



Florida Medical Association

## 2024 FMA Legislative Report

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## 2024 FMA Legislative Report

Healthcare workforce and innovation were front and center during the 2024 Legislative Session. The Florida Medical Association was an active participant in shaping the future of Florida's healthcare landscape, which can be seen through the pro-physician victories outlined in this report.

The Florida Legislative Session concluded on Friday, March 8, at 2:25 p.m. Your FMA team of lobbyists tracked 291 bills and numerous amendments that either directly or indirectly concerned the practice of medicine in Florida. The following is a summary of key legislative issues that the FMA worked on during session to help our members practice medicine.

### LEGISLATION THAT PASSED

#### Live Healthy

*HB 1549, Rep. Grant / SB 7016, Sen. Burton*

The Live Healthy package was designed to grow Florida's healthcare workforce, increase access, and incentivize innovation. As Senate President Kathleen Passidomo's legislative priority, this monumental piece of legislation spans several areas of healthcare. Unlike many bills, which typically have a July 1 effective date, the vast majority of the Live Healthy package goes into effect upon the Governor's signature. However, most of the provisions will require extensive implementation through the rulemaking process. The following summarizes key sections of the 232-page bill that impact physicians and the practice of medicine.

#### **Florida Reimbursement Assistant for Medical Education (FRAME) Program**

In response to the overwhelming success of the Florida Reimbursement Assistance for Medical Education (FRAME) Program, the FMA was able to secure and increase the program's recurring funding from \$6 million to \$16 million for Fiscal Years 2022-2023 and 2023-2024. It is especially exciting that this bill includes an additional \$30 million – increasing the program's recurring funding to a total of **\$46 million**. In addition to increased funding, SB 7016 makes several other notable changes to the program.

#### *Eligible Health Care Practitioners and Specialties*

Under current law, only physicians, advanced practice nurse practitioners (APRNs), physician assistants (PAs), registered nurses (RNs), and licensed practical nurses (LPNs) are eligible to participate in the FRAME Program. The Legislature expanded the list of eligible licensed or certified healthcare professionals to include mental health workers such as clinical social workers, licensed marriage and family therapists, licensed mental health counselors, and licensed psychologists.

In addition to practicing in an underserved area and accepting Medicaid, physicians must practice in a primary care specialty defined to include obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties as determined by the Department of Health. SB 7016 codifies psychiatry, currently included through departmental rule, and adds geriatric medicine as eligible primary care specialties.



### *Award*

For the first two application cycles, eligible physicians could receive up to \$20,000 per year for a year of primary care practice in an underserved area. SB 7016 restructures the program to award an eligible practitioner 25 percent of his or her principal loan balance for each year of service for up to four years. The bill sets a maximum total award amount for eligible practitioners as follows: up to \$150,000 for physicians, up to \$90,000 for autonomous APRNs practicing autonomously, up to \$75,000 for APRNs, PAs, and mental health professionals, and up to \$45,000 for LPNs and RNs. The FMA was able to amend the bill to clarify that the four years do not have to be served consecutively.

### *Volunteer Hours*

Lastly, SB 7016 adds an annual volunteer requirement of 25 hours. Practitioners can fulfil this volunteer requirement by providing primary care services in a free clinic or through another state-operated volunteer program. The FMA will provide more information on acceptable programs once clarified by the department.

Due to the substantial restructuring of the program, we anticipate that awardees from the 2023 and 2024 cycles will not be precluded from eligibility for an additional full four years once SB 7016 is implemented. However, this will ultimately be determined by the department. With the 2024 application cycle already underway, these changes will not be implemented until 2025.

### **Advanced Birth Center**

The Live Healthy package creates a new licensed birthing facility designated as an “advanced birth center.” Advanced birth centers may perform trial of labor after cesarean deliveries for certain patients, planned low-risk cesarean deliveries, and anticipated vaginal deliveries for laboring patients from the 37th to 41st week of gestation. To achieve designation, advanced birth centers must:

- Be operated and staffed 24 hours per day, seven days per week.
- Employ two medical directors, one of whom must be a board-certified obstetrician and the other a board-certified anesthesiologist.
- Have at least one dedicated surgical suite for the performance of cesareans.
- Ensure that at least one RN is always present and has the ability to stabilize and facilitate the transfer of patients and newborn infants when appropriate.
- Enter into a written agreement with a blood bank for emergency blood bank services and have written protocols for the management of obstetrical hemorrhage.
- Meet all standards as adopted by statute and rule for advanced birth centers and birth centers, unless specified otherwise.
- Maintain a Medicaid provider agreement with the agency and provide services to Medicaid recipients.

