance organizations (HMOs) to have ED diversion programs and provide information to consumers about alternatives to the ED, and authorizes them to charge higher copayments for primary care services in an ED.[275] Similarly, current law authorizes hospitals to develop ED diversion programs, but does not require them to do so. Such programs can include a hotline to help patients determine where to seek treatment, and a "fast track" program allowing nonemergency patients to seek treatment at a different location.[276]

Urgent Care Centers

An urgent care center is a facility or clinic that provides immediate but not emergent ambulatory medical care to patients.[277] There is no licensure program specifically for urgent care centers. A hospital-owned urgent care center can operate under the license of the hospital. A physician-owned urgent care center is required to be licensed as a health care clinic, unless it meets one of the exemptions contained in s. 400.9905, F.S.

Federally Qualified Health Centers

A Federally Qualified Health Center (FQHC), also known as a community health center, is a federally funded safety net provider that provides primary and preventive health services.[278] FQHCs integrate access to primary care, pharmacy, mental health, substance use disorder, and oral health services in areas where economic, geographic, or cultural barriers limit access to affordable health care.[279] There are 776 FQHCs in Florida.[280]

Effect of the bill - Emergency Department (ED) Diversion

The bill requires all hospitals with EDs, including hospital-based off-campus EDs, to submit a diversion plan to AHCA for assisting patients with gaining access to appropriate care settings when such patient presents at the ED with non-emergent health care needs or indicate when receiving triage or treatment at the hospital that they lack regular access to primary care. Starting July 1, 2025, the plan must be approved by AHCA prior to first licensure or licensure renewal. The bill requires all hospitals to submit

[269] Uscher-Pines L, Pines J, Kellermann A, Gillen E, Mehrotra A. Emergency department visits for nonurgent conditions: systematic literature review. Am J Manag Care. 2013 Jan;19(1):47-59. PMID: 23379744; PMCID: PMC4156292.
[270] Non-urgent conditions are typically defined as conditions for which a delay in treatment of several hours would not increase the likelihood of an adverse outcome.
[271] *Supra*, note 273.
[272] Weinick RM, Burns RM, Mehrotra A. Many emergency department visits could be managed at urgent care centers and retail clinics. Health Aff (Millwood). 2010 Sep;29(9):1630-6. doi: 10.1377/hlthaff.2009.0748. PMID: 20820018; PMCID: PMC3412873.
[273] The Journal of Urgent Care Medicine, *Reducing Low-Acuity Preventable Emergency Room Visits by Utilizing Urgent Care Center Services via Mobile Health Unit Diversion Program, available at* https://www.jucm.com/reducing-low-acuity-preventable-emergency-room-visits-by-utilizing-urgent-care-center-services-via-mobile-health-unit-diversion-program/ (last visited January 22, 2024).
[274] The Legislature specifically found that the costs of inappropriate utilization of ED services are ultimately borne by the hospital, the insured patients, and state taxpayers, and declared that providers and insurers must share the responsibility of providing alternative treatment options to urgent care patients through consumer education and implementation of mechanisms result in a decrease in ED overutilization. S. 641.31097, F.S.
[275] Sections 627.6405, 641.31097, F.S.
[276] Section 395.1041(7), F.S.
[277] Section 395.002(30), F.S.
[278] 42 U.S.C. §254b.
[279] U.S. Health Resources & Services Administration, *What is a Health Center?*, available at https://bphc.hrsa.gov/about-health-centers/what-health-center (last visited January 22, 2024).
[280] U.S. Health Resources & Services Administration, *FQHCs and LALs by State*, available at https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs (last visited January 22, 2024).

data to AHCA demonstrating the effectiveness of its ED diversion plan annually and update the plan as necessary, or as directed by AHCA, prior to licensure renewal.

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

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

Additionally, the bill requires the ED diversion plan to include outreach to a patient's managed care plan and coordination with the plan to establish a relationship between the patient and a primary care setting. The bill requires AHCA to establish a process for the hospital to share the patient's updated contact information with the managed care plan.

**Potentially Preventable Health Care Events (PPEs)**

PPEs are encounters that could be prevented but lead to unnecessary health care services.[281]

Potentially Preventable Hospital Emergency Department Visits

Potentially preventable hospital emergency department visits happen when a patient seeks services at an emergency department for a health condition that could have been prevented or treated in a non-emergency setting.[282] The AHCA has identified a variety of causes that may result in these visits, e.g., failure to access primary care, lack of ambulatory care coordination, monitoring, or follow-up, inadequate and/or inaccessible nursing care for a nursing sensitive condition, etc.[283]

Throughout federal fiscal year (FFY) 2019-2020, 294,220 potentially preventable emergency department visits were identified, compared to 388,257 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[284]

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

[281] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[282] *Id.*
[283] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[284] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Emergency Room Visits (PPVs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPVsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).

- Fevers.

Potentially Preventable Hospital Admissions

Potentially preventable hospital admissions are when a patient is admitted for necessary treatment to an acute care hospital[285], but the admission could have been avoided, or when a patient is admitted and could have been treated outside of an inpatient hospital setting.[286]

Throughout federal fiscal year (FFY) 2019-2020, 71,541 potentially preventable hospital admissions were identified, compared to 67,048 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[287]

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

Potentially Preventable Hospital Readmissions

Potentially preventable hospital readmissions are when a patient is readmitted to an acute care hospital for a reason that is clinically related to the initial hospitalization or from deficiencies in a post-hospital discharge follow-up after a prior acute care admission[288] within thirty days of a hospital discharge.[289]

Throughout FFY 2019-2020, 30,593 PPEs were identified with at least one potentially preventable hospital readmission, compared to 31,689 during FFY 2018-2019. The top ten condition groups attributing to this type of PPE most recently are as follows:[290]

- Schizophrenia;
- Bipolar disorders;
- Major depression;
- Septicemia;
- Heart failure;
- Sickle cell crises;
- Chronic obstructive pulmonary disease;

[285] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[286] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[287] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Hospital Admissions (PPAs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPAsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[288] Florida Agency for Health Care Administration, *Florida Medicaid: Quality Initiatives,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/QualityInitiativesDashboard/QualityInitiatives?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[289] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Events Dashboard Series,* available at: https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/AboutPPEs?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).
[290] Florida Agency for Health Care Administration, *Florida Medicaid: Potentially Preventable Readmissions (PPRs) by Health Plan, available at* https://bi.ahca.myflorida.com/t/FLMedicaid/views/PPEDashboard-External/PPRsbyHealthPlan?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n (last visited January 22, 2024).

- Diabetes;
- Cesarean deliveries; and
- Child behavior disorders.

Effect of the bill - Potentially Preventable Health Care Events (PPEs)

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

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

**Acute Hospital Care at Home (AHCAH) Initiative**

Hospitals are licensed and regulated pursuant to ch. 395, F.S., by the Agency for Health Care Administration (AHCA). In addition, the federal Centers for Medicare and Medicaid Services establish standards for hospitals to be eligible to treat (and receive payment for) Medicare patients, called Conditions of Participation.

In November, 2020, as part of the *Hospital Without Walls Initiative* to address the COVID-19 public health emergency and concerns about hospital bed capacity, the federal Centers for Medicare and Medicaid Services (CMS) began issuing waivers to eligible hospitals authorizing the practice of acute hospital care at home under the Acute Hospital Care at Home Program (Program).[291] Specifically, CMS waived s. 482.23(b) and (b)(1) of the Medicare Hospital Conditions of Participation, in effect suspending the requirement for nursing services to be provided on premises 24 hours a day, seven days a week, and for the immediate availability of a registered nurse. In December, 2022, CMS extended the program from the first day after the end of the national public health emergency until December 31, 2024.[292] There is speculation that the Program might become permanent.[293]

These authorizations effectively allow hospitals to provide an inpatient level of care to certain patients in their homes.[294] The Program treats patients who require acute inpatient admission to a hospital and at least daily rounding by a physician and a medical team monitoring the patient's care needs on an ongoing basis.[295] Treatment for more than 60 acute conditions, such as asthma, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease, may be provided through the Program.[296] Patient participation in the program is voluntary.[297]

To receive a waiver and participate in the Program, a hospital must:[298]

- Have appropriate screening protocols in place before care at home begins to assess both medical and non-medical factors;

[291] Centers for Medicare and Medicaid Services, Press Release – CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge, https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge (last visited January 22, 2024).
[292] 42 U.S.C. §1395cc-7 (2022).
[293] Bill Siwicki, Healthcare IT News, *Will CMS' Acute Hospital Care at Home Waiver Program Become Permanent?* (August 28, 2023), available at https://www.healthcareitnews.com/news/will-cms-acute-hospital-care-home-waiver-program-become-permanent#:~:text=Even%20with%20the%20public%20health,including%20hospital%2Dat%2Dhome (last visited January 22, 2024).
[294] A patient's home is his or her permanent residence, which includes assisted living, but does not include nursing homes.
[295] *Supra*, note **Error! Bookmark not defined.**.
[296] *Id.*
[297] Centers for Medicare and Medicaid Services, *Acute Hospital Care at Home Frequently Asked Questions,* https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab2 (last visited January 22, 2024).
[298] Centers for Medicare and Medicaid Services, Acute Hospital Care at Home Program Approved List of Hospitals as of 4/5/2021, available at https://www.cms.gov/files/document/covid-acute-hospital-care-home-program-approved-list-hospitals.pdf (last visited January 22, 2024).

- Have a physician or advanced practice provider evaluate each patient daily either in-person or remotely;
- Have a registered nurse evaluate each patient once daily either in-person or remotely;
- Have two in-person visits daily by either registered nurses or mobile integrated health paramedics based on the patient's nursing plan and hospital policies;
- Have the capability of immediate, on-demand remote audio connection with an Acute Hospital Care at Home team member who can immediately connect either an RN or MD to the patient;
- Have the ability to respond to a decompensating patient within 30 minutes;
- Track several patient safety metrics with weekly or monthly reporting, depending on the
- hospital's prior experience level;
- Establish a local safety committee to review patient safety data;
- Use an accepted patient leveling process to ensure that only patients requiring an acute level of care are treated; and
- Providing or contracting for other services required during an inpatient hospitalization.

Programs must obtain a waiver from AHCA rule requiring only registered nurses to conduct evaluations in order for paramedics to conduct such in-person visits.[299] As of December 14, 2023, 308 hospitals in 37 states have Acute Hospital Care at Home Programs. There are 12 hospitals in Florida approved to participate in the Program, including:[300]

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

Effect of the bill - Acute Hospital Care at Home (AHCAH) Initiative

The bill requires AHCA to seek the federal approval necessary to implement an Acute Hospital Care at Home Program under the state Medicaid program, and requires the Program to be substantially consistent with the temporary Program currently authorized by CMS.

Inherent within the foundation of these programs, is that the primary payors for services are Medicare and Private Insurance. The Medicaid population that would be eligible for services under an Acute Hospital Care at Home Program is unknown, but is likely minimal.

**Access to Health Care Act**

Section 766.1115, F.S., creates the "Access to Health Care Act" to provide protections against liability for health care providers who offer free quality medical services to underserved populations in Florida. The act provides that a health care provider that executes a contract with a governmental contractor[301] to provide health care services is considered an agent of the state for sovereign immunity purposes when acting under the scope of duties under the contract and may not be named as a defendant in any action arising out of medical care or treatment provided under the contracts entered into.

[299] Programs must obtain an AHCA waiver for Rule 59A-3.243(4)(c) and (6), F.A.C., relating to nursing services.
[300] *Id.*
[301] The Access to Health Care Act defines "governmental contractor" as DOH, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity. s. 766.1115(3)(c), F.S.

For the purposes of the Access to Health Care Act, a health care provider includes:

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

*Volunteer Health Care Provider Program*

Through the Access to Health Care Act, DOH established the Volunteer Health Care Provider Program (Program). The Program improves access to free medical and dental services for uninsured and underserved low-income residents.[302] For the purposes of the Act, low-income means:[303]

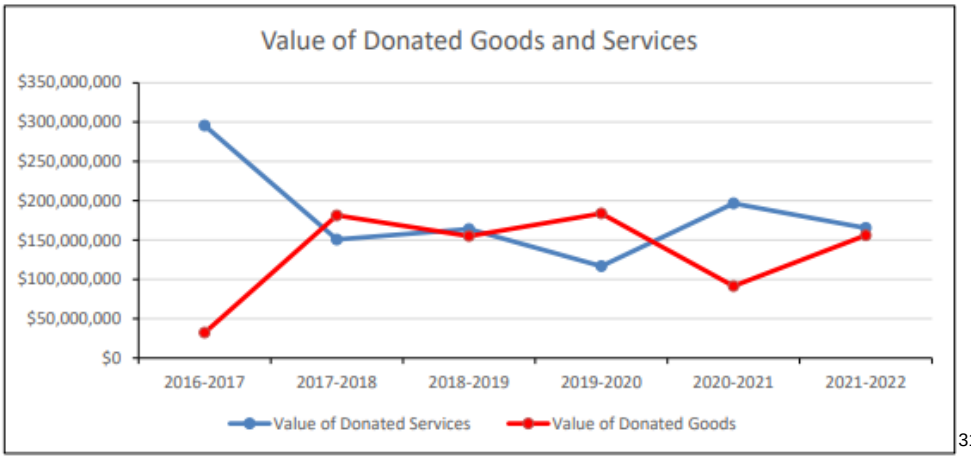
- A person who is Medicaid-eligible under Florida law;
- A person without health insurance and whose family income does not exceed 200 percent of the federal poverty level (FPL) as defined annually be the federal Office of Management and Budget; or
- Any client of DOH who voluntarily chooses to participate in a DOH-offered or DOH-approved program and who meets program eligibility requirements.

The governmental contractor or health care provider will determine and approve client eligibility based on these three eligibility groups.[304] The Program trains non-licensed volunteers to determine eligibility and refer individuals to providers for primary or specialty care. According to DOH's annual report for FY 21-22, DOH maintained 1,382 eligibility and referral specialists.[305] In addition, any federally funded community health center and any volunteer corporation or volunteer health care provider that delivers health care services are also included.[306] The health care providers participating in the Program primarily are community and faith-based medical clinics.[307] In FY 21-22, DOH reports a total of 219 community and faith-based clinics and organizations with 10,043 licensed health care professionals.[308]

Since the inception of the Volunteer Health Care Provider Program (Program) in 1992, DOH documented more than $4.9 billion in donated goods and services.[309] For FY 21-22, DOH reports the value of health-related goods and services totaled more than $321 million.[310] As illustrated in the graph

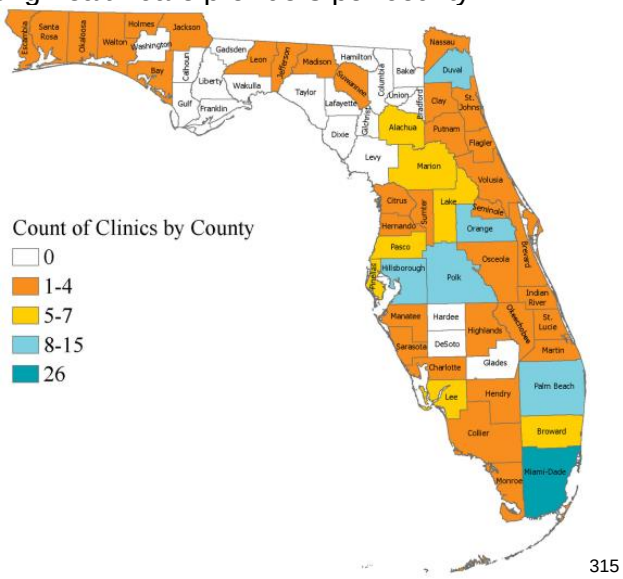
[302] Florida Dept. of Health, *Volunteer Heath Care Provider Program Annual Report Fiscal Year 2021-22*, p. 2 (Dec. 2022) https://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/vhs2122annualreport.pdf (last visited January 22, 2024).
[303] Section 766.1115(3)(e), F.S.
[304] R. 64I-2.002(1), F.A.C.
[305] *Id.* at 1.
[306] Section 766.1115(3)(d), F.S.
[307] *Supra*, FN 2 at 2.
[308] *Id.* at 1.
[309] *Id.*
[310] *Id.*

below, the value of 872,653 donated hours amongst all clinics and organizations is $165 million, and the value of the donations of money, supplies, and equipment received by 140 clinics and organizations is $156 million.[311]



[312]

During FY 21-22, an aggregate total of 443,971 health care services were provided to eligible individuals.[313] The number of counties with participating clinics and organizations increased from 44 to 47.[314] The county-by-county map below depicts which counties the Program served during FY 21-22 and the number of participating health care providers per county.



