

Health Care Compacts

Presentation to the Senate Committee on Health Policy

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OPPAGA

Office of Program Policy Analysis and Government Accountability

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Project Scope and Methodology

As directed by the Legislature, OPPAGA examined the advantages and disadvantages of participation in health care compacts and answered three questions.

1. How does Florida reduce barriers for out-of-state practitioners to become licensed to practice in the state?
2. What are the advantages and disadvantages of joining health care compacts?
3. What are key considerations when contemplating participation in health care compacts?

Methodology

Information
and Data
Requests

Assessment of
Stakeholder
Perspectives

Literature
Review

Compact
Document
Review

Practice Avenues



Florida offers three options for licensed out-of-state practitioners to provide services in Florida



Licensure by Endorsement



Telehealth Registration

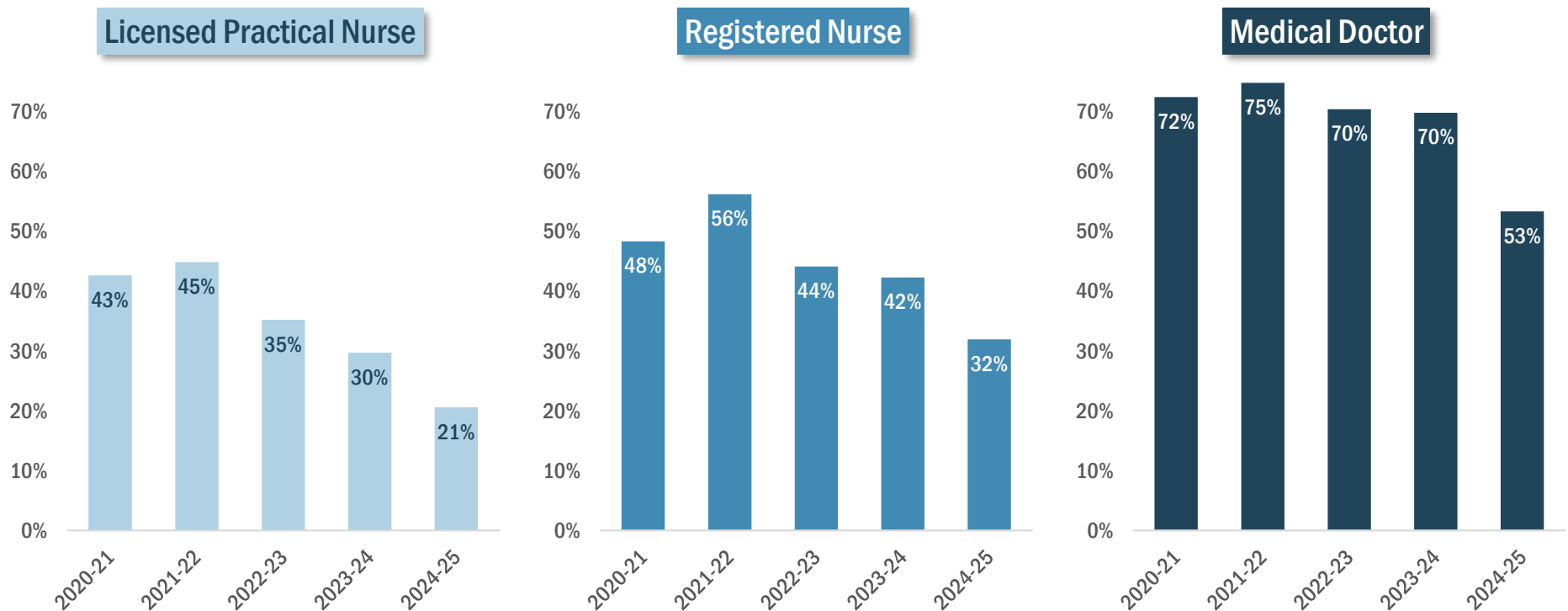


Licensure by Compact

Licensure by Endorsement



The percentage of out-of-state practitioners licensed by endorsement in each fiscal year has generally declined



Source: OPPAGA analysis of data from the Florida Department of Health.

Telehealth Registration



New telehealth registrations for out-of-state practitioners have remained relatively stable; more out-of-state physicians than nurses are registered to provide telehealth in Florida

- Section 456.47(4), *Florida Statutes*, authorizes practitioners located and licensed in other states to register with DOH to perform telehealth services for patients in Florida

Telehealth Profession	Fiscal Year				
	2020-21	2021-22	2022-23	2023-24	2024-25
Licensed Practical Nurse	1	1	3	1	0
Registered Nurse	9	41	16	25	23
Medical Doctor	1,225	2,705	1,282	1,042	1,054
Osteopathic Physician	115	254	172	172	149
Total New Registrations	1,350	3,001	1,473	1,240	1,226

Source: OPPAGA analysis of data from the Florida Department of Health.

Licensure by Compact



Health care compacts are legislatively enacted agreements between states to mutually recognize each state's practitioner licenses

State officials
form an advisory
body

A drafting team
develops model
legislation for
feedback

When model
legislation is
finalized, states
may adopt it

When a pre-set
number of states
adopt model
legislation,
commissions
form and
administer the
compact

States
implement
compact
legislation

States process
compact
applications

Florida Landscape



There are 17 health care compacts; Florida has passed legislation to join six and three are active