Perhaps recognizing that the creation of advanced birth centers was one of Live Healthy’s more controversial provisions, the Senate amended the original bill to grant the Agency for Health Care Administration (AHCA) broad rulemaking authority to develop any requirements or standards it deems necessary for patient safety. The rules must also, at a minimum, be equivalent to the standards adopted for ambulatory surgical centers and include standards for quality of care, blood transfusions, and sanitary conditions for food handling and service.



## Hospital Requirements

### *Clinical Placements*

When securing clinical placement positions for their medical students, Florida medical schools frequently compete for these limited positions with offshore institutions. These offshore institutions are typically for-profit programs that set exorbitant tuition prices and accept large cohorts of students – strengthening their ability to reimburse hospitals for clinical placements at a higher rate than state schools. In an effort to ensure clinical training opportunities remain available for Florida medical students, SB 7016 requires hospitals that accept payment from any medical school in exchange for directly or indirectly allowing their students to obtain clinical hours or instruction at that hospital to give priority to medical students enrolled in Florida medical schools as enumerated in Florida Statute Section 458.3145(1)(i).

### *Emergency Department Diversion Initiative*

Patients who lack access to primary care frequently present to local emergency departments for nonemergent care. It is well documented that these types of encounters add stress to the healthcare system and increase the overall cost of healthcare delivery. Aiming to increase access to primary care services and decrease costs associated with preventable emergency room visits, SB 7016 creates the following emergency diversion requirements for hospitals:

All hospitals with an emergency department, including hospital-based off-campus emergency departments, must submit to AHCA a “nonemergent care access plan” (NCAP) to assist patients who lack regular access to primary care. Before a hospital can renew or receive an initial license, AHCA must approve the hospital’s NCAP by July 1, 2025. Once the plan is approved, each hospital will be responsible for submitting data to the agency demonstrating the implementation and results of its plan. An NCAP must include:

- Procedures that ensure the plan does not interfere with the hospital’s responsibilities under state or federal emergency services law (e.g., EMTALA);
- Procedures to educate patients about care that would be best provided in primary care settings and the importance of primary care; and
- At least one of the following:
  - A collaborative partnership with a federally qualified health center (FQHC) or other primary care setting. A hospital may not prohibit collaborating FQHCs or primary care settings from partnering with other hospitals.
  - The establishment, construction, and operation of a hospital-owned urgent care center collocated within or adjacent to the hospital emergency department that the hospital may divert patients to when appropriate. The hospital must also establish procedures to assist the patient in identifying appropriate primary care settings, provide a current contact list of such settings within 20 miles of the hospital, and subsequently assist the patient in arranging for follow-up care.

For Medicaid patients, the NCAP must include outreach to the patient’s Medicaid managed care plan and coordination with the managed care plan for establishing a relationship between the patient and a primary care setting as appropriate for the patient.

### *Mandatory HIE participation*

Since 2011, the Florida Health Information Exchange (HIE) program has facilitated the secure and electronic exchange of patient health information between healthcare providers, hospital systems, and payers. Florida's HIE is governed by AHCA and operated by Audacious Inquiry. Participating HIE subscribers can receive timely alert notifications of patient hospital encounters and search for a patient's health information across multiple clinical data sources locally, statewide, and nationally. Despite the transmission of over eight million monthly alerts from more than 700 data sources, the program still struggles to obtain complete data sets largely due to encounters at nonparticipating sites. In an effort to support public health data registries and patient care coordination, SB 7016 requires hospitals to make available admit, transfer, and discharge data to the Florida HIE program.

## **Graduate Medical Education**

### *Slots for Doctors Program*

In 2023, the FMA advocated for the creation of the Slots for Doctors Program and secured \$30 million to create 300 new residency positions in specialties with statewide supply-and-demand deficits. The program allocates \$100,000 annually for residency positions in an initial or established accredited residency program first filled on or after June 1, 2023. The Live Healthy package provides an additional \$50 million for the creation of 500 new residency slots.