[315]

Sovereign Immunity

Sovereign immunity means a government is immune from being sued in its own courts without its consent.[316] The Florida Constitution grants absolute sovereign immunity to the state and its agencies.[317] At its discretion, Florida may waive sovereign immunity for any cause of action by legislative enactment or constitutional amendment.[318]

Florida waived sovereign immunity in tort actions.[319] Specifically, a tort action against the state for damages is available to remedy injury or loss of property, personal injury, or death caused by the

[311] *Id.* at 8.
[312] *Id.*
[313] *Id.* at 1.
[314] *Id.* at 4. DOH intends to increase Program service to 55 counties by December 30, 2025. Eight clinics closed in FY 21-22 and did not provide any volunteer services.
[315] *Id.* at 5.
[316] Bryan Garner, *Immunity (1) – Sovereign Immunity (1)*, Black's Law Dictionary, 11th ed. 2019, Accessed Westlaw Dec. 16, 2023.
[317] *Circuit Court of Twelfth Judicial Circuit v. Dep't of Nat'l Resources*, 339 So.2d 1113, 1114 (Fla. 1976); "Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating." Art. X, s. 13, *Fla. Const*.
[318] *Circuit Court of Twelfth Judicial Circuit*, 339 So.2d at 1114.
[319] s. 768.28(1), F.S.

negligent or wrongful act or omission of any state government personnel while acting within the scope of their employment.[320] A state government "officer, employee, or agent" includes any health care provider when providing services under the Access to Health Care Act.[321]

The state currently caps damages in suits against the state at $200,000 per person and $300,000 per incident.[322] MQA reports zero claims filed against the Program since March 2012.

Effect of the bill - Access to Health Care Act

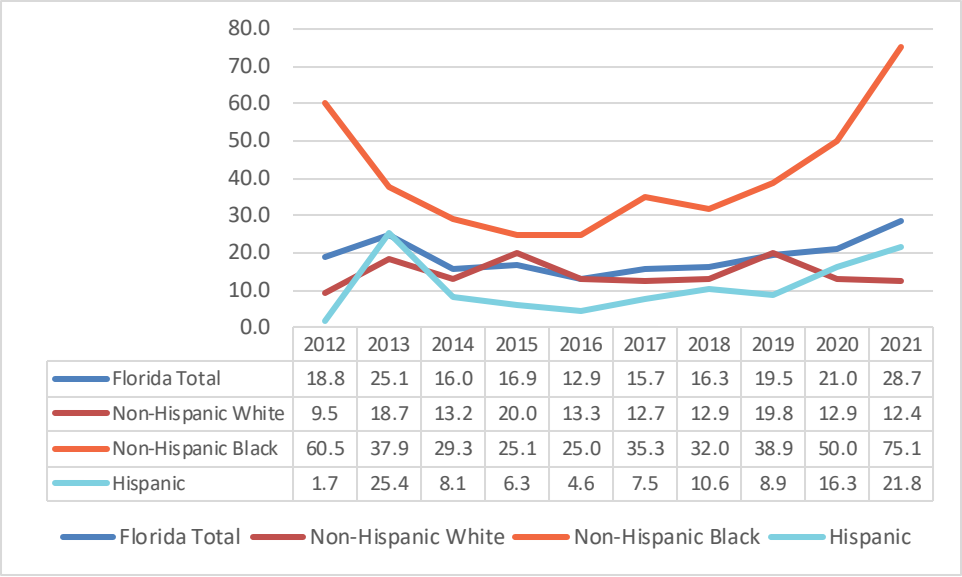
The bill increases the maximum family income allowable under the Program to receive free medical and dental services for uninsured and underserved low-income residents from those whose family income does not exceed 200% of the federal poverty level to those whose family income does not exceed 300% of the federal poverty level. This change will increase the number of people eligible for services under the Program while allowing the providers to retain sovereign immunity protections.

**Telehealth Minority Maternity Care Pilot Program**

Maternal Mortality and Morbidity

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[323] In 2021, more than 1,200 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019.[324] The national maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births.[325] Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 69.9, 26.6, and 28.0 deaths per 100,000 live births, respectively.[326] The overall number and rate of maternal deaths increased in 2020 and 2021 during the COVID-19 pandemic.[327]

[320] *Id*.
[321] Sections 768.28(9)(2); 766.1115(4), F.S.
[322] Section 768.28(5)(a), F.S. For a plaintiff to overcome the cap on damages, the Legislature may enact a claims bill to cover the balance of a judgment in excess of the cap or the state agency can settle a judgment rendered against within the limits of the agency's insurance coverage.
[323] U.S. Dep't of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health*, (Dec. 2020), available at https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (Last visited January 22, 2024).
[324] Donna L. Hoyert, Ph.D., Division of Vital Statistics, National Center for Health Statistics, *Maternal Mortality Rates in the United States, 2021,* (March 2023), available at https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.pdf (last visited January 22, 2024).
[325] *Id.*
[326] *Id*.
[327] United States Government Accountability Office, *Maternal Health Outcomes Worsened and Disparities Persisted During the Pandemic*, (Oct. 2022), available at https://www.gao.gov/assets/gao-23-105871.pdf (Last visited January 22, 2024).




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

Although Florida's maternal mortality rate is lower than the national rate, it has been increasing in recent years. As of 2021, the maternal mortality rate in Florida is 28.7 deaths per 100,000 live births, an increase from a low of 12.9 deaths per 100,000 live births in 2016.[328] Similar to the national trend, racial and ethnic disparities exist in the maternal mortality rates in Florida as evidenced in the following chart:

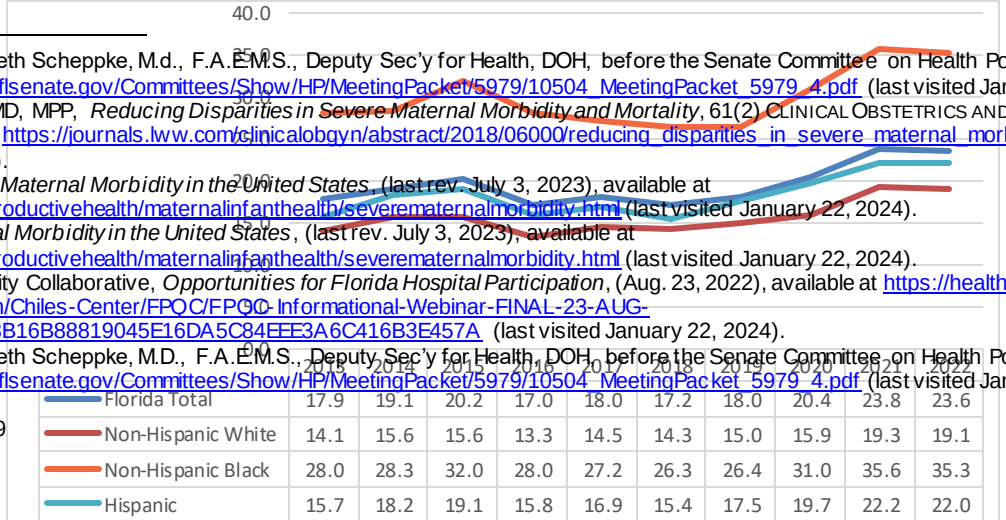
Severe Maternal Morbidity

For every maternal death, 100 women suffer a severe obstetric morbidity, a life-threatening diagnosis, or undergo a lifesaving procedure during their delivery hospitalization.[329] Severe maternal morbidity (SMM) includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. SMM has been steadily increasing in recent years.[330]

The consequences of the increasing SMM prevalence, in addition to the health effects for the woman, are wide-ranging and include increased medical costs and longer hospitalization stays.[331] The leading causes of SMM in 2021 were:

- Blood transfusion;
- Disseminated intravascular coagulation;
- Acute renal failure;
- Sepsis;
- Adult respiratory distress syndrome;
- Hysterectomy;
- Shock;
- Ventilation; and
- Eclampsia.[332]

From 2013 to 2022, there were 51,454 cases of SMM among delivery hospitalization in Florida.[333] The following figure shows the trend over time for SMM rates in Florida per 1,000 delivery hospitalizations:[334]




| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Florida Total | 17.9 | 19.1 | 20.2 | 17.0 | 18.0 | 17.2 | 18.0 | 20.4 | 23.8 | 23.6 | |
| Non-Hispanic White | 14.1 | 15.6 | 15.6 | 13.3 | 14.5 | 14.3 | 15.0 | 15.9 | 19.3 | 19.1 | |
| Non-Hispanic Black | 28.0 | 28.3 | 32.0 | 28.0 | 27.2 | 26.3 | 26.4 | 31.0 | 35.6 | 35.3 | |
| Hispanic | 15.7 | 18.2 | 19.1 | 15.8 | 16.9 | 15.4 | 17.5 | 19.7 | 22.2 | 22.0 | |

[328] Presentation by Kenneth Scheppke, M.d., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 22, 2024).
[329] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), available at https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited January 22, 2024).
[330] *Id.*, and CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 22, 2024).
[331] CDC, *Severe Maternal Morbidity in the United States*, (last rev. July 3, 2023), available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited January 22, 2024).
[332] Florida Perinatal Quality Collaborative, *Opportunities for Florida Hospital Participation*, (Aug. 23, 2022), available at https://health.usf.edu/-/media/Files/Public-Health/Chiles-Center/FPQC/FPQC-Informational-Webinar-FINAL-23-AUG-22.ashx?la=en&hash=93B16B88819045E16DA5C84EEE3A6C416B3E457A (last visited January 22, 2024).
[333] Presentation by Kenneth Scheppke, M.D., F.A.E.M.S., Deputy Sec'y for Health, DOH, before the Senate Committee on Health Policy (Nov. 14, 2023), available at https://www.flsenate.gov/Committees/Show/HP/MeetingPacket/5979/10504_MeetingPacket_5979_4.pdf (last visited January 22, 2024).
[334] *Id.*

Similar to maternal mortality rates, rates of SMM are higher in racial and ethnic minority women.[335]

Telehealth Minority Maternity Care Pilot Program

In 2021, the Legislature created the Telehealth Minority Maternity Care Pilot Program in Duval and Orange counties to increase positive maternal health outcomes in racial and ethnic minority populations.[336]

DOH received funding in the 2023-2024 FY[337] to expand the pilot program to an additional 18 counties.[338] The additional counties are Brevard, Broward, Collier, Escambia, Hillsborough, Lake, Lee, Leon, Manatee, Marion, Miami-Dade, Palm Beach, Pasco, Pinellas, Polk, Sarasota, Seminole, and Volusia.

The pilot programs use telehealth to coordinate with prenatal home visiting programs to provide the following services and education to eligible pregnant women[339] up to the last day of their postpartum period:

- Referrals to Healthy Start's[340] coordinated intake and referral program to offer families prenatal home visiting services;
- Services and education addressing social determinants of health;[341]
- Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in prenatal and postpartum periods;
- For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers; and
- Medical devices for prenatal women to conduct key components of maternal wellness checks.[342]

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

- Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers;
- The use of remote patient monitoring tools;
- How to screen for social determinants of health risks in prenatal and postpartum periods;
- Best practices to screen for, evaluate, and treat mental health conditions and substance use disorders, as needed; and
- Collection of information, recording, and evaluation activities for program and patient evaluations.[343]

According to DOH, since the program's implementation, it has served more than 2,500 women in Duval and Orange counties, and 95 percent of the participants have reported that the program addressed an

[335] Elizabeth A. Howell, MD, MPP, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61(2) CLINICAL OBSTETRICS AND GYNECOLOGY 387 (June 2018), available at https://journals.lww.com/clinicalobgyn/abstract/2018/06000/reducing_disparities_in_severe_maternal_morbidity.22.aspx (last visited January 22, 2024).
[336] Chapter 2021-238, Laws of Florida, codified at s. 381.2163, F.S.
[337] Chapter 2023-239, Laws of Florida, line item 435.
[338] Florida Department of Health, Office of Minority Health, *Request for Applications: Programs to Reduce Severe Maternal Morbidity through Telehealth (SMMT) in Florida, RFA #22-002*, (April 19, 2023), available at https://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/RFA22-002.pdf#Open%20in%20new%20window (last visited January 22, 2024).
[339] An "eligible pregnant woman" is a pregnant woman who is receiving, or is eligible to receive, maternal or infant services from the DOH under ch. 381, F.S. or ch. 383, F.S.
[340] Healthy Start is a free home visiting program that provides education and care coordination to pregnant women and families of children under the age of three. The goal of the program is to lower risks factors associated with preterm birth, low birth weight, infant mortality, and poor development outcomes. *See* DOH, *Healthy Start*, available at https://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html (last visited January 22, 2024).
[341] Social determinants of health refer to the conditions in the places where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. They are grouped into five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environments, and social and community context. *See* U.S. Dep't of Health and Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health*, available at https://health.gov/healthypeople/priority-areas/social-determinants-health (last visited January 22, 2024).
[342] Section 383.2163(3), F.S.
[343] Section 383.2163(4), F.S.

unmet social need.[344] The five most prevalent critical factors were food scarcity, childcare, paid work opportunities, affordability and access to utilities such as the Internet, and access to stable housing.

Additionally, 71 percent of the enrolled women in Duval County and 85 percent of enrolled women in Orange County reported high satisfaction with the implementation of the technology in the pilot program.[345] The enrolled women were provided blood pressure cuffs, scales, and glucose monitors to remotely screen and treat common pregnancy-related complications.

Effect of the bill - Telehealth Minority Maternity Care Pilot Program

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

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

The bill appropriates $23,357,876in recurring funds from the General Revenue Fund to the Grants and Aids – Minority Health Initiative Category, to the DOH to expand the telehealth minority maternity care program statewide.

**Health Care Screening**

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

| Section Number | Type of Screening | Text or Summary | Agency in Charge |
|---|---|---|---|
| **381.815** | Sickle-Cell disease | "Work cooperatively with not-for-profit centers to provide community-based education, patient teaching, and counseling and to encourage diagnostic screening." | DOH |
| **381.0038** | Requires needle exchange programs to provide HIV and hepatitis screenings, or referrals.<br><br>Not state operated or | "An exchange program must:<br><br>Provide onsite counseling or referrals for drug abuse prevention, education, and treatment, and provide onsite HIV and viral hepatitis screening or referrals for such screening. If such services are offered solely by referral, they must be made available to participants within 72 hours." | DOH, however exchange programs are not state operated or funded. |

[344] Email correspondence the DOH dated October 30, 2023 (on file with the Senate Committee on Health Policy).
[345] *Id.*

| | | | |
|---|---|---|---|
| | funded. | | |
| **381.004** | HIV Testing | Requires the DOH to run HIV screening programs in each county. | DOH |
| **381.0056** | School Health Screenings | Includes vision, hearing, scoliosis, growth and development, health counseling, referrals for suspected or confirmed health problems, and preventative dental program. | County Health Departments in conjunction with District School Boards |
| **381.91** | Cancer Screenings | Community faith-based disease-prevention program to offer cancer screening, diagnosis, education, and treatment services to low-income populations throughout the state. | DOH operated from community health centers within the Health Choice Network |
| **381.93** | Breast and Cervical Cancer | "Mary Brogan Breast and Cervical Cancer Early Detection Program."<br><br>The Department of Health, using available federal funds and state funds appropriated for that purpose, is authorized to establish the Mary Brogan Breast and Cervical Cancer Screening and Early Detection Program to provide screening, diagnosis, evaluation, treatment, case management, and follow-up and referral to the Agency for Health Care Administration for coverage of treatment services. | DOH |
| **381.932** | Breast Cancer | "Breast cancer early detection and treatment referral program."<br><br>The purposes of the program are to:<br>(a) Promote referrals for the screening, detection, and treatment of breast cancer among unserved or underserved populations.<br>(b) Educate the public regarding breast cancer and the benefits of early detection.<br>(c) Provide referral services for persons seeking treatment.<br><br>"Underserved Population" defined as:<br>1. At or below 200 percent of the federal poverty level for individuals;<br>2. Without health insurance that covers breast cancer screenings; and<br>3. Nineteen to 64 years of age, inclusive. | DOH |
| **381.96** | Wellness Screenings for women | "Wellness services" means services or activities intended to maintain and improve health or prevent illness and injury, including, but not limited to, high blood pressure screening, anemia testing, thyroid screening, cholesterol screening, diabetes screening, and assistance with smoking cessation. | Pregnancy Care Network (Contracted by DOH). |
| **381.985** | Lead Poisoning | Lead poisoning screenings for children at risk for exposure to lead. | DOH |
| **383.011, 383.14-383.147** | Newborn Screenings | Various required test for newborns and infants. | DOH |
| **385.103** | Cancer, diabetes, heart disease, stroke, hypertension, renal disease, and chronic obstructive lung disease. | Chronic Disease Intervention Programs<br><br>The department shall assist the county health departments in developing and operating community intervention programs throughout the state. At a minimum, the community intervention programs shall address one to three of the following chronic diseases: cancer, diabetes, heart disease, stroke, hypertension, renal disease, and chronic obstructive lung disease.<br><br>Uses community funding, gifts, grans, and other funding. Requires volunteers to be used to the maximum extent possible. | DOH |
| **385.206** | Hematology-Oncology<br><br>Sickle-cell anemia | Allows DOH to make grants and reimbursements to designated centers to establish and maintain programs for the care of patients with hematologic and oncologic disorders.<br><br>Requires such programs to offer screenings and counseling for patients with sickle-cell anemia or other hemoglobinopathies. | DOH, through grants |
| **392.61** | Tuberculosis | DOH is required to operate TB control programs in each state including community and individual screenings | DOH |

## Effect of the bill - Health Care Screening

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

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

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

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

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

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

**Florida Center for Nursing**

Current Situation

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

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

Effect of the bill – Florida Center for Nursing

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

**Linking Industry to Nursing Education**

Established by the Legislature in 2022, the Linking Industry to Nursing Education (LINE) fund is a competitive grant program intended to address critical nursing workforce needs by incentivizing collaboration between nursing education programs and healthcare partners.[346] The LINE fund provides matching funds on a dollar-to-dollar basis, subject to funds availability, to participating institutions that partner with a healthcare provider to meet local, regional, and state workforce needs.[347] LINE funds may be used for resident student scholarships, recruitment of additional faculty, equipment, and simulation centers to advance high-quality nursing education programs throughout the state.[348] LINE funds may not be used for the construction of new buildings.[349]

In order to be eligible to receive LINE funds, an institution[350] must have a nursing education program that meets certain, specified criteria. Among the criteria is a minimum program completion rate or first-time passage rate on the National Council of State Boards of Nursing Licensing Examination (NCLEX). Specifically, the institution must have a nursing education program that meets or exceeds the following[351]:

- For a certified nursing assistant program, a completion rate of at least 70 percent for the prior year.
- For a licensed practical nurse, associate of science in nursing and bachelor of science in nursing program, a first-time passage rate on the National Council of State Boards of Nursing Licensing Examination of at least 70 percent for the prior year.