Active in Florida



2018: Nurse Licensure



2023: Psychology
Interjurisdictional



2024: Interstate Medical
Licensure



Not Yet Active in Florida



Counseling



Audiology and Speech-Language
Pathology



Physical Therapy

Health Care Compacts Florida Has Not Joined



Advanced Practice Registered
Nurse



Athletic Trainers



Dentist and Dental Hygienist



Dietician Licensure



Emergency Medical Services



Interstate Compact for School
Psychologists



Interstate Massage Therapy



Occupational Therapy



Physician Assistant Licensure



Respiratory Care

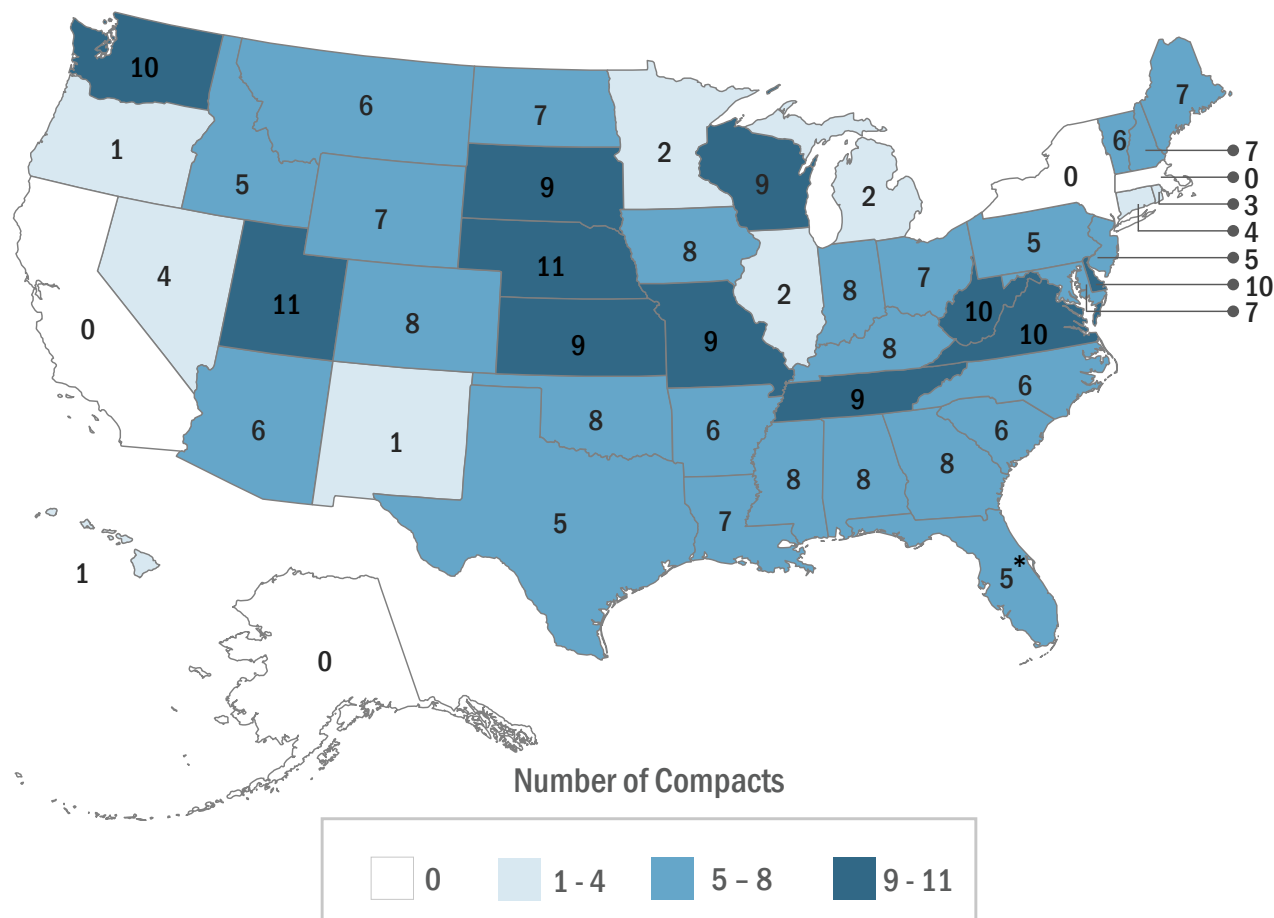


Social Work Licensure

National Landscape



Most states have joined between five and eight health care compacts



* This map excludes the Physical Therapy Compact from the count of Florida's compacts.

Source: OPPAGA analysis of data from Bogulski, Cari A., et al. "Trends in U.S. State and Territory Participation in Interstate Healthcare Licensure Compacts (2015-2024)." *Journal of Medical Regulation* 111.1 (2025): 8-25. <https://doi.org/10.30770/2572-1852-111.1.8>

Advantages and Disadvantages of Compacts



Health care compacts have reported advantages for the state, practitioners, and the public; some may have disadvantages



Compact Advantages

- Facilitates licensure and disciplinary data sharing
- Can expedite practitioner supply during certain circumstances, such as natural disasters
- Eases application requirements for practitioners
- Benefits military families
- Allows for continuity of care



Compact Disadvantages

- Cost and operational challenges
- May alter state scope of practice

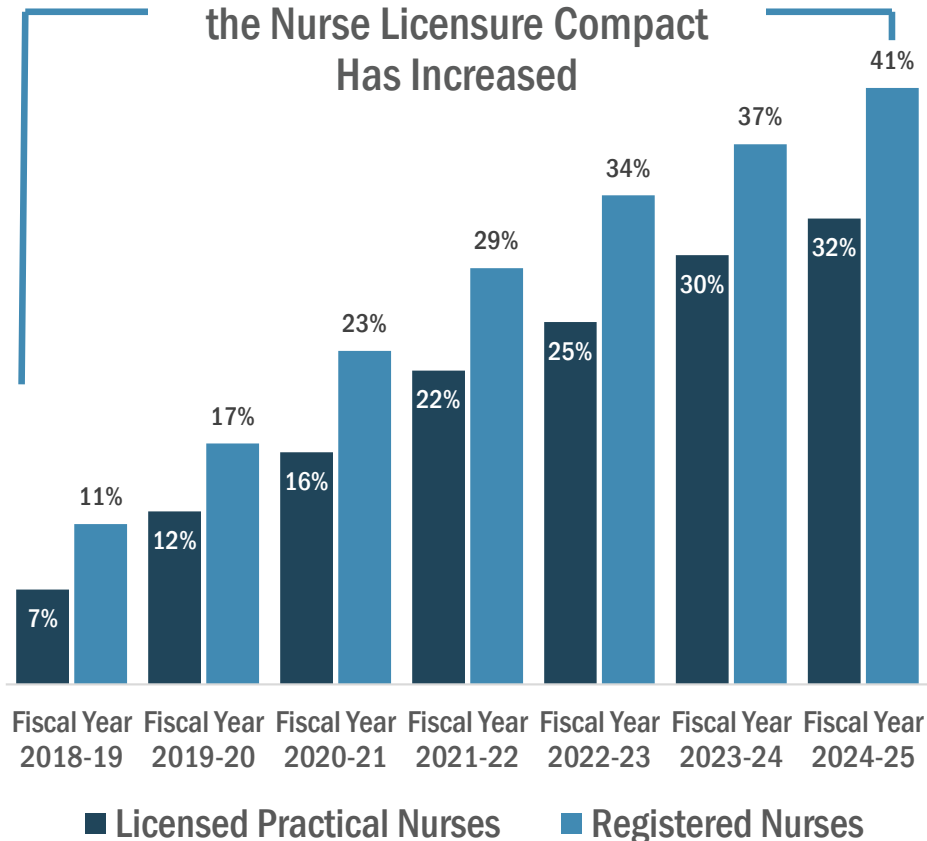
OPPAGA did not find reliable evidence to support claims that health care compacts reduce workforce shortages and increase access to providers

Nurse and Psychologist Compact Participation



Participation in health care compacts by Florida licensed practitioners varies; lack of reporting requirements results in inability to determine number of compact practitioners practicing in compact states

Florida Nurses' Participation in the Nurse Licensure Compact Has Increased



Some Florida Psychologists Have Joined the Psychology Compact



15.6% (1,235) of psychologists can practice telepsychology in other states



0.8% (66) can practice temporary in-person psychology in other states

Data Limitation

OPPAGA was unable to determine the number of compact nurses or psychologists from other states that practice in Florida and the number of Florida licensees that use their license to practice in other states.