Notwithstanding the requirement for a slot to be first filled after June 1, 2023, SB 7016 allows for up to 200 slots that existed prior to July 1, 2023, to qualify for the increased funding. Under this provision, the position must be in a statewide supply-and-demand specialty, have gone unfilled for at least three years, be subsequently filled after June 1, 2024, and be in an initial or established accredited training program. Primary care positions will be prioritized if applications under this provision exceed the number of authorized resident positions or the allocated funding.

In addition to the Live Healthy funding, SB 330, sponsored by Sen. Boyd, appropriated an additional \$12 million to Slots for Doctors for up to 10 newly created resident positions within a designated behavioral health teaching hospital. These designated slots will be funded at an annual rate of \$150,000.

In a phenomenal win for physicians and the future of medicine, this additional \$62 million increases the recurring funding for the Slots for Doctors Program to a total of **\$92 million for 880 new residency slots**.

### *Reporting Requirements*

Accompanying the increased funding for graduate medical education (GME) is an annual reporting requirement for any hospital or qualifying institution that receives state funds under the Statewide Medicaid Residency Program, Graduate Medical Education Startup Bonus Program, or the Slots for Doctors Program. This legislation requires these entities to report specific data sets relating to residency positions and the funding source for each position. Beginning July 1, 2025, hospitals and qualifying institutions will be required to annually submit to AHCA financial records detailing the manner in which state funds allocated to support residency positions were expended.

In addition to the reporting requirements related to funding, each hospital or qualifying institution must provide an exit survey to their exiting residents and submit the results of the survey to AHCA. The survey questions are largely geared toward collecting data on where physicians practice post-residency and what type of employment has been procured.

### *Graduate Medical Education Committee*

With such a strong focus on GME and dedicated funding, SB 7016 creates the Graduate Medical Education Committee. The Committee will be responsible for composing an annual report that must, at a minimum, detail the following:

- The role of residents and medical faculty in the provision of healthcare.
- The relationship of GME 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 GME.
- The use of state funds, including but not limited to intergovernmental transfers, for GME for each hospital or qualifying institution receiving such funds.

The Committee will be composed of the following members:

- Three medical school deans, or their designees, appointed by the chair of the Council of Florida Medical School Deans;
- Four members appointed by the Governor, one physician representing the FMA or FOMA who has supervised residents, a member of the Florida Hospital Association, a member of the Safety Net Hospital Alliance, and a physician who is practicing at a qualifying institution;
- Two members appointed by the Secretary of AHCA, one who represents a statutory teaching hospital, and a physician who has supervised residents;
- Two members appointed by the state Surgeon General, one who represents a teaching hospital, and a physician who has supervised residents; and
- Two members, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives.

The Graduate Medical Education Committee will provide valuable information on the health of Florida's physician workforce.

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

In the spirit of expanding the healthcare workforce in underserved areas, the Live Healthy package creates the Training, Education, and Clinicals in Health (TEACH) Funding Program for qualified facilities to offset administrative costs and loss of revenue associated with establishing, maintaining, or expanding a clinical training program. The bill defines "qualified facility" to include FQHCs, community mental health centers, rural health clinics, and certified community behavioral health clinics. A qualified facility operating a residency program may be reimbursed up to \$100,000 per year and up to \$75,000 for non-physician training programs. The TEACH Program will be administered by AHCA, which will be responsible for developing the application process, collating data, and providing an annual report detailing the effects of the program. This program was appropriated \$25 million in recurring funding.



## Foreign-Trained Physicians

There was considerable interest in creating a pathway for foreign-trained physicians to obtain licensure in Florida without completing a residency program. As initially filed, SB 7016 would have completely relied on a foreign country's determination of adequacy for what constitutes acceptable postgraduate training. The FMA was adamant that foreign-trained physicians should have education and training comparable to U.S. standards and that the Florida Board of Medicine should retain the ability to review a foreign-trained physician's residency or postgraduate medical training. Fortunately, the Legislature agreed that it would be unwise to grant a medical license to an applicant under these circumstances.