The LINE fund is administered by the Board of Governors (BOG) for State University System (SUS) institutions and the Department of Education (DOE) for all other institutions. Per DOE, non-SUS institutions with more than one nursing education program must demonstrate that at least one active program meets or exceeds the completion or passage rate criterion.[352] Additionally, school districts with more than one career center are not required to meet performance metrics for all operating career centers; however, LINE funds may only be expended at the career centers that meet or exceed the completion or passage rate criterion.[353] Additionally, per DOE guidance applicable to non-SUS institutions, new nursing education programs may not be used to determine eligibility.[354]

An institution that wishes to receive LINE funds must submit a timely and complete proposal to the BOG or DOE, as applicable.[355] The proposal must identify a healthcare partner[356] located and licensed to operate in the state whose monetary contributions will be matched on a dollar-to-dollar basis.[357]

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[346] Section 1009.8962, F.S.
[347] Section 1009.8962(5), F.S.
[348] Section 1009.8962(6)(a), F.S.
[349] Section 1009.8962(6)(b), F.S.
[350] For purposes of the LINE program, 'institution' means a school district career center under s. 1001.44, a charter technical career center under s. 1002.34, a Florida College System institution, a state university, or an independent nonprofit college or university located and chartered in this state and accredited by an agency or association that is recognized by the database created and maintained by the United States Department of Education to grant baccalaureate degrees, which has a nursing education program that meets or exceeds certain, specified completion rates or licensure passage rates. *See* s. 1009.8962(3)(b), F.S.
[351] Section 1009.8962(3)(b), F.S.
[352] *See* Florida Department of Education 'Notice of Intent-To-Apply Form, Linking Industry to Nursing Education (LINE)' here. (Last visited January 22, 2024).
[353] *Id.*
[354] *See* 'Linking Industry to Nursing Education (LINE) Fund Frequently Asked Questions,' question #28, here. (Last visited January 22, 2024).
[355] Section 1009.8962(7)(a), F.S.
[356] For purposes of the LINE program, a 'healthcare partner' is defined a provider as defined in s. 408.803, F.S.; a clinical laboratory providing services in this state or services to health care providers in this state, if the clinical laboratory is certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder; federally qualified health center as defined in 42 U.S.C. s. 1396d(l)(2)(B), as that definition existed on March 29, 2021; any site providing health care services which was established for the purpose of responding to the COVID-19 pandemic pursuant to any federal or state order, declaration, or waiver; a health care practitioner as defined in s. 456.001; a health care professional licensed under part IV of chapter 468; a home health aide as defined in s. 400.462(15); a provider licensed under chapter 394

The BOG or DOE, as applicable, must review and evaluate each completed and timely proposal according to the following minimum criteria[358]:

- Whether funds committed by the health care partner will contribute to an eligible purpose.
- How the institution plans to use the funds, including how such funds will be utilized to increase student enrollment and program completion.
- How the health care partner will onboard and retain graduates.
- How the funds will expand the institution's nursing education programs to meet local, regional, or state workforce demands. If applicable, this shall include advanced education nursing programs and how the funds will increase the number of faculty and clinical preceptors and planned efforts to utilize the clinical placement process.

Per BOG regulation, additional criteria for universities may be established by the SUS Chancellor as needed.[359] BOG regulation also states the BOG will award funding based on the merit of each proposal, funds may be awarded on a first-come, first-served basis, and award amounts may be prorated depending on the number of approved proposals and the dollar amounts requested.[360] Per State Board of Education rule, the DOE, for all non-SUS proposals, will also consider the strength of the proposed programs, the geographic location of the proposals and statewide workforce demands in order to promote the distribution of funds and avoid a concentration of funds in a small number of institutions.[361]

Each institution with an approved proposal is required to notify the BOG or DOE, as applicable, upon receipt of the funds from the healthcare partner identified in the proposal. Once notified, the BOG or DOE, as applicable is required to release the LINE funds, on a dollar-to-dollar basis, up to the amount of funds received by the institution.

Annually, by February 1, each institution awarded LINE funds in the previous fiscal year is required to submit a report to the BOG or DOE, as applicable, that demonstrates the expansion as outlined in the proposal and the use of the funds. At minimum, the report must include, by program level, the number of additional nursing education students enrolled; if scholarships were awarded using grant funds, the number of students who received scholarships and the average award amount; as well as student outcomes.

For Fiscal Years 2022-2023 and 2023-2024, the Florida Legislature allocated $6 million in LINE funding each year to the State University System.[362] For Fiscal Year 2022-2023, the BOG approved proposals from eight state universities across two application submission periods.[363] For Fiscal Year 2023-2024, proposals submitted by nine state universities were approved as of December 2023.[364] The requested funds for these proposals were primarily intended to fund student scholarships, simulation centers, and faculty salaries.[365]

For Fiscal Years 2022-2023 and 2023-2024, the Florida Legislature allocated $19 million in LINE funding each year to the Department of Education to fund proposals from Florida's public-school districts (career centers), Florida College System institutions, and independent nonprofit colleges and universities. For Fiscal Year 2022-2023, proposals submitted by 26 school districts and institutions were approved.[366]

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or chapter 397 and its clinical and nonclinical staff providing inpatient or outpatient services; a continuing care facility licensed under chapter 651; a pharmacy permitted under chapter 465. *See* s. 768.38(2), F.S.

[357] Section 1009.8962(7)(b), F.S.

[358] Section 1009.8962(8), F.S.

[359] BOG Regulation 8.008(1)(d)2.

[360] *Id.*

[361] Rule 6A-10.0352(5)(b), F.A.C.

[362] Specific Appropriation 143A, Ch. 2022-156, L.O.F. and Specific Appropriation 142, Ch. 2023-239, L.O.F.

[363] *See* State University System of Florida Board of Governors meeting documents for September 14, 2022, here and November 9, 2022, here. (last viewed January 22, 2024). (Last visited January 22, 2024).

[364] *See* State University System of Florida Board of Governors meeting documents for September 8, 2023, here and November 9, 2023, here. (last viewed January 22, 2024). (Last visited January 22, 2024).

[365] *See* State University System of Florida Board of Governors meeting presentations for September 13, 2022, here, November 9, 2022, here, September 8, 2023, here, and November 9, 2023, here.

[366] *See* '2022-2023 LINE Fund Prioritized Funding List,' here. (Last visited January 22, 2024).

Florida's public career centers, state colleges, state universities, and independent nonprofit colleges and universities that meet the minimum completion or passage rates have been eligible since the LINE Fund's inception. The 2023-2024 General Appropriations Act appropriated $5 million in nonrecurring funds to accredited private educational institutions that meet the same criteria as the public career centers, state colleges, state universities, and other private colleges and universities that are eligible for the LINE program.[367]

Effect of the bill - Linking Industry to Nursing Education

The bill expands the statutory LINE Fund program to include independent schools, colleges, or universities with an accredited nursing program that is located in and chartered by Florida and is licensed by the Commission for Independent Education. Pursuant to the bill, 'accredited program' means a program for the prelicensure education of professional or practical nurses that is conducted in the United States at an educational institution, whether in this state, another state, or the District of Columbia, and that is accredited by a specialized nursing accrediting agency that is nationally recognized by the United States Secretary of Education to accredit nursing education programs.

The also bill increases the passage rate for the NCLEX, from 70 percent to 75 percent, that is required for LPN, associate of science in nursing, and bachelor of science in nursing programs in order to be eligible to participate in the program and receive LINE funds. Additionally, the bill requires the passage rate be based on a minimum of 10 testing participants.

**Developmental Research Laboratory Schools**

Developmental research laboratory schools (lab schools) are an established category of public schools that provide sequential instruction and are affiliated with a college of education within the state university of closet geographic proximity.[368] Lab schools are required to establish admission processes that are designed to result in a representative sample of the public school enrollment based on gender, race, socioeconomic status, and academic ability.[369] As part of a lab school's mission, there must be an emphasis on mathematics, science, computer science, and foreign languages.[370] Additionally, as part of the lab school's primary goal, the school is required to enhance instruction and research in such specialized subjects by using the resources available on the university's campus. Currently, there are four universities that have lab schools:[371]

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

A university is limited to one lab school, except for a charter lab school or one that serves military families near a military installation.[372] State universities operate four charter lab schools, which are Florida State University Charter Lab K-12 School in Broward County, Florida Atlantic University Charter Lab K-12 School in Palm Beach County, Florida Atlantic University Charter Lab K-12 School in St. Lucie County[373]and the Florida State University Collegiate School in Bay County.[374] In considering an application to establish a charter lab school, a state university must consult with the district school board of the county in which the school is located. If a state university denies or does not act on the application, the applicant may appeal such decision to the State Board of Education (SBE).[375]

[367] Specific Appropriation 58, Ch. 2023-239, L.O.F.
[368] Section 1002.32(2), F.S.
[369] Section 1002.32(4), F.S.
[370] Section 1002.34(3), F.S.
[371] Florida Department of Education, *Superintendents,* https://www.fldoe.org/accountability/data-sys/school-dis-data/superintendents.stml (last visited January 22, 2024)
[372] Section 1002.32(2), F.S.
[373] *Id.*
[374] Florida State University, The Collegiate School Panama City, https://tcs.fsu.edu/ (last visited January 22, 2024).
[375] Section 1002.33(6)(g), F.S.

Effect of the bill - Developmental Research Laboratory Schools

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

**Advanced Birth Centers**

Licensure

A birth center is any facility, institution, or place in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy, aside from an ambulatory surgical center, hospital, or part of a hospital.[376] Birth centers are licensed and regulated by the Agency for Health Care Administration (AHCA) under ch. 383. F.S., and part II of ch. 408, F.S. Birth centers must have a governing body responsible for the overall operation and maintenance of the birth center.[377] The governing body must develop and provide to all staff, clinicians, consultants, and licensing authorities, a manual that documents the policies, procedures, and protocols of the birth center.[378]

A birth center may accept only those patients who are expected to have normal pregnancies and deliveries. Prior to being accepted for care, the patient must sign an informed consent form.[379] A mother and her infant must be discharged from a birth center within 24 hours after giving birth, except when:[380]

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

If a mother or infant is retained at the birth center for more than 24 hours after birth, for any reason, the birth center must submit a report to AHCA within 48 hours of the birth describing the circumstances and the reasons for the decision.[381]

*Staff*

Birth centers are required to meet certain staffing requirements. Specifically, a birth center must:[382]

- Have at least one clinical staff[383] member for every two clients in labor;
- Have a clinical staff member or qualified personnel[384] available on-site during the entire time a client is in the birth center;
- Ensure that services during labor and delivery are provided by a physician, certified nurse midwife, or licensed midwife, assisted by at least one other staff member, under protocols developed by clinical staff; and
- Have qualified personnel or clinical staff who are able to perform neonatal resuscitation present during each birth.

Additionally, birth centers must ensure that all qualified personnel and clinical staff are trained in infant and adult resuscitation.[385]

Birth centers must have written consultation agreements with each consultant who has agreed to provide advice and services to the birth center.[386] A consultant must be a licensed medical doctor or

[376] Section 383.302(2), F.S.; Section 383.302(8), F.S. defines "low-risk pregnancy" as a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.
[377] Section 383.307, F.S.
[378] *Id.*
[379] Section 383.31, F.S. The informed consent form must advise the patient of the qualifications of the clinical staff, the risks related to out-of-hospital births, the benefits of out-of-hospital births, and the possibility of referral or transfer if complications arise during pregnancy or childbirth with additional costs for services rendered (Rule 59A-11.010, F.A.C.)
[380] Section 383.318(1), F.S., and Rule 59A-11.016(6), F.A.C.
[381] Section 383.318, F.S.
[382] Rule 59A-11.005(3), F.A.C.
[383] Section 383.302(3), F.S., defines "clinical staff" as individuals employed full-time or part-time by a birth center who are licensed or certified to provide care at childbirth.
[384] Rule 59A-11.002(6), F.A.C., defines "qualified staff" as an individual who is trained and competent in the services that he or she provides and is licensed or certified when required by statute or professional standard.
[385] Rule 59A-11.005(3), F.A.C.

licensed osteopathic physician who is either certified or eligible for certification by the American Board of Obstetrics and Gynecology, or has hospital obstetrical privileges.[387] Consultation may be provided onsite or by telephone.[388]

*Clinical Records*

Birth centers are required to maintain a complete clinical record for each client, which must include:[389]

- Identifying information including the client's name, address, and telephone number;
- Initial history and physical examination;
- Obstetrical risk assessments and pre-term labor risk assessments, including the dates of the assessments;
- The date and time of the onset of labor;
- The exact date and time of birth;
- All treatments rendered to the mother and newborn;
- The metabolic screening report;
- Condition of the mother and newborn, including any complications; and
- Referrals for medical care and transfers to hospitals.

*Medical Treatments and Procedures*

A birth center may perform simple laboratory tests and collect specimens for tests that are requested pursuant to its protocol.[390] A birth center is exempt from the clinical laboratory licensure requirements under ch. 483, F.S., if the birth center employs no more than five physicians and its testing is conducted exclusively in connection with the diagnosis and treatment of patients of the birth center.[391]
Birth centers may perform surgical procedures that are normally performed during uncomplicated childbirths, such as episiotomies and repairs. Birth centers may not perform operative obstetrics or caesarean sections.[392]

Birth centers may not administer general anesthesia or conduction anesthesia. Systemic analgesia and local anesthesia for pudendal block and episiotomy repair may be administered if procedures are outlined by the clinical staff and performed by personnel with statutory authority to do so.[393]
Birth centers may not inhibit, simulate, or augment labor with chemical agents during the first or second stage of labor unless prescribed by personnel with the statutory authority to do so and in connection with and prior to an emergency transport.[394]

Birth centers must provide postpartum care and evaluation that includes physical examination of the infant, metabolic screening tests, referral to pediatric care sources, maternal postpartum assessment, family planning, referral to secondary or tertiary care, and instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.[395]

*Physical Plant*

Birth centers must be designed to ensure adequate provision for birthing rooms, bath and toilet facilities, storage areas for supplies and equipment, examination areas, and reception or family areas.[396]
Birth centers are required to comply with the provisions of the Florida Building Code and Florida Fire Prevention Code applicable to birth centers.[397] The AHCA may enforce the special-occupancy

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[386] Section 383.315(1), F.S.
[387] Section 383.302(4), F.S.
[388] Section 383.315(2), F.S.
[389] Rule 59A-11.005(4), F.A.C.
[390] S. 383.313, F.S.
[391] *Id.*
[392] *Id.*
[393] *Id.*
[394] *Id.*
[395] Section 383.318, F.S.
[396] Section 383.308(1), F.S.
[397] Section 383.309(2), F.S.; Section 452 of the Florida Building Code provides requirements for birth centers.

provisions of the Florida Building Code and the Florida Fire Prevention Code that apply to birth centers when conducting inspections.[398]

*Equipment*

Birth centers must have the equipment necessary to provide low-risk maternity care and readily available equipment to initiate emergency procedures for mothers and infants during life-threatening events.[399] Such equipment must include:

- Oxygen with flow meter and mask or equivalent;
- Resuscitation equipment to include resuscitation bags and oral airways, and laryngoscopes and endotracheal tubes appropriate for the newborn;
- Emergency medications and intravenous fluids with supplies and equipment appropriate for administration;
- Sterile suturing equipment and supplies;
- An examining table and stool;
- An examination light;
- An adult beam scale;
- An infant scale;
- A sphygmomanometer and stethoscope;
- A clinical thermometer;
- A fetoscope or doppler unit;
- A bassinet;
- A sweep second hand clock;
- A mechanical suction or bulb suction; and
- A firm surface suitable for resuscitation.