Physician Compact Participation



Few Florida medical doctors and osteopathic physicians have been licensed through the Interstate Medical Licensure Compact (IMLC)

Physicians Seeking a Compact License in Fiscal Year 2024-25	Compact Licensed Medical Doctors	Compact Licensed Osteopathic Physicians
Florida physicians seeking a license in other states	1,225 (1.2%)	187 (1.3%)
Other state physicians seeking a license in Florida	1,005	163

Data Limitation

- The IMLC requires licensees to obtain a license in each state where they want the ability to practice.
- However, licensees are not required to report where they actually practice.
- As a result, OPPAGA could not determine whether Florida physicians use their compact license to practice in another state or whether physicians from other states use their compact license to practice in Florida.

Proposed Compacts



Of the 11 health care compacts that Florida has not joined, the Legislature proposed legislation to join three compacts

Compact	Proposed or Not Considered	Compact Accepting Applications? *
Interstate Compact for School Psychologists	2025 House Bill 327 proposed joining	No
Occupational Therapy Licensure	2025 House Bill 909 proposed joining	No
Social Work Licensure	2025 House Bill 27 proposed joining	No
Advanced Practice Registered Nurse	Not considered	No
Athletic Trainer	Not considered	No
Dentist and Dental Hygienist	Not considered	No
Dietician Licensure	Not considered	No
Emergency Medical Services	Not considered	Yes
Massage Therapist	Not considered	No
Physician Assistant Licensure	Not considered	No
Respiratory Care	Not considered	No

* Compacts may not be accepting applications because the required number of states have not enacted compact legislation; the compact commission has not yet formed; or the compact commission is developing data systems and bylaws.

Key Considerations



If contemplating joining additional health care compacts, the Legislature should focus on key compact provisions

Shared Provisions

- ✓ Public safety
- ✓ Quality of care
- ✓ Licensure portability
- ✓ Administrative efficiencies



Compacts may conflict with state practice laws

Florida Law

- APRNs must practice under a supervisory agreement with a physician

APRN Compact

- Requires that APRNs comply with the state practice laws of the state where the client is located
- Excludes state laws, rules, or regulations that require supervision from its definition of state practice laws

Key Considerations



The Legislature may also need to consider allocating resources to implement health care compacts; Florida may lose licensing revenue

Costs of State Participation



Compact commissions can collect an annual assessment from each participating state



Florida has paid \$6,000 annually for Nurse Licensure Compact membership since Fiscal Year 2019-20



Florida has paid \$6,000 annually for Psychology Compact membership since Fiscal Year 2023-24



States may need to hire additional staff and invest in technology to implement compacts

Potential Loss of Revenue



Licensing revenue is a major source of funds to support health care practitioner regulation



Some compacts do not have provisions that would allow Florida to charge out-of-state compact practitioners a fee for a multistate license

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FLORIDA LEGISLATURE OFFICE OF PROGRAM POLICY ANALYSIS AND
GOVERNMENT ACCOUNTABILITY

OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations.

Health Care Compacts

November 14, 2025



OPPAGA

Office of Program Policy Analysis and Government Accountability

EXECUTIVE SUMMARY

Occupational licensing for health care professions establishes minimum educational, training, and experience requirements to protect public safety. However, licensing may also create barriers to entering professions, and because each state may have different requirements, reduce geographic mobility in licensed professions. Research suggests that best practices to reduce licensure barriers include promoting licensure reciprocity and aligning license requirements across states, which can be accomplished by joining health care interstate licensure compacts. These legally enacted agreements between two or more states mutually recognize each state's practitioner licenses.

In general, health care compacts are intended to increase access to care and promote practitioner mobility. There are 17 compacts for a variety of health care professions. Health care compacts are developed at the national level with state input and can be characterized as either a mutual recognition model or an expedited licensure model. The mutual recognition model allows a practitioner to practice in other states using their home state license. The expedited licensure model requires applicants to obtain a license from each state where they intend to practice, using a more efficient and centralized application process through the compact.

Florida has passed legislation to join health care compacts for six professions—audiology and speech-language pathologists; counselors; physicians; nurses; physical therapists; and psychologists. Of these, Florida is currently active in three compacts (Nurse Licensure, Psychology, and Interstate Medical Licensure) and anticipates becoming active in two additional compacts (Audiology and Speech-Language Pathology and Counseling) by March 2026. Florida is currently ineligible to participate in the Physical Therapy Compact due to deviation from the required model legislation language.

Health care compacts have several advantages and disadvantages that vary across compact models. Stakeholders reported that advantages include sharing disciplinary data among states and making obtaining a license for multiple states easier. Additional advantages for practitioners are licensure portability, application ease, and for some compacts, streamlined continuing education requirements and lower licensure costs across multiple states. Disadvantages include costs, operational challenges, and potential conflict with existing state law. While some stakeholders reported that health care compacts increase a state's supply of practitioners, OPPAGA found limited reliable research evaluating the effect of compacts on state labor supply or labor mobility. In addition, while Florida's participation in the Nurse Licensure Compact included 32% of licensed practical nurses and 41% of registered nurses in Fiscal Year 2024-25, few Florida psychologists and physicians have joined their respective compacts.

If contemplating Florida's participation in additional health care compacts, the Legislature should focus on key compact provisions related to public safety, quality of care, licensure portability, and administrative efficiencies and should also consider financial and operational characteristics necessary for compact implementation.

REPORT SCOPE

As directed by the Legislature, OPPAGA examined the advantages and disadvantages of participation in health care compacts and answered three questions.

1. How does Florida reduce barriers for out-of-state practitioners to become licensed to practice in the state?
2. What are the advantages and disadvantages of joining health care compacts?
3. What are key considerations when contemplating participation in health care compacts?

BACKGROUND

Occupational licensing establishes minimum educational, training, and experience requirements to protect public safety

Occupational licensure is a regulatory method that requires people to secure a license from the government to practice a certain trade or profession. Licensing laws and regulations are established independently by each state legislature.¹ State laws and regulations may specify the requirements for obtaining a license (e.g., education, training, and experience requirements; licensure examinations; and licensure fees). State legislatures establish occupational licensing laws and regulations to specify requirements that must be met to practice in a licensed profession. Some states authorize state agencies to establish occupational licensing requirements. In other states, boards may perform these duties.