Recognizing that there are high-quality residency programs not based in the U.S., the bill was amended to provide a pathway to licensure for graduates of foreign medical schools if the applicant:

- Holds an unrestricted license to practice medicine in a foreign country,
- Has actively practiced medicine for the immediately preceding four years,
- Has completed a residency or postgraduate medical training, which is substantially similar to a residency program accredited by the Accreditation Council for Graduate Medical Education, as determined by the Board of Medicine,
- Holds a certificate issued by the Educational Commission for Foreign Medical Graduates, and
- Has an offer for full-time employment as a physician from a healthcare provider that operates in-state. The term "healthcare provider" includes a healthcare professional, healthcare facility, or entity licensed or certified to provide health services in this state as recognized by the board.

As a condition of licensure, a physician licensed under this provision must maintain his or her employment with the original employer or with another healthcare provider that operates in this state, at a location within this state, for at least two consecutive years after licensure.

## Graduate Assistant Physician

The Live Healthy package creates a new Graduate Assistant Physician limited license for unmatched medical school graduates who have passed all parts of the USMLE. While only a small percentage of medical school graduates do not match into a residency program, the creation of this limited license will increase workforce mobility and expand opportunities for graduates while they find placement in residency programs. The limited license is valid for two years with the possibility of a one-time renewal for one additional year.

A graduate assistant physician may provide healthcare services only under the direct supervision of a physician who has been approved by the appropriate board to supervise graduate assistant physicians. An approved physician may supervise no more than two graduate assistant physicians and is liable for any acts or omissions of the supervisee.

The Board of Medicine and Board of Osteopathic Medicine will promulgate rules on protocol requirements which, at a minimum, will include a process for the evaluation of the graduate assistant physician's performance and stipulate that the delegation of any medical task or procedure is within the supervising physician's scope of practice and appropriate for the graduate



assistant physician's level of competency. A graduate assistant physician's prescriptive authority will be governed by the protocol and criteria adopted by the boards.

### **Interstate Medical Licensure Compact**

The Interstate Medical Licensure Compact is an agreement among 37 participating U.S. states and territories to significantly streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify. The Live Healthy package brings Florida into this compact.

The compact will create an additional pathway for licensure and does not change Florida's existing medical practice act. A physician who holds a compact license is subjected to the jurisdiction of the state medical board where the patient is located, and the Florida medical boards will retain jurisdiction to impose discipline against a license issued through the compact. Once the compact is implemented, the FMA will collaborate with the Board of Medicine and Board of Osteopathic Medicine to provide detailed information on how to apply for a compact license. There will not be a negative fiscal impact on physicians who choose not to participate.

Unlike the scope-of-practice bills, the Live Healthy package will alleviate physician shortages in underserved communities, encourage more physicians to practice family and general medicine, educate and train more Florida physicians, and increase workforce opportunities.

### **Budget Wins**

Along with the added \$30 million appropriated for the FRAME Program and the added \$62 million for Slots for Doctors, the FMA was able to secure an additional \$43 million to fully implement last year's increased reimbursement rates to, at a minimum, the Medicare level for all physicians who provide care to Medicaid patients under the age of 21. As \$76 million was secured in Fiscal Year 2023-2024, a total of \$119 million has now been appropriated to increase Medicaid reimbursement rates not just for pediatricians, but for any physician providing primary or specialty care.

The General Appropriations Act also included a recurring \$8.2 million to reimburse interprofessional collaboration and collaborative care management services provided by primary care practitioners and behavioral healthcare providers. The FMA will provide further details once AHCA determines how this funding will be implemented.

### **Medical Treatment Under the Workers' Compensation Law**

*HB 161, Rep. Daley / SB 362, Sen. Bradley*

The Florida workers' compensation healthcare delivery system is in shambles – and for obvious reasons. For over 20 years, the physician workers' compensation reimbursement rate has remained stagnant and is the lowest in the country. As a natural consequence, physician participation in the state's workers' compensation network is critically low. Currently, participating physicians are reimbursed at 110% of the Medicare rate for medical office visits and 140% of the Medicare rate for surgical procedures. In a long overdue victory for physicians treating injured workers, rates were increased to 175% and 210%, respectively. The passing of this legislation was the result of fierce advocacy and steadfast bill sponsors, and it will help incentivize increased participation to fuel a depleted system.