*Penalties and Fines*

AHCA may impose an administrative fine not to exceed $500 per violation per day for the violation of any provision of the Birth Center Licensure Act, part II of chapter 408, or applicable rules.[400] AHCA may also impose an immediate moratorium on elective admissions to any birth center when it determines that any condition in the facility presents a threat to the public health or safety.[401]

*Annual Report*

Birth centers are required to submit an annual report to AHCA that details, among other things:[402]

- The number of deliveries by birth weight;
- The number of maternity clients accepted for care and length of stay;
- The number of surgical procedures performed at the birth center by type;
- Maternal transfers, including the reasons for each transfer and whether it occurred intrapartum or postpartum, and the length of the subsequent hospital stay;
- Newborn transfers, including the reasons for each transfer, the birth weight, days in hospital, and Apgar score at five and ten minutes;[403]
- Newborn deaths;
- Stillborn/fetal deaths; and
- Maternal deaths.

[398] *Id.*
[399] Section 383.308(2)(a), F.S.
[400] S. 383.33, F.S.
[401] Id.
[402] Rule 59A-11.019, F.A.C., and AHCA Form 3130-3004, (Feb. 2015).
[403] Apgar is a quick test performed on a baby at 1 and 5 minutes after birth. The 1-minute score determines how well the baby tolerated the birthing process. The 5-minute score tells the health care provider how well the baby is doing outside the mother's womb. In rare cases, the test will be done 10 minutes after birth. See *Apgar Score*, Medline Plus, *available at* https://medlineplus.gov/ency/article/003402.htm (last visited January 22, 2024).

Effect of the bill - Advanced Birth Centers

*Licensure*

The bill creates a new designation for birth centers as advanced birth centers (ABCs), and allows ABCs to treat more types of patients and perform more types of procedures than traditional birth centers. The bill authorizes ABCs to perform trial of labor after cesarean deliveries for screened patients who qualify, planned low-risk cesarean deliveries, and anticipated vaginal deliveries for laboring patients from the beginning of the 37th week of gestation through the end of the 41st week of gestation.

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

- Meet all standards adopted by rule for birth centers, unless specified otherwise.
- Comply with the Florida Building Code and Florida Fire Prevention Code standards for ambulatory surgical centers.
- Be operated and staffed 24 hours per day, 7 days per week.
- Employ two medical directors to oversee the activities of the center, one of whom must be a board-certified obstetrician and one of whom must be a board-certified anesthesiologist, both licensed under either ch. 458 or 459, F.S.
- Employ at least one registered nurse and ensure that at least one registered nurse is present in the center at all times and has the ability to stabilize and facilitate the transfer of patients and newborn infants when appropriate.
- Have at least one properly equipped, dedicated surgical suite for the performance of cesarean deliveries.
- Enter into a written agreement with a blood bank for emergency blood bank services and have written protocols for the management of obstetrical hemorrhage which include provisions for emergency blood transfusions.
- Qualify for, enter into, and maintain a Medicaid provider agreement with AHCA pursuant to s. 409.907, F.S., and provide services to Medicaid recipients according to the terms of the provider agreement.

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

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

*Medical Treatments and Procedures*

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

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

The bill authorizes an ABC to administer general, conduction, and local anesthesia if administered by personnel who have statutory authority to do so. All anesthesia must be administered by an anesthesiologist or certified registered nurse anesthetist (CRNA). If general anesthesia is administered,

a physician or CRNA must be present in the ABC during the anesthesia and the post anesthesia recovery period until the patient is fully alert.

The bill authorizes the use of chemical agents to inhibit, stimulate, or augment labor during the first or second stage of labor at an ABC if prescribed by personnel who have the statutory authority to do so. Labor may be induced at the 39th week of gestation for a patient with a document Bishop score of eight or greater.[404]

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

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

**Health Care Spending**

Health spending in the United States has exploded in the last 50 years, totaling $74.1 billion in 1970, increasing to $1.4 trillion by 2000, then tripling in 2021 to $4.3 trillion.[405] Total national health expenditures grew by $175 billion in 2022 from 2021 with hospital expenditures and retail prescription drugs accounting for approximately one-third of the spending growth.[406]

Private insurance expenditures have also been growing at a faster pace than either Medicaid or Medicare spending. In 1970, private health insurance expenditures represented 20.4 percent of total health spending; whereas, for 2022, the percentage had grown to 28.9 percent.[407] Additionally, per enrollee spending by private insurers increased by 61.6 percent from 2008 to 2022, a rate that was faster than the per enrollee spending for public programs such as Medicare and Medicaid. From 2021 to 2022, the rate for private insurers was 4.3 percent while Medicaid rose by 2.2 percent and Medicare by 3.8 percent.[408]

The following chart illustrates the rate of growth in total national health expenditures from 1970 to 2022[409]:

[404] The Bishop scoring system is based on a digital cervical exam of a patient with a zero point minimum and 13 point maximum. The scoring system utilizes cervical dilation, position, effacement, consistency of the cervix, and fetal station. A Bishop score of 8 or greater is considered to be favorable for induction, or the chance of a vaginal delivery with induction is similar to spontaneous labor. A score of 6 or less is considered to be unfavorable if an induction is indicated cervical ripening agents may be utilized. See Wormer KC, Bauer A, Williford AE. Bishop Score. [Updated 2023 Sep 4]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available at https://www.ncbi.nlm.nih.gov/books/NBK470368/, (last visited January 22, 2024).

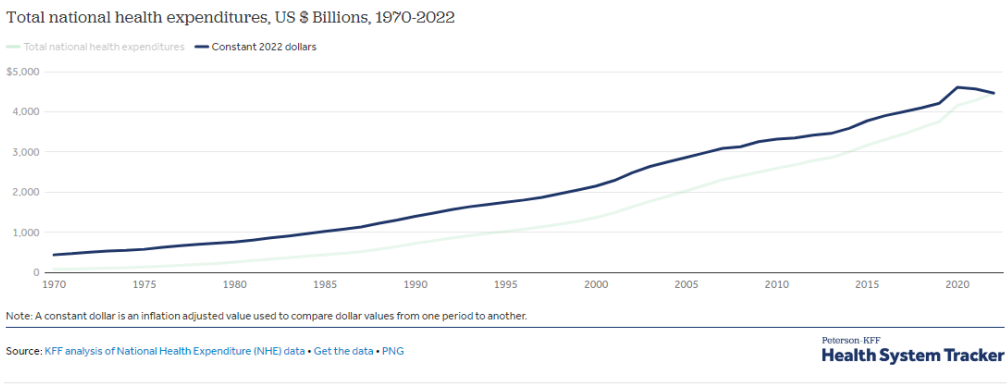
[405] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How has U.S. spending on healthcare changed over time?*, December 15, 2023, available at https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Total%20national%20health%20expenditures,%20US%20$%20Billions,%201970-2022 https://healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/ (last viewed on January 22, 2024).

[406] *Id.*

[407] *Id.*

[408] *Id.*

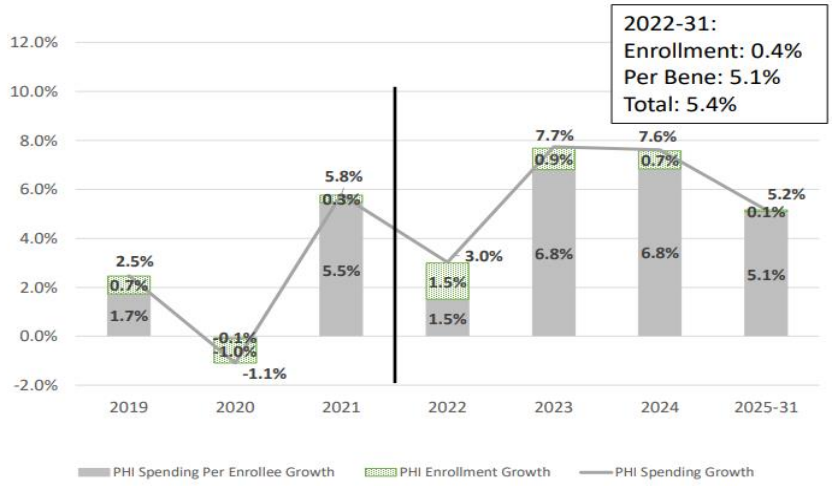
[409] *Supra*, note **Error! Bookmark not defined.**.




Health care prices are a primary driver of health care spending. While health care spending has slowed in recent decades, from a high of 12 percent in the 1970s to the current 9.6 percent for the 2020-2022 period, spending still consistently exceeds growth in the country's GDP.[410] Per enrollee spending for those with private health insurance in 2023 to 2024 is expected to be at a faster pace than in 2022 due to an increase in health care utilization and health care costs. Growth in the private health insurance market, according to the Chief Actuary's report,[411] is tied to increased enrollment in the Marketplace while additional subsidies were available under the American Rescue Plan Act.[412]

Projections for 2022-31 by the Office of the Actuary at Centers for Medicare and Medicaid Services show an average predicted growth rate in national health expenditures (NHE) of 5.4 percent which would outpace the expected average GDP growth rate for the same time period of 4.6 percent.[413] The chart below illustrates the average annual growth in enrollment per beneficiary spending, and total spending, by the designated time period.[414] The reductions shown for the outlier years of 2025 through 2031 are tied to the expiration of the Marketplace subsidies which exist in current law and the associated projected 10 percent or 2 million beneficiaries drop in privately purchased health insurance coverage.[415]

[410] *Supra*, note **Error! Bookmark not defined.**
[411] Centers for Medicare and Medicaid Services, *National Health Expenditures Projections 2022-31: Growth to Stabilize Once Public Health Emergency Ends*, June 14, 2023, Slide 10, available at *https://www.cms.gov/files/document/release-presentation-slides-national-health-expenditure-projections-2022-31-growth-stabilize-once.pdf* (Last visited January 22, 2024).
[412] *Id*. The American Rescue Plan Act of 2021 (P.L. 117-7) amended the Patient Protection and Affordable Care Ac (P.L. 111-148, March 28, 2010 and Health Care and Education Reconciliation Act of 2010 ((P.L. 2010 -152, March 30, 2010)), collectively know n as PPACA) to provide additional funding relief to the states to address a range of impacts from the COVID-19 pandemic. Included in its provisions, w as a special rule for any individual w ho had received or had been approved to receive unemployment compensation during 2021 for the plan year in w hich the compensation be gan w hich qualified any such individual for the same cost sharing subsidies for health care expenses under qualified health insurance plans in the Marketp lace as any other individual in a household income of 133 percent of the poverty or less for the family size involved. The special rule w as effective with plan years w hich began after December 31, 2020. (Section 2305 of H.R. 1319; March 11, 2021).
[413] *Supra* note, **Error! Bookmark not defined.**
[414] *Id.*

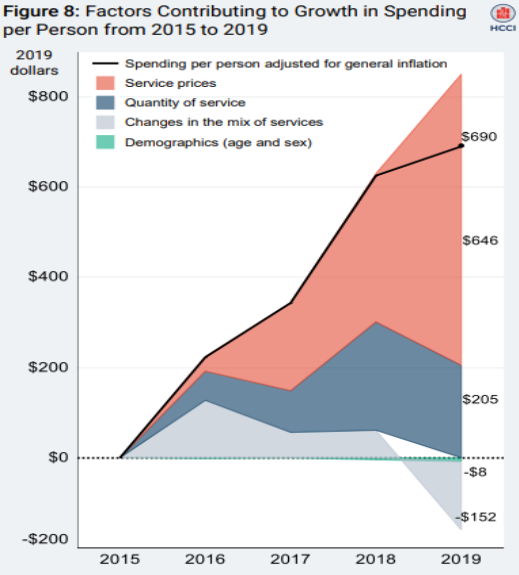



NOTE: Average annual growth rates are from previous year shown.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

The United States spends more per person on health care than any other high-income country in the world and spending has continued to increase over the past few decades. Health spending per person in the U.S. was $12,914 in 2021 and increased for 2022 to $13,493, more than $5,000 greater than any other high income nation.[416]


The Organization for Economic Cooperation Development estimated that total spending in 2019 in its member countries averaged 8.8 percent of GDP, compared with 16.8 percent in the U.S.[417] One study found that United States commercial health spending per enrollee increased by 21.8% between 2015 and 2019.[418] The rising prices of health care services accounted for approximately two-thirds of that growth, with prices for prescription drugs, provider services (physical examinations, screenings and procedures) and inpatient and outpatient care rising by 18.3%.[419] The following chart details the factors contributing to the growth in spending, per capita, in the United States:[420]

[416] Peterson-Kaiser Family Foundation, Health System Tracker, *Health Spending – How does health spending in the U.S. compare to other countries?*, February 9, 2023, available at (https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/ last viewed on January 22, 2024). The average amount spent on health per person in comparable countries – $6,125 – is less than half of what the U.S. spends.
[417] *Supra*, note **Error! Bookmark not defined.**.
[418] Health Care Cost Institute, *2019 Health Care Cost and Utilization Report*, pg. 2, available at https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf (last viewed January 22, 2024).
[419] *Id.*
[420] *Supra*, note **Error! Bookmark not defined.**




## Health Care Price Transparency

This country is experiencing significant changes in the payment and delivery of health care services. Consumers bear a greater share of health care costs, and more consumers participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data needs to be free, timely, reliable, and reflect individual health care needs, and insurance coverage.

Price transparency can refer to the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties.[421] Price can be defined as an estimate of a consumer's complete cost on a health care service or services that reflects any negotiated discounts; is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and, identifies a consumer's out-of-pocket cost.[422] Further, price transparency can be considered "readily available information on the price of health care services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value."[423] Indeed, the definition of the price or cost of health care has different meanings depending on who is incurring the cost.[424]

### *Employee Out of Pocket Costs*

As health care costs continue to rise, most health insurance buyers are asking their consumers to take on a greater share of their costs, increasing both premiums and out-of-pocket expenses. According to the *2023 Kaiser Family Foundation Employer Health Benefits Survey*, 30 percent of Americans with private insurance were enrolled in a HDHP in 2023.[425] Additionally, employees in most firms, 77 percent, do not have a choice of health plans or benefit options, including 26 percent who are in firms where the only offer is a high deductible plan with savings option (HDHP/SO).

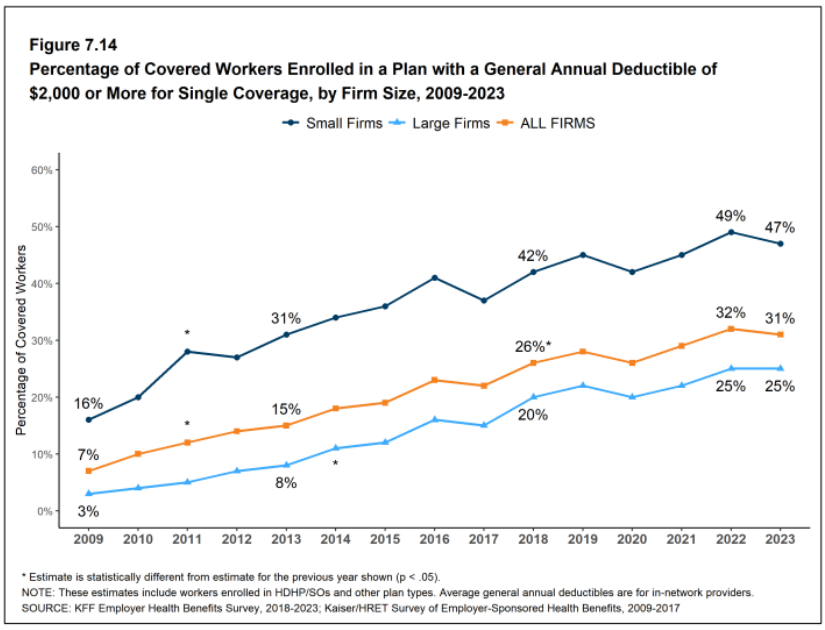
Most covered workers face additional out-of-pocket costs when they use health care services, such as co-payments or coinsurance for physician visits and hospitalizations. For 2023, ninety percent of

[421] Government Accounting Office, *Meaningful Price Information is Difficult for Consumers to Obtain Prior to Receiving Care*, September 2011, pg. 2, available at https://www.gao.gov/products/gao-11-791 (last viewed January 22, 2024).
[422] *Id.*
[423] Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, pg. 2, April 10, 2014 available at https://www.hfma.org/payment-reimbursement-and-managed-care/pricing/22274/ (last viewed January 22, 2024).
[424] *Id.*
[425] The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey,* October 18, 2023, p. 79, available at https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (last viewed on January 22, 2024).

covered workers had a general annual deductible[426] for single coverage that must be met before most services are paid for by their health plan.[427] Ten years ago, the percentage of covered workers with a general annual deductible was 78 percent and 85 percent five years ago.[428]

Among covered workers with a general annual deductible, the 2023 average deductible amount for single coverage across all plan types is $1,735 which is similar to the average amount for 2022 of $1,763.[429] Deductibles can differ greatly by a number of factors, including firm size, region, or whether a plan incorporates other cost sharing provisions. Looking at costs by firm size in 2023; the average amount for single coverage was $2,434 in small firms and $1,478 in large firms.[430]

The 2023 plan deductible averages reflect moderate reductions from the average deductibles for small and large group plans in 2022 which were $2,543 and $1,493, respectively. Seventy-four percent of covered workers in small firms are in a plan with a deductible of at least $1,000 for single coverage compared to 58 percent in large firms;[431] a similar pattern exists for those in plans with a deductible of at least $2,000 (47 percent for small firms vs. 25 percent for large firms). The chart below shows the percent of workers enrolled in employer-sponsored insurance with an annual deductible of $1,000 or more for single coverage by employer size for 2009 through 2023.[432]




From 2013 to 2023, the average premium contribution required of covered workers with family coverage increased 19 percent and if broken down by just the last 5 years, the average worker contribution towards family health insurance coverage has increased by 22 percent compared to a 27 percent in workers' wages and 21 percent inflation.[433] The dramatic increases in the costs of health care in recent years have focused significant attention on the need for greater communication and transparency to inform individual health care choices.