In general, there are benefits of occupational licensing, such as enhanced public safety due to minimum educational, training, and experience requirements for licensure. However, occupational licensing may also create barriers to entering professions and reduce employment and geographic mobility in licensed professions. Research suggests that best practices to reduce licensure barriers include promoting licensure reciprocity and aligning license requirements across states, which can be accomplished by joining health care interstate licensure compacts, legally enacted agreements between two or more states to mutually recognize each state's practitioner licenses.

Health care interstate licensure compacts may increase access to care and reduce occupational licensure barriers

Health care compacts are legislatively enacted agreements between two or more states to mutually recognize each state's practitioner licenses. There are 17 compacts for a variety of health care professions. In general, health care compacts are created to increase access to care by expanding practitioner mobility and reducing barriers to licensure, such as duplicative licensure processes. Health care compacts are developed at the national level with state input and can be characterized as either a mutual recognition model or an expedited licensure model.

Compacts are intended to increase access to care and promote interstate practitioner mobility

- A **member state** is a state that has enacted the compact.
- A **home state** is the member state that is the licensee's primary residence.
- A **remote state** is a member state, other than the home state, where a licensee is exercising or seeking to exercise compact authorization.

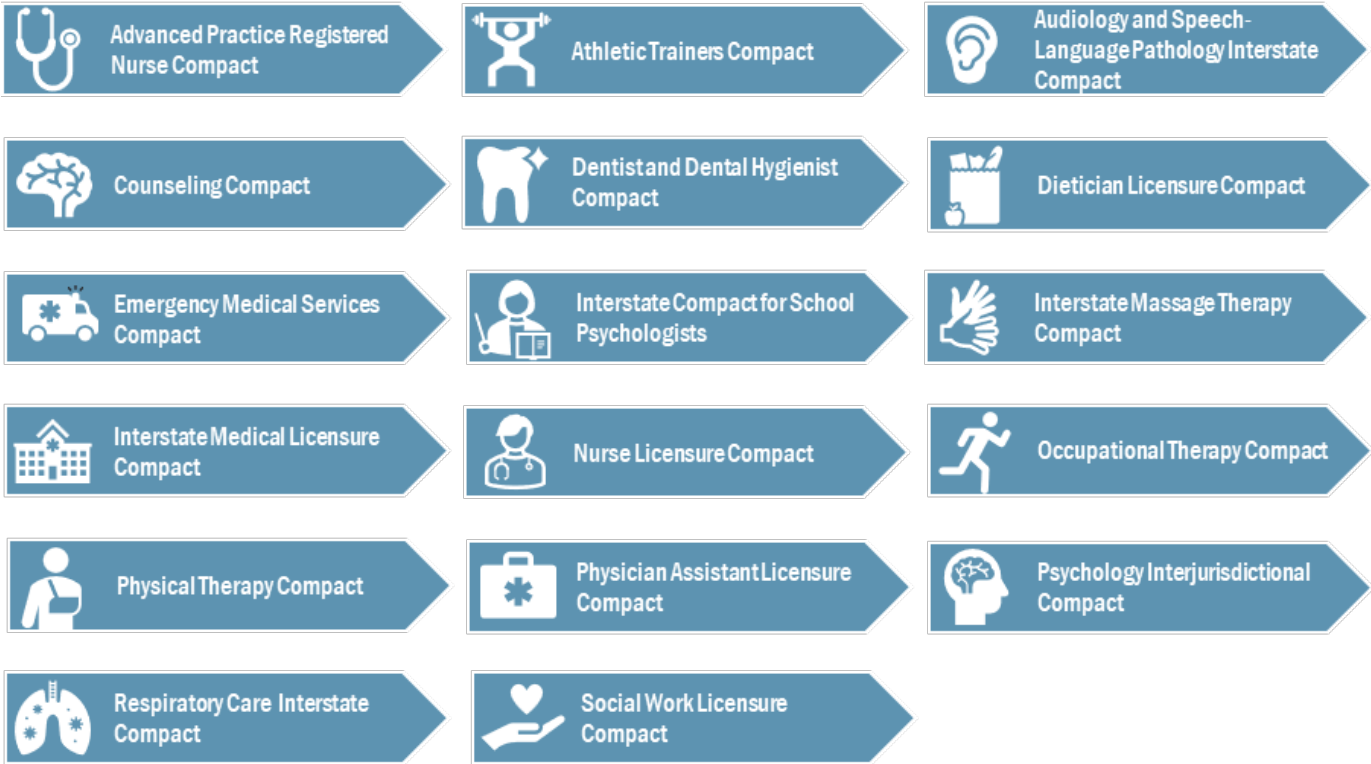
Health care compacts are legislatively enacted agreements between two or more states to mutually recognize each state's practitioner licenses. Health care compacts generally allow health care practitioners to practice in more than one state through a multi-state license via a compact (i.e., compact license) without obtaining separate licenses in each state. The practitioner must already hold or be eligible to hold a license in a state that participates in the compact and meet eligibility criteria that differs by

¹ The Tenth Amendment of the U.S. Constitution reserved for the states those powers not explicitly assigned to the federal government, including occupational licensing. It also authorized states to establish laws and regulations protecting the health, safety, and general welfare of citizens.

compact but may include not having a criminal history, meeting educational requirements, and having passed a national standardized examination. The practitioner application process varies by compact. For some compacts, the state licensing board submits information on a practitioner’s eligibility and then the practitioner applies via the compact program’s website by uploading paperwork to demonstrate that they have met the eligibility criteria, pays fees, and confirms passage of a jurisprudence exam if required by the state.² For other compacts, the home state licensing board determines eligibility, the practitioner pays an administrative fee, and the home state issues the compact license. Typically, states charge more for a compact license than a single state license. All health care compacts require an FBI criminal background check. One compact requires practitioners to obtain a single-state license for each state where they wish to practice, but the process of obtaining a license for an additional state is streamlined through a centralized database application.

A compact enacted in state legislation does not automatically require a practitioner in the state to apply for a compact license nor does it qualify a practitioner to practice in multiple states; however, it provides practitioners the option to obtain interstate professional reciprocity, if desired. As of December 31, 2024, there were 17 health care compacts in the United States. (See Exhibit 1.)

Exhibit 1
There Are 17 Health Care Compacts for a Variety of Professions in the United States



Source: National Center for Interstate Compacts.

In general, health care compacts are created to improve access to care and reduce barriers to licensure. While health care compacts do not increase the overall number of practitioners in the national workforce, compacts can redistribute practitioners across states to where they are most needed, potentially increasing access to care in some places. For example, assuming two contiguous states are compact member states, practitioners who participate in compacts (i.e., compact

² A jurisprudence exam protects the public by measuring an individual’s mastery of the knowledge and skills regulated by state law.

practitioners) from a populated county close to a state border can cross the border and provide services to a rural county in the neighboring state that has a provider shortage.