### **Coverage for Skin Cancer Screenings**

*HB 241, Rep. Massullo, MD / SB 56, Sen. Harrell*

One of the few drawbacks of living in the Sunshine State is the constant exposure to ultraviolet rays. With over 9,600 new cases of skin cancer diagnosed in Florida each year, early detection is key to high long-term survival rates. The FMA was proud to support legislation championed by the Florida Academy of Dermatology that requires the state employee group health plan to cover skin cancer screenings at no cost for over 300,000 state employees by Jan. 1, 2025. While this is a great start, we will continue advocating for all private and state payers to cover these life-saving screenings.

### **Coverage for Biomarker Testing**

*HB 885, Rep. Gonzalez-Pittman / SB 964, Sen. Calatayud*

Among the many benefits of biomarker testing is expedited diagnoses and targeted treatment, which will save lives and ultimately save the state and healthcare system money. Effective Jan. 1, 2025, this legislation will require the state employee group health plan and Florida Medicaid to provide coverage for biomarker testing if medical and scientific evidence indicates that the testing would provide clinical utility. Similar to the coverage for skin cancer screening legislation, the FMA will continue to support coverage for all Florida patients, regardless of the type of insurance they hold.

### **Access to HIV Post-Exposure Prophylaxis Medication**

*HB 159, Rep. Franklin / SB 1320, Sen. Calatayud*

Recognizing that HIV post-exposure prophylaxis (PEP) medications must be taken within 72 hours after exposure to be effective, the FMA supported HB 159 as a means to expedite the dispensing of these medications. As originally filed, this legislation would have allowed pharmacists broad authority to screen for HIV exposure and order and dispense both pre- and post-exposure prophylaxis medications with limited physician involvement. The FMA worked closely with the bill sponsors to retain physician oversight and strengthen patient protection measures.

As amended, this legislation authorizes a pharmacist, certified by the Board of Pharmacy, to order and dispense PEP medications pursuant to a written collaborative agreement with a physician licensed under chapter 458 or 459. At a minimum, collaborative practice agreement under this section must:

- Establish the terms and conditions relating to the screening for HIV and the ordering and dispensing of PEP medications by a pharmacist,
- Identify specific categories of patients the pharmacist is authorized to screen for HIV and for whom the pharmacist may order and dispense PEP medications,
- Require the pharmacist to maintain records for PEP medications ordered and dispensed,
- Include the physician's instructions for obtaining a relevant medical history for the purpose of identifying disqualifying health conditions, adverse reactions, and contraindications to the use of PEP medications,
- Provide a process and schedule for the physician to review the pharmacist's records and actions under the practice agreement,
- Contain evidence of the pharmacist's current certification by the board, and
- Include any other requirements as established by the board with the approval of the Board of Medicine and the Board of Osteopathic Medicine.

The pharmacist must provide the patient with written information to seek follow-up care from his or her primary care physician. In addition to the prescriptive collaborative practice agreement, a pharmacy in which a pharmacist is providing services under this collaborative practice agreement must develop and maintain an access-to-care plan and comply with such procedures when a patient indicates that he or she lacks access to primary care. The access-to-care plan is designed to assist patients in gaining access to an appropriate primary care setting.

### **Sickle Cell Disease**

*HB 7085, Rep. Skidmore/ SB 7070, Sen. Rouson*

This legislation establishes the Sickle Cell Disease Research and Treatment Grant Program to fund projects aimed at improving healthcare services, increasing access to healthcare, and spreading awareness among healthcare practitioners of the best practices for the treatment of sickle cell disease. This program received a \$10 million appropriation.

In lieu of this significant grant program, an earlier iteration of this bill would have required all physicians, APRNs, PAs, RNs, LPNs, and Anesthesiologist Assistants (AAs) to complete a two-hour mandatory continuing education course on sickle cell disease care management every other biennium, regardless of the licensee's specialty. Fortunately, the FMA was able to change the direction of the bill and remove the mandatory continuing education course. Despite the removal of the mandatory course, the FMA believes that increased awareness and education on sickle cell disease is imperative. To that end, we are committed to developing educational content on the identification and management of sickle cell disease to further enhance physician awareness.