Employer contributions to coverage vary widely based on the type of coverage and plan. For small plans, 30 percent of employers pay the entire premium for individual coverage of their workers whereas this is only the case with 6 percent of large firm employers. For family coverage, however, only small

[426] The term "general annual deductible" means a deductible which applies to both medical and pharmaceutical benefits and which must be met by the insured individual before most services are covered by the health plan. *See* The Henry J. Kaiser Family Foundation, *2023 Employer Health Benefits Survey,* October 18, 2023, p. 106, available at https://www.kff.org/report-section/ehbs-2023-section-4-types-of-plans-offered/ (last viewed on January 22, 2024).
[427] *Id.*
[428] *Id.*, and FIG. 7.2 at p.108.
[429] *Id.*
[430] *Id.* at 107-108.
[431] *Id.* at 115 and FIG. 7.13.
[432] *Id.*, at116 and FIG.7.14.
[433] *Id.* at 7.

firm employees contribute more than half the premium costs for family coverage, compared to 8 percent of covered workers in large firms.[434]

For workers in high deductible health plan plans (HDHP), they may receive contributions from their employer into a savings account which may be used to reduce cost sharing amounts or to cover items not included in the employer's benefit package. In 2023, 7 percent of covered workers with a HDHP with a health reimbursement arrangement (HRA)[435] and 4 percent of covered workers in a Health Savings Account (HSA) – qualified HDHP received an employer contribution to their accounts that was greater than or equal to their annual deductible.[436] An HRA is defined by the Internal Revenue Service (IRS) as an account-based group health plan provided by an employer to provide for the reimbursement of medical expenses under IRS Code section 213(d) and is subject to maximum, fixed-dollar amounts for reimbursements within a specified period, usually a plan year.[437]

For those employees with an HDHP with an HRA, 12 percent of those workers received an employer contribution that if the amount had been applied to the worker's annual deductible, the remaining deductible would be less than $1,000.[438] HSA-qualified HDHPs are required by federal law to have an annual out of pocket maximum of no more than $7,500 for single coverage and $15,000 for family coverage. For HDHPs with an HRA option that are not grandfathered plans, the out of pocket maximum in 2023 was $9,100 for single coverage and $18,200 for family coverage. The average out of pocket maximum for 2023 was $5,456 for HDHP/HRAs and $4,415 for HSA-qualified HDHPs.[439]

Such funding arrangements are more likely to be found in firms with more than 200 workers (57 percent) than smaller firms (29 percent).[440] Enrollment has increased over the past 10 years in HDHP/SOs growing from 10 percent of covered workers in 2013 to 29 percent in 2023.[441]

*National Price Transparency Studies*

To explore how expanding price transparency efforts could produce significant cost savings for the healthcare system, the Gary and Mary West Health Policy Center funded an analysis, "Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending." As noted by the authors, American consumers have historically found it difficult to comparison shop for health care services as information about pricing and service delivery is buried in secrecy and shrouded in medical jargon once information is uncovered by the consumer.[442] The authors also provide a two-step definition of price transparency: A process which, first, more generally describes price transparency as the readily available price data for the purposes of price comparison, and a second which focuses on different audiences who use that data and the unique needs of those different audiences.[443]

This report, conducted in collaboration with researchers from the Center for Studying Health System Change and RAND, found that implementation of three policy changes could save $100 billion over ten years.

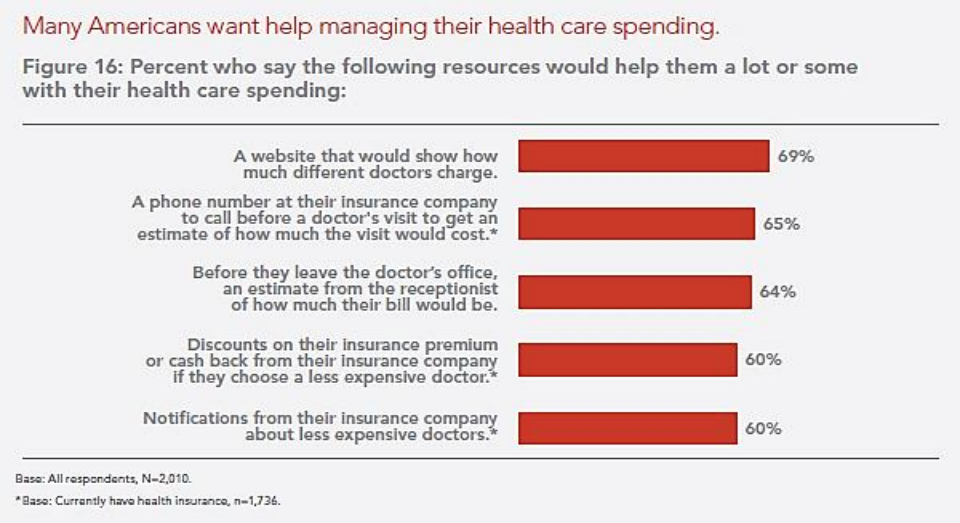
- Provide personalized out-of-pocket expense information to patients and families before receiving care.
- Provide prices to physicians through electronic health record systems when ordering treatments and tests.

[434] *Id*. at 9.
[435] A high deductible health plan with a savings option (HDHP/SOs) are health plans which have a deductible of at least $1,000 for individual coverage and $2,000 for family coverage which are paired with a health reimbursement account (HRA), or a high deductible health plan that is considered by federal requirements to be a qualified HDHP. Funds in these savings accounts are pre-tax dollars which may be used to cover out-of-pocket medical expenses and other plan cost sharing.
[436] *Supra*, note **Error! Bookmark not defined.** at 12.
[437] *Health Reimbursement Arrangements and Other Account Based Group Health Plans*, Supplementary Information – Final Rule, 84 Fed.Reg.119, 28887 (June 20, 2019), available at https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf (last viewed January 22, 2024).
[438] *Supra*, note **Error! Bookmark not defined.** at 12.
[439] *Supra*, note **Error! Bookmark not defined.** at 147.
[440] *Supra*, note **Error! Bookmark not defined.** at 140.
[441] *Supra*, note **Error! Bookmark not defined.** at 142.
[442] White, C., Ginsburg, P., et al., Gary and Mary West Health Policy Center, *Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending*, May 2014, p. 3, available at https://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf (last viewed January 22, 2024) .
[443] *Id.*

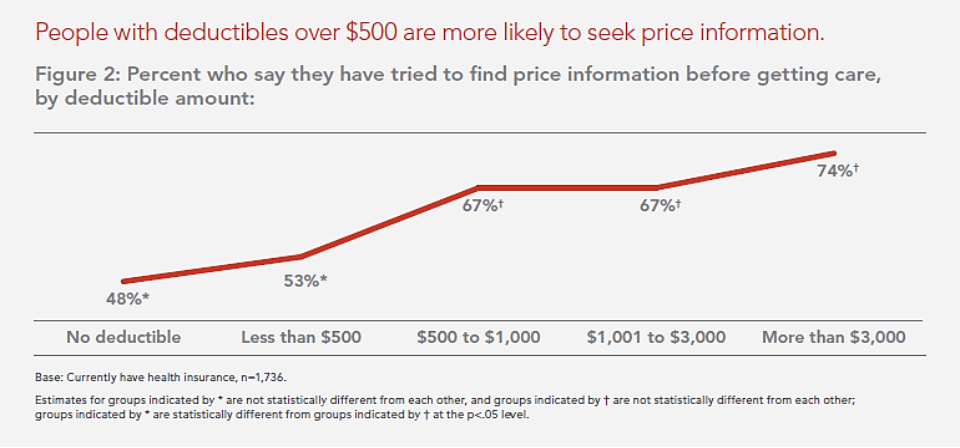
- Expand state-based all-payer health claims databases, which could save up to $55 billion by collecting and providing data and analytics tools that supply quality, efficiency and cost information to policy makers, employers, providers, and patients.[444]

The report specifically found that requiring all private health insurance plans to provide personalized out-of-pocket price data to enrollees would reduce total health spending by an estimated $18 billion over the 10-year period from 2014 to 2023.[445]

As Americans take on more of their health care costs, research suggests that they are looking for more and better price information.[446]




One study in 2014, which included a survey of more than 2,000 adults from across the country, found that 56 percent of Americans actively searched for price information before obtaining health care, including 21 percent who compared the price of health care services across multiple providers.[447] The chart below illustrates the finding that, as a consumer's health plan deductible increases, the consumer is more likely to seek out price information.[448]




The individuals who compared prices stated that such research affected their health care choices and saved them money.[449] In addition, the study found that most Americans do not equate price with quality of care. Seventy-one percent do not believe higher price reflects higher level care quality and 63

[444] *Id.*
[445] *Id.*, at. 1.
[446] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 34, available at https://www.publicagenda.org/reports/how-much-will-it-cost-how-americans-use-prices-in-health-care/ (last viewed January 22, 2024).
[447] *Id.*, at 3.
[448] *Id.*, pg. 13.
[449] *Id.*, pg. 4.

percent do not believe that lower price is indicative of lower level care quality.[450] Consumers enrolled in high-deductible and consumer-directed health plans are more price-sensitive than consumers with plans that have much lower cost-sharing obligations. Accordingly, these consumers find an estimate of their individual out-of-pocket costs more useful than any other kind of health care price transparency tool.[451] Another study found that when they have access to well-designed reports on price and quality, 80 percent of health care consumers will select the highest value health care provider.[452]

*Florida Price Transparency: Florida Patient's Bill of Rights and Responsibilities*

In 1991, the Legislature enacted the Florida Patient's Bill of Rights and Responsibilities (Patient's Bill of Rights).[453] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[454] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity;
- Provision of information;
- Financial information and the disclosure of financial information;
- Access to health care;
- Experimental research; and
- Patient's knowledge of rights and responsibilities.

A patient has the right to request certain financial information from health care providers and facilities.[455] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[456] Estimates must be written in language "comprehensible to an ordinary layperson."[457] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[458] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[459]

Currently, under the Patient's Bill of Rights financial information and disclosure provisions:

- A request is necessary before a health care provider or health care facility must disclose to a Medicare-eligible patient whether the provider or facility accepts Medicare payment as full payment for medical services and treatment rendered in the provider's office or health care facility.
- A request is necessary before a health care provider or health care facility is required to furnish a person an estimate of charges for medical services before providing the services. The Florida Patient's Bill of Rights and Responsibilities does not require that the components making up the estimate be itemized or that the estimate be presented in a manner that is easily understood by an ordinary layperson.
- A licensed facility must place a notice in its reception area that financial information related to that facility is available on the website of the Agency for Health Care Administration (AHCA).
- The facility may indicate that the pricing information is based on a compilation of charges for the average patient and that an individual patient's charges may vary.
- A patient has the right to receive an itemized bill upon request.

[450] Supra, FN 14.
[451] American Institute for Research, *Consumer Beliefs and Use of Information About Health Care Cost, Resource Use, and Value*, Robert Wood Johnson Foundation, October 2012, pg. 4, available at https://www.air.org/sites/default/files/Resource-rwjf402126.pdf (air.org)(last viewed January 22, 2024).
[452] Hibbard, JH, et al., *An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care*, Health Affairs 2012; 31(3): 560-568 ,available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.1168 (last viewed on January 22, 2024).
[453] S. 1, Ch. 91-127, Laws of Fla. (1991); s. 381.026, F.S.
[454] S. 381.026(3), F.S.
[455] S. 381.026(4)(c), F.S.
[456] S. 381.026(4)(c)3., F.S.
[457] *Id.*
[458] *Id.*
[459] S. 381.026(4)(c)5., F.S.

Health care providers and health care facilities are required to make available to patients a summary of their rights. The applicable regulatory board or Agency may impose an administrative fine when a provider or facility fails to make available to patients a summary of their rights.[460]

The Patient's Bill of Rights also authorizes, but does not require, primary care providers[461] to publish a schedule of charges for the medical services offered to patients.[462] The schedule must include certain price information for at least the 50 services most frequently provided by the primary care provider.[463] The law also requires the posting of the schedule in a conspicuous place in the reception area of the provider's office and at least 15 square feet in size.[464] A primary care provider who publishes and maintains a schedule of charges is exempt from licensure fees for a single renewal of a professional license and from the continuing education requirements for a single 2-year period.[465]

The law also requires urgent care centers to publish a schedule of charges for the medical services offered to patients.[466] This applies to any entity that holds itself out to the general public, in any manner, as a facility or clinic where immediate, but not emergent, care is provided, expressly including offsite facilities of hospitals or hospital-physician joint ventures; and licensed health care clinics that operate in three or more locations. The schedule requirements for urgent care centers are the same as those established for primary care providers.[467] The schedule must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day (until the schedule is published and posted).[468]

*Florida Price Transparency: Health Care Facilities*

Under s. 395.301, F.S., a health care facility[469] must provide, within 7 days of a written request, a good faith estimate of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group[470] or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

[460] S. 381.0261, F.S.
[461] S. 381.026(2)(d), F.S., defines primary care providers to include allopathic physicians, osteopathic physicians, and nurses who provide medical services that are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[462] S. 381.026(4)(c)3., F.S.
[463] *Id.*
[464] *Id.*
[465] S. 381.026(4)(c)4., F.S.
[466] S. 395.107(1), F.S.
[467] S. 395.107(2), F.S.
[468] S. 395.107(6), F.S.
[469] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of Chapter 395, F.S.
[470] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention and resource intensity. For more information, see https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last viewed January 22, 2024).

Current law also directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates, and that actual charges will be based on the services actually provided.[471] Under s. 408.05, F.S., AHCA contracts with a vendor to collect and publish this cost information to consumers on an internet site.[472] Hospitals and other facilities post a link to this site - https://pricing.floridahealthfinder.gov/ - to comply with the price transparency requirements. The cost information is searchable, and based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[473]

The law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.[474]

Federal Price Transparency Laws and Regulations

Congress and federal regulatory agencies recently took steps to improve the quantity and quality of health care cost information available to patients.

Hospital Facility Transparency

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[475] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file of standard charges and a consumer-friendly presentation of prices for at least 300 shoppable health care services. The regulations became effective on January 1, 2021.[476]

The regulations define a shoppable service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This information should provide a patient with both a reasonable point estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall.

The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[477] Very early indications suggest that there are varying levels of compliance with the new rules among hospital facilities.[478]

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[471] S. 395.301, F.S.
[472] S. 408.05(3)(c), F.S.
[473] *Id.*
[474] S. 456.0575(2), F.S.
[475] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 FR 65524 (November 27, 2019)(codified at 45 CFR Part 180).
[476] *Id.*
[477] *Supra*, note **Error! Bookmark not defined.**.
[478] ADVI, "*Implementation of Newly Enacted Hospital Price Transparency*," available at https://advi.com/analysis/Hospital_Transparency_-_ADVI_Summary.pdf.

### Health Insurer Transparency

On October 29, 2020, the federal Departments of Health and Human Services, Labor, and Treasury finalized regulations[479] imposing new transparency requirements on issuers of individual and group health insurance plans.