In addition, compacts address barriers to licensure in several ways. Compacts can reduce the amount of paperwork required for licensure in multiple states. Practitioners who apply for multiple single-state licenses must submit duplicative and sometimes different paperwork for each state license. In contrast, compact practitioners can submit a single application to practice in more than one state, making it easier to apply for licensure in multiple states, which may encourage practitioner mobility. Rather than having to adhere to varying state licensure requirements, compact practitioners must instead meet uniform educational and continuing education requirements as specified in the compact's model legislation.³ Once the home state determines that the practitioner meets the uniform compact requirements, they will be able to practice in other member states without meeting additional requirements.

Public health and safety can be monitored by member states that share licensure and disciplinary information in a coordinated database containing information on compact practitioners, allowing each state to access practitioner disciplinary information. Member states must provide investigatory and disciplinary information on compact practitioners to the data system after an adverse action is recognized. Member states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state. Some compacts allow states to use shared disciplinary information to discipline practitioners who commit an adverse action in their home state and to participate in joint disciplinary investigations when a licensee has committed an adverse action in multiple states.⁴

Compacts are developed at the national level with state input; there are two compact models

National stakeholder groups develop health care compacts, states enact model legislation to join compacts, and national commissions administer compacts. According to the Council of State Governments, while compact development processes may vary across compacts, there are common steps.

- State officials and other stakeholders form an advisory body—typically about 20 individuals representing different groups and states—to make recommendations about the structure of the compact.
- A drafting team—composed of five to eight compact and issue experts—takes the advisory body's recommendations and develops a draft compact that is circulated to state officials, stakeholders, and the public for feedback. For example, a group of state medical board executives, administrators, and attorneys assisted by the Federation of State Medical Boards developed model legislation for the Interstate Medical Licensure Compact, the National Council for State Boards of Nursing created model legislation for the Nurse Licensure Compact, and the Department of Defense provided funding to the Council of State Governments to assist in the development of the Social Work Compact to help licensed social workers who are military spouses. Following a comment period, the drafting team revises the draft compact and releases it to the advisory body for final review.

³ Each member state must adopt the compact's model legislation, a legally binding contract between states.

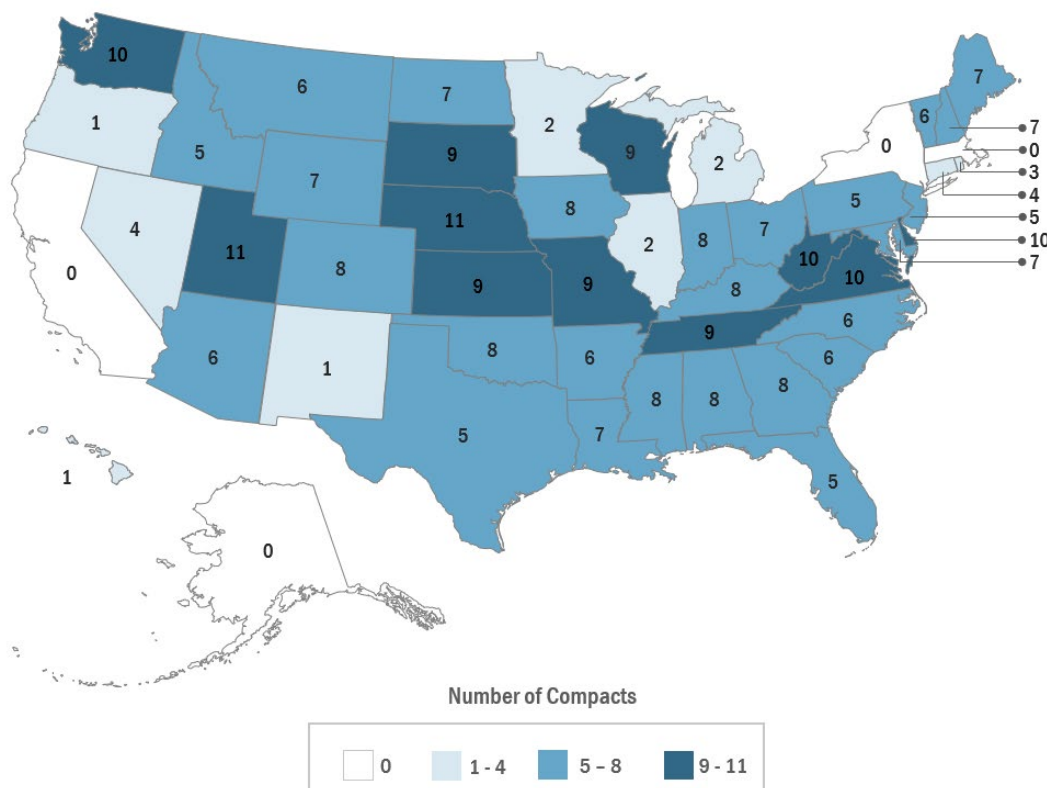
⁴ Generally, adverse action means a disciplinary action taken against a practitioner's license by a licensing board based on a practitioner's misconduct.

- Once the model legislation is finalized, states may adopt it. Once active, compacts generally permit health care practitioners to practice in other states that share the same enacted legislation (i.e., member states).⁵

Every state except Alaska, California, Massachusetts, and New York are members of at least one health care compact. (See Exhibit 2.)

Exhibit 2

All But Four States Are Members of at Least One Health Care Compact



Source: OPPAGA analysis of data from Bogulski, Cari A., et al. "Trends in U.S. State and Territory Participation in Interstate Healthcare Licensure Compacts (2015-2024)." *Journal of Medical Regulation* 111.1 (2025): 8-25. <https://doi.org/10.30770/2572-1852-111.1.8>

Compact commissions are the governing bodies that form after the compact is enacted, usually after a pre-set number of states join the compact. The number of required states needed to enact compacts, which is established in the model legislation, varies. For example, the Interstate Medical Licensure Compact became effective when seven states joined, and the Nurse Licensure Compact became effective when 26 states joined. Following enactment by the required number of states, the compact commission notifies states and hires staff to oversee the compact agreement.

Each compact commission is composed of representatives from all member states and promulgates uniform rules to implement and administer the compact. Commissions have a variety of functions, including

- prosecuting legal proceedings or actions in the name of the commission;
- purchasing and maintaining insurance and bonds;
- borrowing, accepting or contracting for services of personnel;

⁵ The authorizing language in each state's compact legislation must be the same for the compact to be enforceable.