### **Office Surgeries**

*HB 1561, Rep. Busatta Cabrera / SB 1188, Sen. Garcia*

During the 2023 Legislative Session, HB 1471 (2023) codified the standard of care when performing gluteal fat grafting procedures – better known as Brazilian Butt Lifts (BBLs). This legislation has thus far proved to reduce the number of BBL-related deaths. The focus of the legislation this year shifted to a problem that is pervasive in South Florida – facilities that should be licensed as ambulatory surgical centers operating under the guise of office surgery facilities. Instead of granting the Department of Health the ability to revoke a sham office's registration, as originally filed, HB 1561 and SB 1188 would have required every office in which a physician performs BBLs or liposuction procedures where a patient is rotated 180 degrees or more to *reregister* with the department, and set ambiguous standards for the department to determine whether an office was improperly registered. This would have shut down these offices for an undetermined length of time until the department could conduct an inspection.

As the FMA and other stakeholders were working to remove the reregistration requirement, each bill went in a drastically different direction. In the House, there was concern over whether injured patients were able to adequately recover judgments when harmed by bad actors. An amendment was adopted that removed the reregistration provision, but required every physician that performs BBLs to carry professional liability insurance – removing the ability for these physicians to go bare. In the Senate, the amended bill would have codified the standard of care for office surgery rules (Rules 64B8-9.009 and 64B15-14.007, Florida Administrative Code), added additional standards for all registered offices, not just those where BBLs are performed, and still contained the reregistration requirement.

While it appeared uncertain that the bill sponsors would come to a consensus, Sen. Garcia ultimately agreed to accept the House version of the bill. However, instead of requiring physicians to carry liability coverage, the bill was amended to place the requirement on an office in which BBLs are performed. Effective upon the bill becoming law, an office in which a BBL is performed must establish financial responsibility by obtaining and maintaining professional liability coverage or an irrevocable letter of credit in an amount not less than \$250,000 per claim, with a minimum annual aggregate of not less than \$750,000 as provided by Sections 458.320(2)(b) or (c) and 459.0085(2)(b) or (c), F.S., as applicable. The FMA will support our specialty partners in petitioning the department to provide a grace period for compliance once the bill is signed by the Governor.

### **Interstate Mobility**

*HB 1273, Rep. Plasencia / SB 1600, Sen. Collins*

This well-intended, yet poorly drafted legislation creates the Mobile Opportunity by Interstate Licensure Endorsement (MOBILE) Act. The MOBILE Act streamlines licensure by endorsement for health professionals. Unfortunately, by eliminating each profession's carefully crafted and specifically tailored endorsement statutes, this bill will prevent many allopathic physicians and other healthcare professionals from practicing in the state.

Under the new endorsement process, an applicant physician must hold a license in another U.S. state or territory, passed the USMLE, have practiced medicine for three of the previous four years, not be the subject of discipline in another state, have not had disciplinary action taken against his or her license in the preceding five years, meet the required financial responsibility requirements, and submit to a background screening. While these requirements seem reasonable on a surface level, the language does not allow for the Board of Medicine to examine an application that fails to meet all of these requirements, as the board is able to do now. For example, if a Canadian trained physician holds a license in another U.S. state, but has not taken the USMLE, then that physician could not apply for licensure in Florida.

The Act goes on to state that any applicant who has been reported to the National Practitioner Data Bank (NPDB) is ineligible for a license under the MOBILE Act. Because a medical malpractice settlement is an NPDB reportable event, this provision will have a disparate impact on highly specialized physicians who take on the most complicated of cases - as these physicians may be more likely to have settled a medical malpractice case. These unintended consequences were explained to Sen. Collins and the Board of Medicine went so far as to provide a simple amendment that would have retained the board's ability to examine the applications of physicians who fail to meet one of these requirements. Unfortunately, the bill was never amended to reflect this improvement. The FMA will monitor the effects of this legislation and work with the Board of Medicine to report applications that would have been approved if not for this Act, as this will stymie recruitment and negatively impact the physician workforce.