### Estimates

Central to the new regulations is a requirement for health plans to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurance plans must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs *before* receiving health care to encourage shopping and price competition amongst providers.[480]

Each health plan will be required to establish an online shopping tool that will allow insureds to see the negotiated rate between their provider and their plan, as well as a personalized estimate of their out-of-pocket cost for 500 of the most shoppable items and services. This requirement is scheduled to take effect on January 1, 2023. Beginning in 2024, health plans will need to provide personalized cost-sharing information to patients across the full range of covered health care services.[481]

### Medical Loss Ratio

The regulations also clarify the treatment of shared savings expenses under medical loss ratio (MLR) calculations required by the Patient Protection and Affordable Care Act (PPACA). MLR refers to the percentage of insurance premium payments that are actually spent on medical claims by an insurer. In general, MLR requirements are intended to promote efficiency among insurers.[482] The PPACA established minimum MLR requirements for group and individual health insurance plans.[483] Under the PPACA, large group plans must dedicate at least 85 percent of premium payments to medical claims, while small group and individual market plans must dedicate at least 80 percent of premium payments to medical claims.[484] Further, the law requires a health plan that does not meet these standards to provide annual rebates to individuals enrolled in the plan.[485]

The regulations finalized in October 2020 specify that expenses by a health plan in direct support of a shared savings program shall be counted as medical expenditures.[486] Thus, a health plan providing shared savings to members will receive an equivalent credit towards meeting the MLR standards established by PPACA. In theory, this policy should provide an additional incentive for insurers who have not already done so to adopt shared savings programs.

### The Federal No Surprises Act

On December 27, 2020, Congress enacted the No Surprises Act as part of the Consolidated Appropriations Act of 2021.[487] The No Surprises Act includes a wide-range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of care. Most sections of the Act went into effect on January 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor were tasked with issuing regulations and guidance to implement a number of the provisions.[488]

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[479] Transparency in Coverage, 85 FR 73158 (November 12, 2020)(codified at 29 CFR Part 54, 29 CFR Part 2590, 45 CFR Part 147, and 45 CFR Part 158).
[480] Trump Administration Finalizes Transparency Rule for Health Insurers," Health Affairs Blog, November 1, 2020. Available at https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last viewed on January 22, 2024).
[481] *Supra*, note 72.
[482] "Explaining Health Care Reform: Medical Loss Ratio (MLR)", Henry J Kaiser Family Foundation, February 29, 2012. Available at https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ (last viewed on January 22, 2024).
[483] PPACA s. 1001; 42 U.S.C. 300gg-18.
[484] *Supra*, note **Error! Bookmark not defined.**.
[485] *Id.*
[486] 45 CFR Part 158.
[487] PL 116-260. The No Surprises Act is found in Division BB of the Act.
[488] *Id.*

Estimates – Facilities

In the realm of price transparency, the No Surprises Act establishes the concept of an "advanced explanation of benefits" that combines information on charges provided by a hospital facility with patient-specific cost information supplied by a health insurance plan. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a "good faith estimate" of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured).[489]

Estimates – Health Plans

Once the "good faith estimate" has been shared with a patient's health plan, the plan must then develop a more detailed and "advanced explanation of benefits". This personalized cost estimate must include the following:

- An indication of whether the facility participates in the patient's health plan network. If the facility is non-participating, information on how the patient can receive services from a participating provider;
- The good-faith estimate prepared by the hospital facility based on billing/diagnostic codes;
- A good-faith estimate of the amount to be covered by the health plan;
- A good-faith estimate of the amount of the patient's out-of-pocket costs;
- A good-faith estimate of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's health plan;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (i.e., medical necessity determinations, prior authorization, step therapy, etc.); and,
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.[490]

Furthermore, the Act directs the Secretary of Health and Human Services (HHS) to establish by January 1, 2022, a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals that substantially differ from a provider's good faith estimate provided prior to the service being rendered.[491]

The new requirements placed on hospitals and health plans by the No Surprises Act are cumulatively intended to provide patients with increased certainty about the total and out-of-pocket costs associated with health care services. In turn, patients may be more equipped to seek out cost-effective care and avoid unforeseen costs that can lead to financial strain,
Many hospitals currently do not comply with the federal transparency requirements. A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.[492] Further, an August 2022 review of 2,000 hospitals found that 16 percent complied with all transparency requirements.[493] Nearly 84 percent of hospitals failed to post machine-readable files containing standard charges, and roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.[494] Another review of more than 6,400 hospitals showed wide-spread non-compliance with the federal transparency rule- more than 63 percent of hospitals were not in compliance as of the report date.[495] According to that same review, only 38 percent of Florida hospitals were in compliance.[496] The first fines were not levied by federal CMS against Northside until almost 18 months

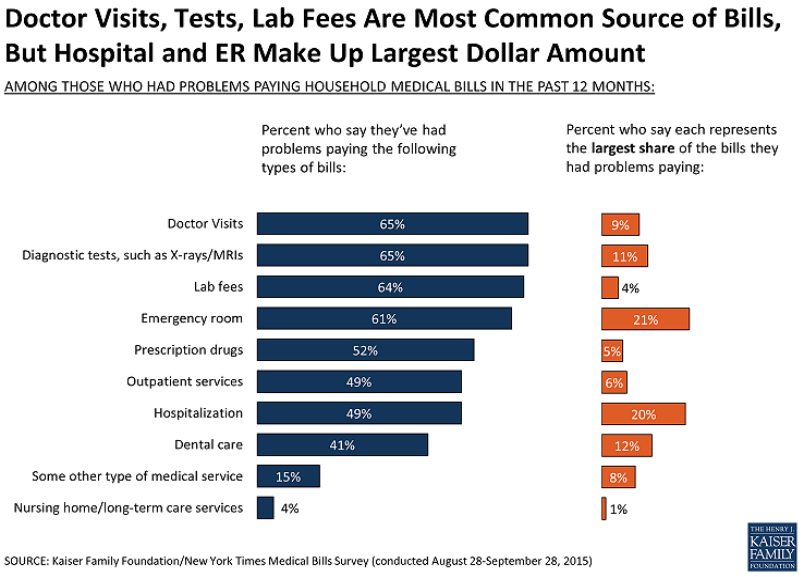
[489] PL 116-260, Division BB, Section 112.
[490] PL 116-260, Division BB, Section 111.
[491] Supra, FN 80.
[492] John Xuefeng Jiang, et al., *Factors associated with compliance to the hospital price transparency final rule: A national landscape study*, Journal of General Internal Medicine (2021), available at https://link.springer.com/article/10.1007/s11606-021-07237-y (last viewed on January 22, 2024).
[493] Patients' Rights Advocates, *Third semi-annual hospital transparency compliance report, 2022*, available at https://www.patientrightsadvocates.org/august-semi-annual-compliance-report-2022 (last reviewed January 22, 2024)..
[494] *Id.*
[495] Foundation for Government Accountability, *How America's Hospitals Are Hiding the Cost of Health Care*, pg. 3, August 2022, available at https://www.TheFGA.org/paper/americas-hospitals-are-hiding-the-cost-of-health-care. (last viewed on January 22, 2024). As of the date of the report, only two hospitals to date had been fined for noncompliance with the transparency rule, both of which were in Georgia's Northside Hospital System.
[496] *Id.* at 4.

after the rule's effective date and even when levied, the total amount of those fines were less than 0.1 percent of Northside Hospital system's total gross revenues[497].

**Medical Debt**

Medical costs can result in overwhelming debts to patients, and in some cases, bankruptcy. Nationwide, over 100 million have some form of medical debt.[498] A 2007 study suggested that illness and medical bills contributed to 62.1 percent of all personal bankruptcies filed in the United States during that year.[499] A more recent analysis, which considered only the impact of hospital charges, found that 4 percent of U.S. bankruptcies among non-elderly adults resulted from hospitalizations.[500] Four in ten U.S. adults have some form of health care debt,[501] including one in 8 people who reported health care debts of at least $10,000 or more in a 2022 Kaiser Family Foundation poll.[502]

About half of adults – including three in ten who do not currently have health care debt – are vulnerable to falling in the debt, saying they would be unable to pay a $500 unexpected medical bill without borrowing money.[503] While about a third of adults with health care debt owe less than $1,000, even small amounts of debt can have significant financial consequences for some.[504] Though a third of those with current debt expect to pay it off within a year and about a quarter expect to pay it within one to two years, nearly one in five adults with health care debt think they will never be able to pay it off.[505]




Even when medical costs do not result in personal bankruptcy, they often weigh heavily on the financial health of patients and their families. According to the Kaiser Family Foundation, about a quarter of U.S. adults ages 18-64 say they or someone in their household had problems paying or having an inability to pay medical bills in the past 12 months.[506] About three in ten survey respondents reported medical debt of $5,000 or more, with 13 percent of respondents indicating medical debt in excess of $10,000. Even

[497] *Id*. at 4.
[498] Kaiser Health News, *Diagnosis: Debt – 100 Million People in America Are Saddled with Health Care Debt*, June 16, 2022, available at https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/ (last viewed on January 22, 2024).
[499] David U. Himmelstein, et al. *"Medical Bankruptcy in the United States, 2007: Results of a National Study."* *American Journal of Medicine* 2009; 122: 741-6. available at https://www.amjmed.com/article/S0002-9343(09)00404-5/abstract.
[500] Carlos Dobkin, et al. *"Myth and Measurement: The Case of Medical Bankruptcies."* *New England Journal of Medicine* 2018; 378:1076-1078. Available at https://www.nejm.org/doi/full/10.1056/NEJMp1716604.
[501] Lopes, L., Kearney, A., et al, *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills*, June 16, 2022 (using results from the Kaiser Family Foundation Health Care Debt Survey), available at https://www.kff.org/health-costs/report/kff-health-care-debt-survey/ (last viewed on January 22, 2024).
[502] *Id.*
[503] *Id.*
[504] *Id.*
[505] *Id.*
[506] The Henry J. Kaiser Family Foundation, *"The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey."* January 5, 2016, available at https://www.kff.org/health-costs/report/the-burden-of-medical-debt-results-from-the- kaiser-family-foundationnew-york-times-medical-bills-survey/(last viewed on January 22, 2024)

patients with lower amounts of medical debt reported that the outstanding bills led to financial distress, in light of other financial commitments and/or limited income.[507]

Among those who reported problems paying medical bills, 66 percent said the bills were the result of a one-time or short-term medical expense such as a hospital stay or an accident, while 33 percent cited bills for treatment of chronic conditions that had accumulated over time. Respondents to the Kaiser survey reported a wide range of illnesses and injuries that led to an accumulation of medical debt. The largest share (36 percent) named a specific disease, symptom, or condition like heart disease or gastrointestinal problems, followed by issues related to chronic pain or injuries (16 percent), accidents and broken bones (15 percent), surgery (10 percent), dental issues (10 percent), and infections like pneumonia and flu (9 percent).[508]

More than two thirds of hospitals sue or take other legal action against patients with outstanding bills. Nearly 25 percent sell patient medical debt to collection agencies, who in turn can pursue patients for years to collect on unpaid bills. Further, one in five providers deny nonemergency care to people with outstanding medical debt.

Further polling results contained in the 2022 Kaiser report also showed that families who had experienced medical debt problems were also more likely to ask about the cost of a medical service or doctor's office visit beforehand than someone who had not had such difficulties (49 percent compared to 34 percent). Such families were also much more likely to shop around for services for the best price (34 percent compared to 17 percent) and to attempt to negotiate a lower rate before receiving a health care service (22 percent compared to six percent). Impacted families with medical debt also reported a higher rate of being asked to pay for health care services up front before services would be delivered.[509]

Personal Credit Ratings

Recognizing the inherent difficulties associated with medical debt, the three major credit rating companies in July 2023 agreed to exclude from an individual's credit report medical debts that have been paid off and unpaid medical debts less than $500. This action followed a 2015 settlement agreement with several state Attorney Generals which had established a minimum time period of 180 days before a medical debt could be report to a credit agency.[510] The national credit reporting companies announced that this time period would be expanded voluntarily to one year in 2022.

With the 2023 agreement and the $500 capped medical debt collection, regulators expect that the majority of medical debt will fall under this dollar threshold, although geographic differences in the average amount of medical debt across the county exist as do higher amounts in neighborhoods that are majority Black or Hispanic and have lower median incomes.[511]

When a person first takes out a line of credit as an individual—a first credit card or a loan to pay for college, for example—this begins a personal credit history and the process of building a personal credit score. This score is linked to a person's Social Security Number.

From then on, the score reflects one's personal financial history. If a person always pays bills on time, does not use too much of the available credit at once, and avoids negative information like foreclosures and charge-offs, the person will develop a good personal credit score, also known as a FICO score. If, instead, one carries a balance on lines of credit, fails to develop a diverse mix of credit sources—different credit cards, an automobile loan, and a mortgage, for example—and accrues many "hard inquiries" on your credit score (which occurs when upon application for a new source of credit), the FICO score will be low. Personal credit scores generally range 350-800 with 800 being a "perfect" score.

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[507] *Id.*a
[508] *Id.*
[509] *Id.* at 23.
[510] Consumer Financial and Protection Bureau, *Paid and Low-Balance Medical Collections on Consumer Credit Reports,* July 27, 2022, available at https://www.consumerfinance.gov/data-research/research-reports/paid-and-low-balance-medical-collections-on-consumer-credit-reports/ (last viewed on January 22, 2024).
[511] *Id.*

In 2018-2020, more than a quarter of the nation's largest hospitals and health systems pursued nearly 39,000 legal actions regarding consumer medical debt.[512]

Medical Debt Collection Process

Current law provides a court process for the collection of lawful debts, including medical debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding monetary damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means to collect on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current law provides that certain property is exempt from being taken by a creditor. The Florida Constitution provides that the debtor's homestead and $1,000 of personal property is exempt.[513] Statutory law provides numerous categories of exempt property, and federal statutory law also provides certain exemptions that apply in all of the states.[514]

In addition to the protection from creditors contained in the Florida Constitution, chapter 222, F.S., protects other personal property from certain claims of creditors and legal process: garnishment of wages for a head of family;[515] proceeds from life insurance policies;[516] wages or unemployment compensation payments due certain deceased employees;[517] disability income benefits;[518] assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;[519] $1,000 interest in a motor vehicle; professionally prescribed health aids; certain refunds or credits from financial institutions; and $4,000 interest in personal property, if the debtor does not claim or receive the benefits of a homestead exemption under the State Constitution.[520]

Bankruptcy is a means by which a person's assets are liquidated in order to pay the person's debts under court supervision. The United States Constitution gives Congress the right to uniformly govern bankruptcy law.[521] Bankruptcy courts are operated by the federal government. A debtor (the bankrupt person) is not required to give up all of his or her assets in bankruptcy. Certain property is deemed "exempt" from the bankruptcy case, and may be kept by the debtor without being subject to creditor claims. The Bankruptcy Code provides for exempt property in a bankruptcy case.[522] In general, a debtor may choose to utilize the exempt property listing in state law or the exempt property of the Bankruptcy Code. However, federal law allows a state to opt-out of the federal law and thereby insist that debtors only utilize state law exemptions.[523] Florida, like most states, has made the opt-out election to prohibit the use of the federal exemptions and require that debtors may only use state law exemptions.[524]

Statutes of Limitations

A statute of limitations bars a lawsuit's filing after a certain amount of time elapses following an injury.[525] This time period typically begins to run when a cause of action accrues (that is, on the date of the

[512] Using data from Johns Hopkins University, study authors analyzed the top 100 hospitals in the U.S. (by revenue) to measure debt collection methods and frequency, average charges markups and billing scores, and compare that data to safety grades and charity care ratings, by hospital type (government, nonprofit and for-profit). See, "How America's top hospitals hound patients with predatory billing", July 2021, available at https://www.axios.com/hospital-billing (last viewed March 26, 2023). Twelve Florida hospitals were included in the analysis, with a wide range of scores in each category.
[513] Art. X, s. 4(a), Fla. Const.
[514] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[515] S. 222.11, F.S.
[516] S. 222.13, F.S.
[517] S. 222.15, F.S.
[518] S. 222.18, F.S.
[519] S. 222.22, F.S.
[520] S. 222.25, F.S.
[521] Art. 1, s. 8, cl. 4, U.S. Const.
[522] 11 U.S.C. s. 522.
[523] 11 U.S.C. s. 522(b).
[524] S. 222.20, F.S.
[525] Legal Information Institute, Statute of Limitations, https://www.law.cornell.edu/wex/statute_of_limitations (Last visited January 22, 2024).

injury), but may also begin to run on the date the injury is discovered or on which it would have been discovered with reasonable efforts.[526] In other words, a statute of limitations bars the available civil remedy if a lawsuit is not timely filed after an injury.