- hiring employees;
- electing and appointing commission officers; and
- other functions as may be necessary to achieve compact purposes.

Health care compact commissions can collect an annual assessment from each participating state to fund commission operations and activities.

There are two health care compact models—mutual recognition and expedited licensure. Both models require practitioners to pay a fee to obtain a compact license in their home state. With the ***mutual recognition model*** a practitioner can practice in remote states using their home state license. Under this model, applicants who want a multistate license via a compact apply for a single state compact license where they live and practice, which allows them to practice in other states. Sixteen of 17 compacts use the mutual recognition model. The model has two sub-models.

- ***Remote state authorization required.*** When the practitioner applies in their home state for a compact license through the compact database, they select the remote state(s) where they want to practice. If the remote state charges a fee, the practitioner pays it, and then the remote state grants authorization to practice in the remote state via a compact license.⁶
- ***Remote state authorization not required.*** When the practitioner is granted a compact license in their home state, they may practice in any remote state without receiving authorization from the remote state.⁷ Practitioners may practice in remote states without paying licensure fees to each remote state.

The ***expedited licensure model*** requires applicants to obtain a license from each state where they intend to practice, but the compact makes the application process more efficient through data centralization and uniform application requirements. The application process begins when applicants provide their credentials to a central entity for storage and transfer. Officials from the home state then determine whether the applicant qualifies for expedited licensure by ensuring that the practitioner meets the educational, licensure, experience, and criminal background check requirements in their state. If qualified, other member states then grant applicants an expedited license to practice. The Interstate Medical Licensure Compact is the only health care compact that uses the expedited licensure model.

QUESTIONS AND ANSWERS

How does Florida reduce barriers for out-of-state practitioners to become licensed to practice in the state?

Florida reduces barriers for out-of-state practitioners by offering multiple avenues for practice. For example, out-of-state practitioners can practice in Florida through licensure by endorsement, telehealth registration, or for some health care professions, interstate licensure compacts. Each of

⁶ Professions in compacts that follow this sub-model are audiology and speech-language pathologists, counselors, dentists and dental hygienists, dietitians, occupational therapists, physical therapists, physician assistants, respiratory therapists, and school psychologists.

⁷ Professions in compacts that follow this sub-model are advanced practice registered nurses, EMS personnel, nurses, psychologists, and social workers.

these pathways has specific application requirements and requires practitioners to practice within the scope of their license.

Health care practitioners from other states can use licensure by endorsement, telehealth registration, or licensure by compact to practice in Florida

Florida provides three options for practitioners from other states who wish to provide health care in the state. This includes licensure by endorsement, telehealth registration, and licensure by compact. **Licensure by endorsement** is an expedited licensure process that allows a health care professional to become licensed in Florida via telehealth or in-person practice based on holding a substantially equivalent or similar health care professional license from another state. **Telehealth registration** allows health care professionals who are not located in Florida to provide health care services in the state via telehealth; telehealth registration prohibits a health care practitioner from opening an office or providing in-person services in Florida. **Licensure by compact** is intended to offer a faster pathway to providing health care across state lines, via telehealth and in-person care. (See Exhibit 3.)

Exhibit 3

Florida Offers Three Options for Licensed Out-of-State Health Care Practitioners to Provide Services in the State

Licensure Component	Licensure by Endorsement ¹	Telehealth Registration	Licensure by Compact ²
Practitioner Eligibility	Any out-of-state practitioner	Any out-of-state practitioner	Compact member state practitioners
License to Practice	Yes	No	Yes
State of Licensure	Florida	Other state	Other state ³
State of Practice	Florida	Florida	Compact member state(s) or chosen expedited member states
Type of Practice	In-person or telehealth	Telehealth	In-person or telehealth
Fee	Varies by profession	None	Compact dependent ⁴

¹ Licensure by endorsement is granted through s. 456.0145, F.S., Mobile Opportunity by Interstate Licensure Endorsement Act.

² Not all health care professions have an interstate licensure compact.

³ With the exception of the Interstate Medical Licensure Compact, for which the state of licensure would be Florida.

⁴ While home states may charge practitioners an initial fee to obtain a compact license, remote states can also charge a fee.

Source: OPPAGA analysis of Ch. 456, F.S.

Licensure by endorsement allows practitioners from other states to become licensed in Florida and includes both in-person and telehealth practice; telehealth registration allows for telehealth practice in Florida only. Licensure by endorsement is an alternative to licensure by examination and allows a health care practitioner to become licensed in Florida based on holding a license in another state that has near-equivalent licensure requirements. In 2024, the Legislature passed Ch. 2024-274, *Laws of Florida*, which created s. 456.0145, *Florida Statutes*, to establish a new universal process for licensure by endorsement for health care professions regulated by the Florida Department of Health (DOH). Seventeen health care professions, including osteopathic physicians, were ineligible for licensure by endorsement prior to the new law.^{8,9} Section 456.0145, *Florida Statutes*, authorizes all health care practitioners who hold an active, unencumbered license issued by another state, the District of Columbia, or a U.S. territory in a profession with a similar scope of practice—determined by the board or DOH—and obtain a passing score on a national licensure