### **Health Care Innovation**

*HB 1501, Rep. Gonzalez Pittman / SB 7018, Sen. Harrell*

Traveling in tandem with the Live Healthy bill, SB 7018 creates the Health Care Innovation Council to promote innovation in Florida's healthcare system. This 15-member council is charged with leading statewide discussions with Florida's healthcare leaders and stakeholders to create best practice recommendations for the advancement of the delivery of healthcare in Florida. This legislation also

creates a revolving loan program to provide low-interest loans to applicants who demonstrate a plan to implement innovative technologies, workforce pathways, service delivery models, or other solutions in order to improve the quality and delivery of healthcare, which will lower costs and allow savings to be passed on to healthcare consumers. The council will be responsible for reviewing applications and may make recommendations to the Department of Health for the administration of the loans. The revolving loan program is appropriated \$50 million.

## **LEGISLATION THAT WAS DEFEATED**

### **Scope of Practice**

For the fourth consecutive year, the FMA succeeded in defeating all scope-of-practice legislation. While increasing the number of physicians in Florida is crucial, expanding the scope of practice for non-physician providers does not translate to increased access to healthcare, resolve the physician shortage, or incentivize service in underserved areas.

### **Psychiatric Nurse Autonomous Practice**

*HB 771, Rep. Barnaby / SB 936, Sen. Rodriguez*

Supported by popular telehealth companies looking to hire countless inexperienced nurse practitioners to blindly prescribe controlled substances, this legislation would have given psychiatric nurse practitioners the ability to practice psychiatry and prescribe controlled psychiatric medications without a protocol with a supervising physician. Psychotropic medications can be some of the most medically complex and should only be prescribed under the supervision of a physician. Thanks to efforts led by the FMA and the Florida Psychiatric Society, this legislation was temporarily postponed in its first committee in the House and never resurfaced.

### **Naturopathic Medicine**

*HB 843, Rep. Smith / SB 898, Sen. Rodriguez*

Possibly the most egregious scope-of-practice legislation filed this session, HB 843 and SB 898 would have created a licensure structure for naturopaths. The proposed practice act would have given naturopaths the ability to practice as physicians and call themselves such. This bill would have granted naturopaths prescriptive authority, including the ability to prescribe controlled substances – quite counterintuitive for a profession that rejects modern medicine. The FMA was successful in defeating this dangerous scope-of-practice expansion, which only received one hearing in the House and died in committee.



## **Certified Registered Nurse Anesthetists Autonomous Practice**

*HB 257, Rep. Giallombardo / SB 810, Sen. Ingoglia*

This bill would have allowed Certified Registered Nurse Anesthetists (CRNAs) to engage in specialty medical practice without a protocol under a supervising physician. This would have allowed CRNAs to have the same authority as anesthesiologists, despite a more than 10,000-hour differential in education and training. The Legislature in 2020 believed that autonomous APRNs would fill the access-to-care gap in rural and underserved communities. We now know that the Legislature's goal was never accomplished, as APRNs have not moved to practice in these areas, and neither will CRNAs. This legislation was temporarily postponed in its first committee in the House and died in Committee.

## **Psychology Prescribing**

*HB 955, Rep. Franklin / SB 1282, Sen. Simon*

This legislation would have authorized psychologists to prescribe medications, including controlled substances, to individuals with psychiatric, mental, cognitive, nervous, emotional, developmental, or behavioral disorders. Under current law, psychologists are appropriately prohibited from prescribing medication. While psychologists are experts in important behavioral interventions and are highly valued members of the mental healthcare community, allowing for prescriptive authority will not solve the mental health crisis in Florida. This legislation did not receive a hearing in either chamber.

## **Acupuncture**

*HB 1405, Rep. Altman / SB 614, Sen. Hooper*

As part of redefining the term of "Oriental medicine" to "Eastern medicine," this legislation would have changed the scope of practice of acupuncturists by defining "Eastern medicine" as a "primary healthcare system of medicine that includes differential diagnoses and treatment principles, modalities, procedures, and techniques employing . . . medical assessments, examinations, and evaluations for the promotion, maintenance, and restoration of health and the prevention of human disease." Acupuncturists would have been allowed to order and interpret diagnostic laboratory tests and imaging procedures and would have been specifically allowed to use the term "acupuncture physician." This legislation was never heard in the Senate and never made it past its second committee of reference in the House.