Chapter 95, F.S., contains the bulk of Florida's statutes of limitations. Specifically, s. 95.11, F.S., details a variety of statutes of limitation for legal actions other than for recovery of real property. Some of the limitations require legal actions to be commenced as follows:

- WITHIN TWENTY YEARS.—An action on a judgment or decree of a court of record in this state.[527]
- WITHIN FIVE YEARS.—
    - An action on a judgment or decree of any court, not of record, of this state or any court of the United States, any other state or territory in the United States, or a foreign country.
    - A legal or equitable action on a contract, obligation, or liability founded on a written instrument, except for an action to enforce a claim against a payment bond, which shall be governed by the applicable provisions of paragraph (5)(e), s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), and except for an action for a deficiency judgment governed by paragraph (5)(h).
    - An action to foreclose a mortgage.
    - An action alleging a willful violation of s 448.110.
    - Notwithstanding paragraph (b), an action for breach of a property insurance contract, with the period running from the date of loss.[528]
- WITHIN FOUR YEARS.—
    - An action founded on negligence.
    - An action relating to the determination of paternity, with the time running from the date the child reaches the age of majority.
    - An action founded on the design, planning, or construction of an improvement to real property, with the time running from the date of actual possession by the owner, the date of the issuance of a certificate of occupancy, the date of abandonment of construction if not completed, or the date of completion of the contract or termination of the contract between the professional engineer, registered architect, or licensed contractor and his or her employer, whichever date is latest, with some exceptions.
    - An action to recover public money or property held by a public officer or employee, or former public officer or employee, and obtained during, or as a result of, his or her public office or employment.
    - An action for injury to a person founded on the design, manufacture, distribution, or sale of personal property that is not permanently incorporated in an improvement to real property, including fixtures.
    - An action founded on a statutory liability.
    - An action for trespass on real property.
    - An action for taking, detaining, or injuring personal property.
    - An action to recover specific personal property.
    - A legal or equitable action founded on fraud.
    - A legal or equitable action on a contract, obligation, or liability not founded on a written instrument, including an action for the sale and delivery of goods, wares, and merchandise, and on store accounts.
    - An action to rescind a contract.
    - An action for money paid to any governmental authority by mistake or inadvertence.
    - An action for a statutory penalty or forfeiture.
    - An action for assault, battery, false arrest, malicious prosecution, malicious interference, false imprisonment, or any other intentional tort, except as provided in subsections (4), (5), and (7).
    - Any action not specifically provided for in these statutes.
    - An action alleging a violation, other than a willful violation, of s. 448.110.[529]

[526] *Id.*
[527] S. 95.11(1), F.S.
[528] S. 95.11(2), F.S.

- WITHIN TWO YEARS.—
  - An action founded on negligence.
  - An action for professional malpractice, other than medical malpractice, whether founded on contract or tort; provided that the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
  - An action for medical malpractice shall be commenced within 2 years from the time the incident giving rise to the action occurred or within 2 years from the time the incident is discovered, or should have been discovered with the exercise of due diligence. However. the limitation of actions herein for professional malpractice shall be limited to persons in privity with the professional.
  - An action to recover wages or overtime or damages or penalties concerning payment of wages and overtime.
  - An action for wrongful death.
  - An action founded upon a violation of any provision of chapter 517, with the period running from the time the facts giving rise to the cause of action were discovered or should have been discovered with the exercise of due diligence, but not more than 5 years from the date such violation occurred.
  - An action for personal injury caused by contact with or exposure to phenoxy herbicides while serving either as a civilian or as a member of the Armed Forces of the United States during the period January 1, 1962, through May 7, 1975; the period of limitations shall run from the time the cause of action is discovered or should have been discovered with the exercise of due diligence.
  - An action for libel or slander.[530]
- WITHIN ONE YEAR.—
  - An action for specific performance of a contract.
  - An action to enforce an equitable lien arising from the furnishing of labor, services, or material for the improvement of real property.
  - An action to enforce rights under the Uniform Commercial Code—Letters of Credit, chapter 675.
  - An action against any guaranty association and its insured, with the period running from the date of the deadline for filing claims in the order of liquidation.
  - Except for actions governed by s. 255.05(10), s. 337.18(1), or s. 713.23(1)(e), an action to enforce any claim against a payment bond on which the principal is a contractor, subcontractor, or sub-subcontractor as defined in s. 713.01, for private work as well as public work, from the last furnishing of labor, services, or materials or from the last furnishing of labor, services, or materials by the contractor if the contractor is the principal on a bond on the same construction project, whichever is later.
  - Except for actions described in subsection (8), a petition for extraordinary writ, other than a petition challenging a criminal conviction, filed by or on behalf of a prisoner as defined in s. 57.085.
  - Except for actions described in subsection (8), an action brought by or on behalf of a prisoner, as defined in s. 57.085, relating to the conditions of the prisoner's confinement.
  - An action to enforce a claim of a deficiency related to a note secured by a mortgage against a residential property that is a one-family to four-family dwelling unit. The limitations period shall commence on the day after the certificate is issued by the clerk of court or the day after the mortgagee accepts a deed in lieu of foreclosure.[531]

Direct Health Care Agreements

Created in Florida law by the 2008 Legislature,[532] *direct health care agreements*, are non-insurance contracts between certain, statutorily designated health care providers or groups of providers and patients. Such agreements are not subject to the Florida Insurance Code and are not regulated by the

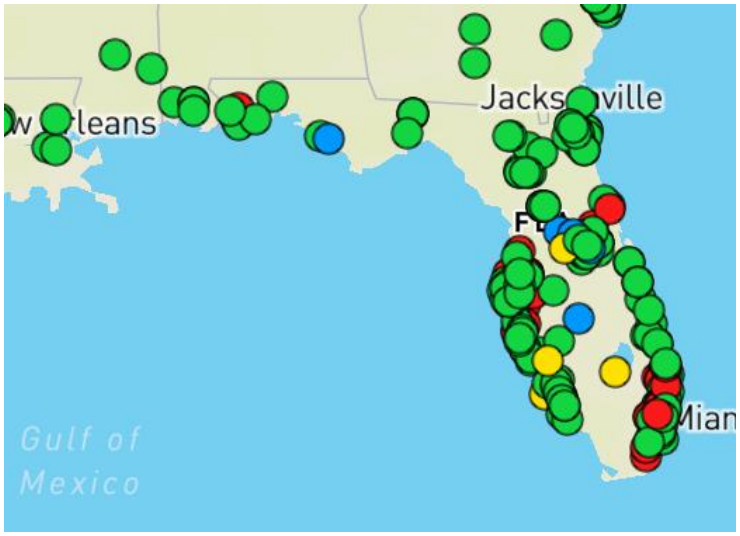
[529] S. 95.11(3), F.S.
[530] S. 95.11(4), F.S.
[531] S. 95.11(5), F.S.
[532] Ch. Law 2018-89, L.O.F.

Department of Financial Services or the Office of Insurance Regulation. The direct provider arrangement eliminates third party payors and instead creates a contractual relationship between the health care provider and the patient usually with a small monthly fee (usually around $70 per individual) for access to the designated scope of benefits.

These agreements must adhere to specific statutory requirements to be a valid agreement. The requirements for a valid agreement are for the agreement to:

- Be in writing.
- Be signed by the health care provider or an agent of the health care provider and the patient, the patient's legal representative, or the patient's employer.
- Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.
- Describe the scope of health care services that are covered by the monthly fee.
- Specify the monthly fee and any fees for health care services not covered by the monthly fee.
- Specify the duration of the agreement and any automatic renewal provisions.
- Offer a refund to the patient, the patient's legal representative, or the patient's employer of monthly fees paid in advance if the health care provider ceases to offer health care services for any reason.
- Contain, in contrasting color and in at least 12-point type, the following statement on the signature page: "This agreement is not health insurance and the health care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any health care services covered by the agreement. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act, 26 U.S.C. s. 5000A. This agreement is not workers' compensation insurance and does not replace an employer's obligations under chapter 440.[533]

The Direct Primary Care Coalition reports over 1,000 associated practices.[534] On the map below, each green dot equals a pure direct primary care model, a red dot is a hybrid model, and a blue dot equals an onsite model. A provider with a hybrid model may have a mix of both direct primary care patients as well as other patients.




Patients who seek services under these agreements may see health care providers for any services for which the provider is licensed and has the competency and training to provide.[535] In Florida, state law allows direct health care arrangements to include: Currently, direct health care arrangements are limited to those defined as a "health care provider", and as designated by a specific licensure type. Those provider types are:

- Chapter 458 (medical doctors);

[533] S. 624.67(4)(a)-(h), F.S.
[534] Direct Primary Care Coalition, *Direct Primary Care Mapper,* available at https://mapper.dpcfrontier.com/ (last viewed January 22, 2024).
[535] S. 624.67(1)(c), F.S.

- Chapter 459 (osteopathic doctors);
- Chapter 460 (chiropractic physicians);
- Chapter 461 (podiatrists);
- Chapter 464 (nursing, including advanced or specialized nursing practice, advanced practice registered nurse, licensed practice nurse, or registered nurse);
- Chapter 466 (dental or dental hygienist), or
- A health care group practice, who provides health care services to patients.[536]

Effect of the bill - Health Care Price Transparency and Medical Debt

The bill increases patient access to health care cost information, and offers a measure of protection from unreasonable and burdensome medical debt. The various provisions apply to hospitals, ambulatory surgical centers, health insurers, and HMOs. The bill brings provisions from recent federal law and regulation into the Florida Statutes; in doing so, the bill requires compliance by facilities and insurers as a condition of state licensure, thus ensuring that these provisions will be fully adopted and adequately enforced in Florida.[537]

**Facility Price Transparency**

Facility Billing Estimates

The bill requires that all patients receive cost-of-care information prior to receiving scheduled, nonemergency treatment in hospitals and ambulatory surgical centers, and from physicians providing services in those facilities.

At present, licensed facilities are required to provide a customized estimate of "reasonably anticipated charges" to a patient for treatment of the patient's specific condition, *upon request of the patient*. The bill makes these personalized estimates mandatory, rather than dependent on patient requests. A facility must submit the estimate of charges to a patient's health plan at least 3 business days before a service is to be furnished, according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after the service is scheduled;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after a service is scheduled.

By requiring facilities to provide a good-faith estimate of charges to each patient in advance of treatment, the bill mirrors the requirements of the federal No Surprises Act. Compliance with the Act was required by January 1, 2022.

Shoppable Services

The bill requires each licensed hospital and ambulatory surgical center to post a consumer-friendly list of standard charges for at least 300 shoppable health care services on a facility website. A facility that provides less than 300 distinct services will be required to post standard charges for each service it does provide.

The bill requires facilities to post pricing information for shoppable services in accordance with the definition of "standard charges" established in federal rule.[538] This information extends beyond the traditional concept of charges to include negotiated and actual prices paid for selected services. For each shoppable service, a hospital must disclose the following pricing benchmarks:

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;

[536] S. 624.27(1)(b), F.S.
[537] SS. 395.003, 395.301, 408.802, 624.401, and 641.22, F.S.
[538] *Supra*, note **Error! Bookmark not defined.**.

- A de-identified maximum negotiated charge; and,
- The discounted cash price.

This bill is intended to mirror the shoppable services requirement included in the hospital facility transparency regulations finalized by the CMS in 2019. The bill requires facilities to disclose the relevant cost information as a condition of state licensure, which should result in uniform compliance among facilities.

**Facility Medical Debt Collection**

The bill prohibits hospitals and ASCs from engaging in any "extraordinary collection actions" against a patient prior to determining whether that patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, for 30 days after notifying a patient in writing that a collections action will commence, and while the patient is negotiating in good faith the final amount of the bill or is complying with the terms of a payment plan with the facility. For purposes of the provision, "extraordinary collection action" means any action that requires a legal or judicial process, including:

- Placing a lien on an individual's property;
- Foreclosing on an individual's real property;
- Attaching or seizing an individual's bank account or any other personal property;
- Commencing a civil action against an individual;
- Causing an individual's arrest; or,
- Garnishing an individual's wages.

The bill also establishes a new set of debt collection exemptions in chapter 222, F.S. that apply explicitly to debt incurred as a result of medical services provided in hospitals, ambulatory surgical centers, or urgent care centers. Under current law, this type of medical debt is subject to the uniform exemptions that apply to all types of debt and are described above. The bill increases the ceiling on the debt collection exemptions, when the debt results from services provided in a hospital facility or ambulatory surgical center, as follows:

- To $10,000 interest in a single motor vehicle (versus the current law exemption of $1,000);
- To $10,000 interest in personal property, provided that a debtor does not claim the homestead exemption under s. 4, Art. X of the state constitution (versus the current law exemption of $4,000).

The bill also requires each hospital and ASC to establish an internal grievance process allowing a patient to dispute any charges that appear on an itemized statement or bill. When a patient initiates a grievance, the facility must then provide an initial response to that patient within 7 business days.

Lastly, the bill creates a three-year statute of limitations for any legal action related to medical debt for services rendered by a facility licensed under chapter 395, F.S., such as hospitals, ambulatory surgical centers, and urgent care centers. The statute of limitations begins running on the date that the facility refers the debt to a third-party collection entity.

**Insurer Price Transparency**

Shared Savings Programs

The bill establishes an accounting standard to remove a barrier to shared savings incentive programs. It specifies that insurer shared savings payments to patients shall be counted as medical expenses for rate development and rate filing purposes.[539] This change aligns Florida law with the federal regulations that became final in 2020.[540]

[539] Current law indicates that a shared savings incentive offered by a health plan is "not an administrative expense for rate development or rate filing purposes," but does not affirmatively categorize the expense. SS. 627.6387, 627.6648, and 641.31076, F.S.
[540] *Supra*, note **Error! Bookmark not defined.**.

Advanced Explanation of Benefits

The bill requires health plans to issue an advance explanation of benefits statement when a covered patient schedules a service in a hospital or ambulatory surgical center. This requirement builds on the facility charges estimate provision in the bill. Once a facility notifies a health plan that a patient has scheduled a medical service, the health plan must prepare a personalized estimate of costs for the patient in accordance with the federal No Surprises Act. A health plan must provide an advanced explanation of benefits to the patient according to the following schedule:

- In the case of a service scheduled less than 10 business days in advance, no later than 1 business day after receiving the estimate of charges from the facility;
- In the case of a service scheduled 10 or more business days in advance, no later than 3 business days after receiving the estimate of charges from the facility.

Health insurers and HMOs were required comply with the federal Act by January 1, 2022.

Cash Price Communication

Under the Public Health Services Act, section 2799A-9(a)(2), health insurance issuers that offer individual health insurance coverage are prohibited from entering into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the issuer from—

(1) Providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or
(2) Sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in (1) with a business associate, consistent with the privacy regulations promulgated pursuant to section 264(c) of HIPAA, GINA, and the ADA.[541]

These regulations further restrict group health plans and health plan issuers from restricting the release of provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage.[542]

The first attestation of compliance from health plans and issuers was due on December 31, 2023 and will be due annually thereafter.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 381.4018, F.S., relating to physician workforce assessment and development.
**Section 2:** Amends s. 381.4019, F.S., relating to dental student loan repayment program.
**Section 3:** Amends s. 1009.65, F.S., relating to medical education reimbursement and loan repayment program.
**Section 4:** Creates s. 381.4021, F.S., relating to student loan repayment programs reporting.
**Section 5:** Creates s. 381.9855, F.S., relating to health care screening and services grant program.
**Section 6:** Amends s. 383.2163, F.S., relating to telehealth minority maternity care pilot programs.
**Section 7:** Amends s. 383.302, F.S., relating to definitions.
**Section 8:** Creates s. 383.3081, F.S., relating to advanced birth center designation.
**Section 9:** Amends s. 383.309, F.S., relating to minimum standards for birth centers; rules and enforcement.
**Section 10:** Amends s. 383.313, F.S., relating to performance of laboratory and surgical services; use of anesthetic and chemical agents.