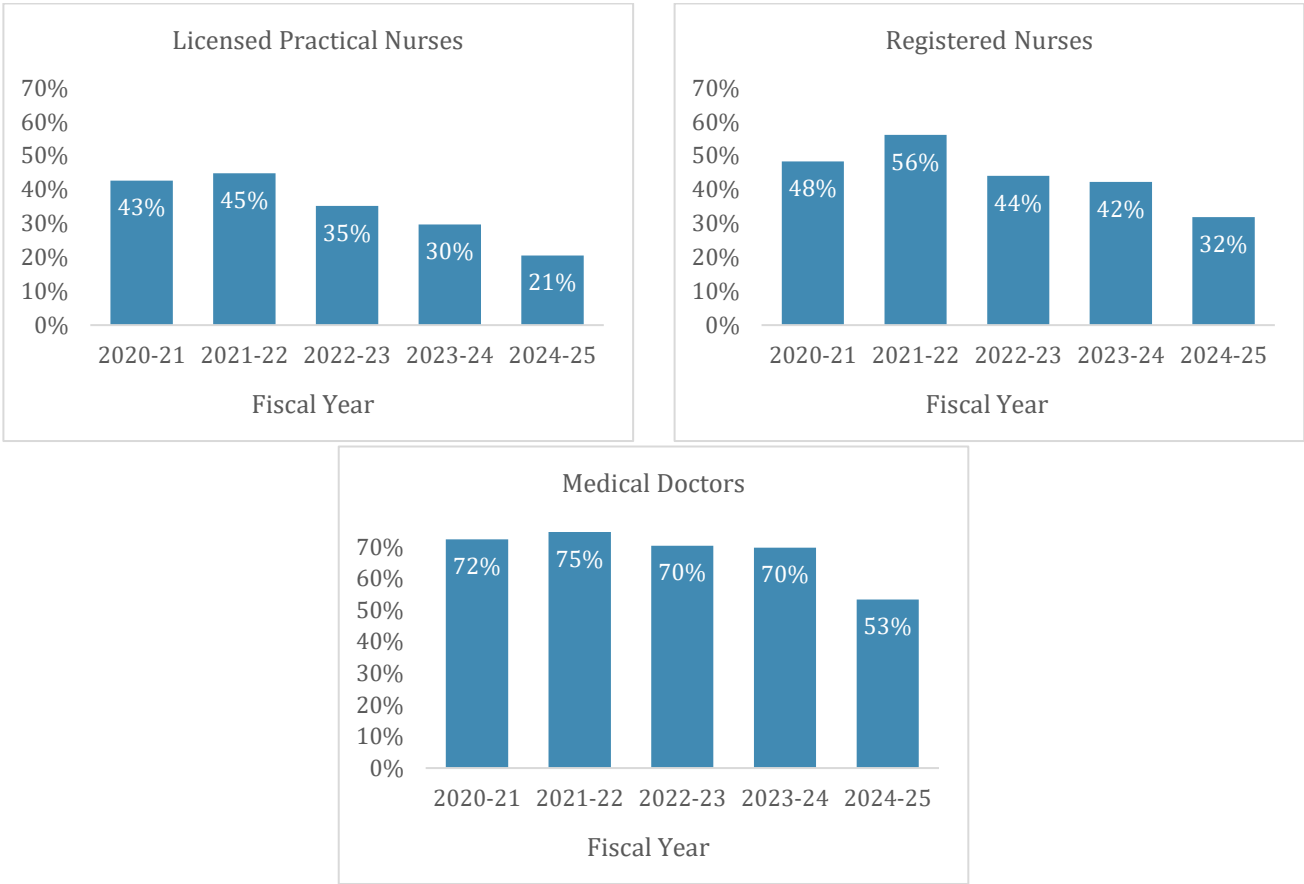
⁸ Anesthesiologist assistants, athletic trainers, chiropractors, clinical laboratory personnel, dental hygienists, dentists, emergency medical technicians/paramedics, genetic counselors, hearing aid specialists, medical physicists, optometrists, opticians, orthotists and prosthetists, osteopathic physicians, physician assistants, podiatrists, and registered pharmacy technicians were previously ineligible for licensure by endorsement.

⁹ The Florida Senate, Committee on Fiscal Policy. *CS/SB 1600 Bill Analysis*. February 2024.

examination or hold a national certification recognized by the board (or the department if there is no board) to be eligible for licensure by endorsement.^{10,11} For example, under licensure by endorsement, a practitioner licensed in Georgia who has practiced for at least three years could then practice in Florida.

The percentage of licensed practitioners in Florida who obtain licensure by endorsement has generally declined since Fiscal Year 2021-22. Of all licensed practical nurses who became licensed in Fiscal Year 2020-21, 43% were licensed by endorsement. Similarly, 48% of registered nurses and 72% of medical doctors were licensed by endorsement that same year. By Fiscal Year 2024-25, these rates declined to 21%, 32%, and 53%, respectively. (See Exhibit 4.) Additionally, in Fiscal Year 2024-25, 2% of osteopathic physicians were licensed by endorsement.

Exhibit 4
In Florida, the Percentage of Practitioners Licensed by Endorsement in Each Fiscal Year Has Generally Declined Since Fiscal Year 2021-22



Note: This figure shows the percentage of all practitioners newly licensed in each fiscal year that were licensed by endorsement.

Source: OPPAGA analysis of data from the Florida Department of Health.

¹⁰ An unencumbered license means a license that permits a practitioner to perform all duties authorized under a license without restriction. Other requirements include that the out-of-state practitioner must have actively practiced for at least three years during the four-year period immediately preceding the application submission date; must not be, at the time of application submission, the subject of a disciplinary proceeding in a jurisdiction where they hold a license or by the U.S. Department of Defense for reasons related to the practice of the profession for which the applicant is applying; must not have had disciplinary action taken against them in the five years immediately preceding the application submission date; and must meet the financial responsibility requirements of s. 456.048, F.S., or the applicable practice act, if required for the profession for which they are applying.

¹¹ An applicant for a profession that does not require national examination or certification is eligible for licensure if the applicable board, or DOH if there is no board, determines that the jurisdiction where the applicant currently holds an active, unencumbered license meets established minimum educational requirements and, if applicable, examination, work experience, and clinical supervision requirements are substantially similar to the requirements for licensure in that profession in Florida.

Section 456.47(4), *Florida Statutes*, authorizes health care practitioners located and licensed in other states to perform telehealth services for patients in Florida as long as practitioners register with the applicable board or the Department of Health if there is no board.¹² For example, a practitioner licensed in Georgia could register for telehealth practice in Florida and provide telehealth services to patients in Florida at no additional licensing cost. However, if the practitioner moved to Florida, they would need to get a Florida license to perform telehealth or in-person services. Licensure by endorsement also allows telehealth practice. New telehealth registrations have remained relatively stable for most years since Fiscal Year 2020-21, and more physicians (including medical doctors and osteopathic physicians) than nurses register through telehealth. (See Exhibit 5.)

Exhibit 5
More Out-of-State Physicians Than Out-of-State Nurses Have Registered to Provide Telehealth in Florida in Each Fiscal Year Since Fiscal Year 2020-21

Telehealth Profession	Fiscal Year 2020-21	Fiscal Year 2021-22	Fiscal Year 2022-23	Fiscal Year 2023-24	Fiscal Year 2024-25
Licensed Practical Nurse	1	1	3	1	0
Registered Nurse	9	41	16	25	23
Medical Doctor	1,225	2,705	1,282	1,042	1,054
Osteopathic Physician	115	254	172	172	149
Total	1,350	3,001	1,473	1,240	1,226

Note: This table shows the number of out-of-state practitioners newly registered to provide telehealth in Florida in each fiscal year since Fiscal Year 2020-21.

Source: OPPAGA analysis of data from the Florida Department of Health.

Florida’s participation in several health care compacts provides additional licensure pathways for out-of-state practitioners

Of the existing 17 health care compacts, Florida has passed legislation to join 6. These include compacts for audiology and speech-language pathologists; counselors; physicians; nurses; physical therapists; and psychologists. Of these, Florida actively participates in three compacts. (See Exhibit 6.)