## **Wrongful Death**

*SB 248, Sen. Yarborough / HB 77, Rep. Roach*

This legislation would have eliminated an exemption in medical malpractice wrongful death claims to allow for the recovery of noneconomic damages by adult children for the loss of a parent, and by the parents for the loss of an adult child with no surviving spouse or children. The trial bar has been trying to remove this exception since the law was enacted – and it has named this effort the "Free Kill" bill, arguing that the law encourages physicians to kill patients whom they have committed malpractice on, as it would be cheaper from a liability standpoint. This characterization is grossly insulting and completely lacks factual support.

While the FMA has defeated this legislation several times, it has recently gained significant attention and bipartisan support. As such, the FMA worked with Sen. Yarborough to strike a compromise that



would cap noneconomic damages in all medical malpractice actions at \$500,000 per claimant. These caps will prevent premiums from further skyrocketing and help to avoid deterring physicians from practicing in Florida. Ultimately, the compromise language died in committee and was never heard in the House. We expect this bill to be filed again next year and the FMA will continue to fight against the wrongful death legislation.

## **LEGISLATION THAT DID NOT PASS**

### **Health Care Practitioner Titles and Designations**

*HB 1295, Rep. Massullo, MD / SB 1112, Sen. Harrell*

Prompted by a 2019 Board of Nursing ruling that allowed a certified registered nurse anesthetist to advertise his services as a “nurse anesthesiologist,” bills have been filed during the last four sessions to restrict the titles and designations that allied health professionals can use. During the 2023 legislative session, both chambers agreed on language that would have reserved to MDs and DOs a laundry list of specialty designations and terms, notably the term “physician.” In addition, the bill would have required all healthcare practitioners to wear nametags with specific professional identifying information in certain circumstances. For unstated reasons, but most likely due to the objections of the Florida Optometric Association, the Governor vetoed the 2023 legislation.

Sen. Harrell and Rep. Massullo filed virtually the same legislation again this session. The key difference was that the House bill contained a provision that would have specifically allowed optometrists to refer to themselves as “optometric physicians.” The Senate version deleted the prohibition on the use of the term “physician” but refused to concur with the House provision on “optometric physician.” Despite unanimous support for the bill in the House and a 38-1 vote in the Senate, ultimately the impasse over the optometric physician provision left the bill languishing in House messages on the last day of session.

### **Corporate Practice of Medicine**

*HB 345, Rep. Skidmore / SB 316, Sen. Powell*

This legislation would have changed Florida’s law regarding the corporate practice of medicine by prohibiting the employment of a physician by any entity other than a group of physicians, a not-for-profit hospital, or a medical school licensed pursuant to general law. In addition to the prohibition on employment, only the enumerated entities would have been able to:

- Direct, control or interfere with a physician’s clinical judgment.
- Have a relationship with a physician that would allow the unlicensed person or entity to exercise control over:
  - The selection of a course of treatment for a patient, the procedures or materials to be used as part of such course of treatment, and the manner in which such course of treatment is carried out by the physician,
  - The patient records of the physician,
  - Policies and decisions relating to billing and advertising, and
  - Policies and decisions relating to physician staffing, office personnel, and hours of practice.





Despite the FMA's efforts to advance this legislation, there was no interest in changing Florida's long settled position on the corporate practice of medicine. Neither bill received a hearing in either chamber.

### **Invalid Restrictive Covenants with Physicians**

*HB 11, Rep. Rudman / SB 458, Sen. Brodeur*

This legislation would have prohibited the use of restrictive covenants that would prevent physicians from practicing within a geographical boundary for any period of time upon the termination of a contract, partnership, employment, or professional relationship. The House and Senate bills differed in that the House bill provided no exceptions to this prohibition, whereas the Senate bill allowed for several exceptions. While the FMA has members on both sides of this issue, we will continue to monitor the impact this type of legislation has on the practice of medicine in other states and track its movement at the federal level.

\*Please note, the Governor has yet to sign any of the abovementioned bills as of the original publication date of this report. Once a bill is sent to the Governor, he has 15 days to sign or veto legislation. If the Governor does not sign a bill, it will become law at the expiration of the 15-day window.