[541] Centers for Medicare and Medicaid Services, *Gag Clause Prohibition Attestation Compliance,* https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/gag-clause-prohibition-compliance-attestation (last viewed January 22, 2024).
[542] *Id.*

**Section 11:** Creates s. 383.3131, F.S., relating to advanced birth center performance of laboratory and surgical services; use of anesthetic and chemical agents.
**Section 12:** Amends s. 383.315, F.S., relating to agreements with consultants for advice or services; maintenance.
**Section 13:** Amends s. 383.316, F.S., relating to transfer and transport of clients to hospitals.
**Section 14:** Amends s. 383.318, F.S., relating to postpartum care for birth center clients and infants.
**Section 15:** Amends s. 394.455, F.S., relating to definitions.
**Section 16:** Amends s. 394.457, F.S., relating to operations and administration.
**Section 17:** Amends s. 394.4598, F.S., relating to guardian advocate.
**Section 18:** Amends s. 394.4615, F.S., relating to clinical records; confidentiality.
**Section 19:** Amends s. 394.4625, F.S., relating to voluntary admissions.
**Section 20:** Amends s. 394.463, F.S., relating to involuntary examination.
**Section 21:** Amends s. 394.4655, F.S., relating to involuntary outpatient services.
**Section 22:** Amends s. 394.467, F.S., relating to involuntary inpatient placement.
**Section 23:** Amends s. 394.4781, F.S., relating to residential care for psychotic and emotionally disturbed children.
**Section 24:** Amends s. 394.4785, F.S., relating to children and adolescents; admission and placement in mental facilities.
**Section 25:** Creates an unnumbered section of law, relating to Medicaid coverage of mobile crisis response services.
**Section 26:** Amends s. 394.875, F.S., relating to crisis stabilization units, residential treatment facilities, and residential treatment centers for children and adolescents; authorized services; license required.
**Section 27:** Amends s. 395.1055, F.S., relating to rules and enforcement.
**Section 28:** Amends s. 395.301, F.S., relating to price transparency; itemized patient statement or bill; patient admission status notification.
**Section 29:** Creates s. 395.3011, F.S., relating to billing and collection activities.
**Section 30:** Amends s. 408.051, F.S., relating to Florida Electronic Health Records Exchange Act.
**Section 31:** Amends s. 409.909, F.S., relating to Statewide Medicaid Residency Program.
**Section 32:** Creates s. 409.91256, F.S., relating to Training, Education, and Clinicals in Health Funding Program.
**Section 33:** Amends s. 409.967, F.S., relating to managed care plan accountability.
**Section 34:** Amends s. 409.973, F.S., relating to benefits.
**Section 35:** Creates an unnumbered section of law, relating to Medicaid hospital care at home.
**Section 36:** Creates s. 456.0145, F.S., relating to Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act.
**Section 37:** Amends s. 456.073, F.S., relating to disciplinary proceedings.
**Section 38:** Amends s. 456.076, F.S., relating to impaired practitioner programs.
**Section 39:** Creates s. 456.4501, F.S., relating to Interstate Medical Licensure Compact.
**Section 40:** Creates s. 456.4502, F.S., relating to Interstate Medical Licensure Compact; disciplinary proceedings.
**Section 41:** Creates s. 456.4504, F.S., relating to Interstate Medical Licensure Compact rules.
**Section 42:** Creates an unnumbered section of law, relating to Interstate Medical Licensure Compact fees.
**Section 43:** Amends s. 457.105, F.S., relating to licensure qualifications and fees.
**Section 44:** Amends s. 458.311, F.S., relating to licensure by examination; requirements; fees.
**Section 45:** Repeals s. 458.3124, F.S., relating to restricted license; certain experienced foreign-trained physicians.
**Section 46:** Amends s. 458.313, F.S., relating to licensure by endorsement; requirements; fees.
**Section 47:** Amends s. 458.314, F.S., relating to certification of foreign educational institutions.
**Section 48:** Amends s. 458.3145, F.S., relating to medical faculty certificate.
**Section 49:** Amends s. 458.315, F.S., relating to temporary certificate for practice in areas of critical need.
**Section 50:** Amends s. 458.317, F.S., relating to limited licenses.
**Section 51:** Amends s. 459.0075, F.S., relating to limited licenses.
**Section 52:** Amends s. 459.0076, F.S., relating to temporary certificate for practice in areas of critical need.

**Section 53:** Amends s. 464.009, F.S., relating to licensure by endorsement.
**Section 54:** Creates s. 464.0121, F.S., relating to temporary certificate for practice in areas of critical need.
**Section 55:** Amends s. 464.0123, F.S., relating to autonomous practice by an advanced practice registered nurse.
**Section 56:** Amends s. 464.019, F.S., relating to approval of nursing education programs.
**Section 57:** Amends s. 465.0075, F.S., relating to licensure by endorsement; requirements; fee.
**Section 58:** Amends s. 467.0125, F.S., relating to licensed midwives; qualifications; endorsement; temporary certificates.
**Section 59:** Amends s. 468.1705, F.S., relating to licensure by endorsement; temporary license.
**Section 60:** Repeals s. 468.213, F.S., relating to licensure by endorsement.
**Section 61:** Amends s. 468.3065, F.S., relating to certification by endorsement.
**Section 62:** Repeals s. 468.358, F.S., relating to licensure by endorsement.
**Section 63:** Amends s. 478.47, F.S., relating to licensure by endorsement.
**Section 64:** Amends s. 480.041, F.S., relating to massage therapists; qualifications; licensure endorsement.
**Section 65:** Amends s. 486.081, F.S., relating to physical therapist.
**Section 66:** Amends s. 491.006, F.S., relating to licensure or certifications by endorsement.
**Section 67:** Creates s. 458.3129, F.S., relating to Interstate Medical Licensure Compact.
**Section 68:** Creates s. 459.074, F.S., relating to Interstate Medical Licensure Compact.
**Section 69:** Amends s. 468.1135, F.S., relating to board of speech-language pathology and audiology.
**Section 70:** Amends s. 468.1185, F.S., relating to licensure.
**Section 71:** Amends s. 468.1295, F.S., relating to disciplinary proceedings.
**Section 72:** Creates s. 468.1335, F.S., relating to Practice of Audiology and Speech-Language Pathology Interstate Compact.
**Section 73:** Creates an unnumbered section of law, relating to Audiology and Speech-Language Pathology Interstate Compact fees.
**Section 74:** Amends s. 486.028, F.S., relating to license to practice physical therapy required.
**Section 75:** Amends s. 486.031, F.S., relating to physical therapist; licensing requirements.
**Section 76:** Amends s. 486.102, F.S., relating to physical therapist assistant; licensing requirements.
**Section 77:** Amends s. 486.107, F.S., relating to physical therapist assistant.
**Section 78:** Amends s. 490.006, F.S., relating to licensure by endorsement.
**Section 79:** Creates s. 486.112, F.S., relating to Physical Therapy Licensure Compact.
**Section 80:** Creates an unnumbered section of law, relating to Physical Therapy Licensure Compact fees.
**Section 81:** Amends s. 486.023, F.S., relating to board of physical therapy practice.
**Section 82:** Amends s. 486.125, F.S., relating to refusal, revocation, or suspension of license; administrative fines and other disciplinary measures.
**Section 83:** Amends s. 624.27, F.S., relating to direct health care agreements; exemption from code.
**Section 84:** Amends s. 95.11, F.S., relating to limitations other than for the recovery of real property.
**Section 85:** Creates s. 222.26, F.S., relating to additional exemptions from legal process concerning medical debt.
**Section 86:** Creates s. 627.446, F.S., relating to advanced explanation of benefits.
**Section 87:** Creates s. 627.447, F.S., relating to disclosure of discounted cash prices.
**Section 88:** Amends s. 627.6387, F.S., relating to shared savings incentive program.
**Section 89:** Amends s. 627.6648, F.S., relating to shared savings incentive program.
**Section 90:** Amends s. 641.31076, F.S., relating to shared savings incentive program.
**Section 91:** Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
**Section 92:** Amends s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.
**Section 93:** Amends s. 1002.32, F.S., relating to developmental research (laboratory) schools.
**Section 94:** Amends s. 1004.015, F.S., relating to Florida Development Council.
**Section 95:** Amends s. 1009.8962, F.S., relating to the Linking Industry to Nursing Education (LINE) fund.

**Section 96:** Amends s. 486.025, F.S., relating to powers and duties of the Board of Physical Therapy Practice.
**Section 97:** Amends s. 486.0715, F.S., relating to physical therapist; insurance of temporary permit.
**Section 98:** Amends s. 486.1065, F.S., relating to physical therapist assistant; issuance of temporary permit.
**Section 99:** Amends s. 395.602, F.S., relating to rural hospitals.
**Section 100:** Amends s. 458.316, F.S., relating to public health certificate.
**Section 101:** Amends s. 458.3165, F.S., relating to public psychiatry certificate.
**Section 102:** Amends s. 468.209, F.S., relating to requirements for licensure.
**Section 103**: Amends s. 468.511, F.S., relating to dietitian/nutritionist; temporary permit.
**Section 104:** Amends s. 475.01, F.S., relating to definitions.
**Section 105:** Amends s. 475.611, F.S., relating to definitions.
**Section 106:** Amends s. 517.191, F.S., relating to injunction to restrain violations; civil penalties; enforcement by Attorney General.
**Section 107:** Amends s. 787.061, F.S., relating to civil actions by victims of human trafficking.
**Section 108:** Appropriates funds to DOH for the Florida Reimbursement Assistance for Medical Education Program.
**Section 109:** Appropriates funds to DOH for the Dental Student Loan Repayment Program.
**Section 110:** Appropriates funds to DOH to expand statewide the telehealth minority maternity care program.
**Section 111:** Appropriates funds to AHCA to implement the TEACH Funding program.
**Section 112:** Appropriates funds to UF, FSU, FAU, and FAMU to implement lab school articulated health care programs.
**Section 113:** Appropriates funds to DOE to implement the LINE fund.
**Section 114:** Appropriates funds to AHCA for the Slots for Doctors Program.
**Section 115:** Appropriates funds to AHCA to provide to statutory teaching hospitals.
**Section 116:** Appropriates funds to AHCA to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping reimbursement methodology.
**Section 117:** Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for dental care services.
**Section 118:** Appropriates funds to APD to provide a uniform iBudget Waiver provider rate increase; appropriates funds to AHCA to establish budget authority for Medicaid services.
**Section 119:** Appropriates funds to DCF to enhance crisis diversion through mobile response teams.
**Section 120:** Appropriates funds to DOH to implement the Heath Care Screening and Services Grant Program.
**Section 121:** Appropriates funds to AHCA to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers.
**Section 122:** Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses.
**Section 123:** Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers.
**Section 124:** Appropriates funds to AHCA to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services.
**Section 125:** Appropriates funds and provides Full-Time Equivalent positions to AHCA to implement provisions in the bill.
**Section 126:** Appropriates funds and provides Full-Time Equivalent positions to DOH to implement provisions in the bill.
**Section 127:** Provides the bill will take effect upon becoming law, except as otherwise provided in the bill.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill provides the following appropriations for the 2024-2025 state fiscal year:

   - The sum of $30 million in recurring funds from the General Revenue Fund is appropriated to the DOH for FRAME.
   - The sum of $8 million in recurring funds from the General Revenue Fund is appropriated to the DOH for the DSLR Program.
   - The sum of $23,357,876 in recurring funds from the General Revenue Fund is appropriated to the DOH to expand statewide the telehealth minority maternity care program. This appropriation directs the DOH to establish 15 regions in which to implement the program statewide based on the location of hospitals providing obstetrics and maternity care and pertinent data from nearby counties for severe maternal morbidity and maternal mortality. The DOH must identify the criteria for selecting providers for regional implementation and, at a minimum, consider the maternal level of care designations for hospitals within the regions, the neonatal intensive care unit levels of hospitals within the regions, and the experience of community-based organizations to screen for and treat common pregnancy-related complications.
   - The sum of $25 million in recurring funds from the General Revenue Fund is appropriated to the AHCA to implement the TEACH Funding Program.
   - The sum of $2 million in recurring funds from the General Revenue Fund is appropriated to the University of Florida, Florida State University, Florida Atlantic University, and Florida Agricultural and Mechanical University for the purpose of implementing lab school articulated health care programs. Each state university will receive $500,000 from this appropriation.
   - The sum of $5 million in recurring funds from the General Revenue Fund is appropriated to the Department of Education for the purpose of implementing the Linking Industry to Nursing Education (LINE) Fund.
   - The sums of $21,315,000 in recurring funds from the General Revenue Fund and $28,685,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA for the Slots for Doctors Program.
   - The sums of $42,630,000 in recurring funds from the Grants and Donations Trust Fund and $57,370,000 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide to statutory teaching hospitals as defined in s. 408.07(46), F.S., meeting certain criteria, distributed according to specified parameters.
   - The sums of $57,402,343in recurring funds from the General Revenue Fund and $77,250,115 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to establish a Pediatric Normal Newborn, Pediatric Obstetrics, and Adult Obstetrics Diagnosis Related Grouping (DRG) reimbursement methodology.
   - The sums of $83,456,275 in recurring funds from the General Revenue Fund and $112,312,609 in recurring funds from the Operations and Maintenance Trust Fund are appropriated in the Home and Community Based Services Waiver category to the Agency for Persons with Disabilities to provide a uniform iBudget Waiver provider rate increase.
   - The sum of $11,525,152 in recurring funds from the General Revenue Fund is appropriated to the Department of Children and Families to enhance crisis diversion through mobile response teams by adding an additional 16 mobile response teams to ensure coverage in every county.
   - The sum of $10 million in recurring funds from the General Revenue Fund is appropriated to the DOH to implement the Health Care Screening and Services Grant Program.

- The sum of $150,000 in nonrecurring funds from the General Revenue Fund and $150,000 in nonrecurring funds from the Medical Care Trust Fund are appropriated to the AHCA to contract with a vendor to develop a reimbursement methodology for covered services at advanced birth centers.
- Effective October 1, 2024, the sums of $14,888,903 in recurring funds from the General Revenue Fund and $20,036,979 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for dental care services. The funds shall be held in reserve and released upon approval of a budget amendment pursuant to chapter 216, Florida Statutes. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $12,365,771 in recurring funds from the General Revenue Fund, $127,300 in recurring funds from the Refugee Assistance Trust Fund, and $16,514,132 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for private duty nursing services provided by licensed practical nurses and registered nurses. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $14,580,660 in recurring funds from the General Revenue Fund and $19,622,154 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for occupational therapy, physical therapy, and speech therapy providers. Health plans that participate in the Statewide Medicaid Managed Care program will pass through the fee increase to providers in this appropriation.
- Effective October 1, 2024, the sums of $5,522,795 in recurring funds from the General Revenue Fund and $7,432,390 in recurring funds from the Medical Care Trust Fund are appropriated to the AHCA to provide a Medicaid reimbursement rate increase for Current Procedural Terminology codes 97153 and 97155 related to behavioral analysis services. Health plans that participate in the Statewide Medicaid Managed Care program shall pass through the fee increase to providers in this appropriation.
- Effective July 1, 2024, the sums of $585,758 in recurring funds and $1,673,421 in nonrecurring funds from the General Revenue Fund, $928,001 in recurring funds and $54,513 in nonrecurring funds from the Health Care Trust Fund, $100,000 in nonrecurring funds from the Administrative Trust Fund, $585,758 in recurring funds and $1,573,421 in nonrecurring funds from the Medical Care Trust Fund, and 20 full-time equivalent positions with the associated salary rate of 1,247,140 are provided to the Agency for Health Care Administration implement provisions in the bill.
- Effective July 1, 2024, the sums of $2,389,146 in recurring funds and $1,190,611 in nonrecurring funds from the General Revenue Fund, and $1,041,578 in recurring funds, $287,633 in nonrecurring funds from the Medical Quality Assurance Trust Fund, and 25 full-time equivalent positions with the associated salary rate of 1,739,740 are provided to the Department of Health implement provisions in the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have an indeterminate positive fiscal impact on health care practitioners who are able to participate in FRAME or the DSLR Program.

The bill may have an indeterminate positive fiscal impact for nonprofit entities that take advantage of the Health Care Screening and Services Grant program or anyone who is able to find free or reduced cost services through the DOH's portal.

The bill may have an indeterminate positive fiscal impact on facilities that participate in the TEACH program.

The bill may have an indeterminate positive fiscal impact on nursing schools that are able to participate in the LINE program due to changes made in the bill.

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

The bill may increase costs for facilities licensed under ch. 395, F.S., by requiring them to issue cost estimates for all non-emergency patients, but only if the facilities are out of compliance with the current federal requirement to provide these estimates.

Facilities may forego revenues due to the bill's limits on the use of extraordinary collection activities; however, some facilities may already be providing similar due process for patients, such that the bill will have little impact on them.

The bill may have a negative, but indeterminate, fiscal impact on health insurers and HMOs, due to the costs of producing advanced explanations of benefits for insureds and subscribers, triggered by the estimates provided by facilities, but only if these health plans are out of compliance with the current federal requirement to provide these to subscribers.

Additionally, the bill's increased dollar limit on personal property exemptions under ch. 222, F.S., may reduce revenues for medical service providers or their collection agents.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments

2. Other:

Fees

Pursuant to Article 7 Section 19 of the Florida Constitution, new taxes or fees imposed by the Legislature must be approved by a two-thirds vote of both Legislative chambers in a bill containing no other subject. This requirement does not apply to fees authorized under current law.

There are no new fee provisions in the bill. The fee provisions contained within the bill move or reiterate existing fee requirements in current law. As such, the bill's provisions do not implicate Article 7 Section 19 of the Florida Constitution.

Compacts

The multistate compacts enacted in the bill authorize their commissions to adopt reasonable rules to effectively and efficiently achieve the purposes of the compacts, and these rules carry the force of law

in member states, which is potentially an unlawful delegation of legislative authority. If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the commissions.

The Legislature delegated similar rulemaking powers to compact commissions when it adopted the compact language for the Nurse Licensure Compact, Professional Counselors Licensure Compact, and the Psychology Interjurisdictional Compact into statute. The rules adopted by these compacts are now applicable to Florida without the Legislature's subsequent approval, similar to what the state would encounter with the enactment of multistate compacts under the bill and the included rulemaking provisions. In the case of these compacts, should Florida find that rules adopted by any of the three commissions are not acceptable, the compacts provide a mechanism for a majority of state legislatures to override commission rules. Furthermore, the state maintains the ability to withdraw from any of the compacts.

B. RULE-MAKING AUTHORITY:

The bill provides requisite authority to all impacted state agencies and boards necessary to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 6, 2024, the Health Care Appropriations Subcommittee adopted one amendment, and reported the bill favorably as a committee substitute. The amendment makes changes to several appropriations within the bill, and provided full-time equivalent positions to AHCA and DOH to implement the bill.

This analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.