Of the six health care compacts that Florida has passed legislation to join, the state is not currently using the Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC) and the Counseling Compact. The ASLP-IC is active for licensees in Louisiana and West Virginia, but 33 additional states, including Florida, have passed legislation to join the compact. Similarly, the Counseling Compact is active for licensees in Arizona and Minnesota, but 37 additional states, including Florida and the District of Columbia, are completing the necessary steps to begin receiving applications and authorizing practitioners under the compact.¹³ DOH officials reported that the department anticipates that Florida will become active in both the ASLP-IC and the Counseling Compact by March 2026.

In addition, although Florida passed legislation to join the Physical Therapy Compact, the commission did not accept Florida’s membership because the state’s legislation deviated from the model compact language. Specifically, provisions in 2024’s Senate Bill 7016 materially deviate from the model statute, including omission of the definition of party state, fee language, and language giving qualified

¹² Telehealth registration prohibits the practitioner from opening an office in Florida and from providing in-person health care services to patients located in Florida. While there is no fee to apply or to become registered as an out-of-state telehealth provider, qualified practitioners must maintain liability coverage or financial responsibility that includes coverage for telehealth services provided to patients not located in the provider’s home state.

¹³ The necessary steps include adopting rules and establishing fees; implementing federal criminal background checks with FBI authorization; preparing IT systems to provide data in the required format; assigning and training staff for system use and customer support; conducting full testing of data upload and validation processes; and creating an application process.

immunity to the commission and its representatives.¹⁴ Party state is a term that appears in several operative provisions of the model statute, such as adverse action evidence produced by a party state and investigative information being available to party states via the data system. The legislation also omitted the section of the model statute that states, “the licensee shall pay any applicable fees, including any state fee, for compact privilege;” omission of this language prohibits the commission from collecting practitioner fees for the compact license.¹⁵ Moreover, the legislation removed the qualified immunity granted to the commission and its representatives; removal of this language would expose other member states to potential liability. If Florida enacts new legislation to align with the model legislation, the state can reapply for compact membership.

Exhibit 6
Florida Has Passed Legislation to Join Six Compacts but is Currently Active in Only Three Compacts

Compact	Year Florida Passed Model Legislation	Year Florida Is Active in Compact	Compact Accepting Applications?
Nurse Licensure	2016	2018	Yes
Counseling	2022	N/A ¹	Yes
Psychology Interjurisdictional	2023	2023	Yes
Interstate Medical Licensure	2024	2024	Yes
Audiology and Speech-Language Pathology	2024	N/A	Yes ²
Physical Therapy	2024	N/A ³	Yes

¹ Florida is finalizing rulemaking that will allow the state to begin issuing and receiving compact licenses. The Department of Health reports that Florida will become active by March 2026.

² As of October 28, 2025, the Audiology and Speech-Language Pathology Interstate Compact began accepting applications and issuing practice privileges to practitioners in Louisiana and West Virginia.

³ The Physical Therapy Commission deemed Florida ineligible to grant authorization to practitioners to practice under the compact or accept compact practitioners from other member states because the compact language in Florida statutes deviates from compact model legislation language.

Source: OPPAGA analysis of Florida’s health care compact legislation.

Florida has proposed legislation to join three additional compacts for school psychologists, occupational therapists, and social workers and has not considered joining an additional eight compacts. (See Exhibit 7.) States can enact legislation to join compacts that are not yet active.

¹⁴ The Physical Therapy Compact administrator sent a letter of ineligibility to the Governor, President of the Senate, and Speaker of the House of Representatives on May 8, 2024.

¹⁵ Compact privilege is the authorization granted to a practitioner by a state to practice in said state.

Exhibit 7

Of the 11 Health Care Compacts That Florida Has Not Joined, the Legislature Proposed Legislation to Join Three Compacts

Compact	Proposed or Not Considered	Compact Accepting Applications?	Compact Status
Interstate Compact for School Psychologists	2025 House Bill 327 proposed joining	No	Finalized and available for state enactment. Seven states have officially enacted legislation, allowing for the compact to begin operation. In 2025 compact member states will nominate commissioners and meet to draft the bylaws and rules of the compact.
Occupational Therapy Licensure	2025 House Bill 909 proposed joining	No	Enacted in some states but not yet operationalized; the process to apply for and receive compact privileges still in development.
Social Work Licensure	2025 House Bill 27 proposed joining	No	Enacted in at least seven states and reached activation status; however, multistate licenses are not yet being issued.
Advanced Practice Registered Nurse	Not considered	No	Activation threshold of seven states. As of October 2025, four states have enacted legislation, and five states have pending legislation. The compact will come into effect when seven states have fully enacted the model legislation.
Athletic Trainer	Not considered	No	Activation threshold of seven states. As of October 2025, no states have enacted legislation.
Dentist and Dental Hygienist	Not considered	No	Reached activation status for seven states, however, the compact commission is still acquiring a data system and holding additional rulemaking meetings. The estimated time for the process to be completed is 18 to 24 months from April 22, 2024.
Dietician Licensure	Not considered	No	Finalized and enacted into law by at least seven states, meeting the activation threshold. Commission is continuing to operationalize the compact by acquiring a data system; the process is projected to be ongoing throughout 2026.
Emergency Medical Services	Not considered	Yes	As of November 2025, twenty-five states are members of this compact.
Massage Therapist	Not considered	No	Activation threshold of seven states. As of October 2025, five states have enacted the model legislation and three states have legislation pending.
Physician Assistant Licensure	Not considered	No	Currently developing and implementing the data system. Commission is projected to begin granting compact privileges to practice in early 2027.
Respiratory Care	Not considered	No	Activation threshold of seven states. As of October 2025, four states have enacted legislation, and two states have filed legislation.

Source: OPPAGA analysis of health care compact model legislation and compact websites.

Health care compacts that Florida has joined or considered joining share similar governance and oversight mechanisms

Each compact has model legislation standards that permit licensed health care practitioners to practice in other states that share the same legally adopted regulations. A state must adopt such legislation to be recognized as a compact member. The model legislation for the nine health care compacts that Florida has joined or considered joining have substantively similar governance and oversight mechanisms. (See Exhibit 8.)

Exhibit 8

Health Care Compact Governance and Oversight Elements Include Several Common Provisions

Governance and Oversight Mechanism	Compact Model Elements
Compact Oversight	Each member state shall enforce and take all necessary actions to enforce the rules. The commission has power to intervene in certain circumstances such as during an administrative proceeding pertaining to subject matter of the compact that affects the commission's responsibilities.
Compact Commission	Commission comprised of member states with the power and responsibilities of upholding the compact.
Rulemaking	Commission shall promulgate reasonable rules to effectively and efficiently achieve the compact's purpose.
Default Procedures	- If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or commission rules, the commission will provide written notice to the defaulting state and other member states. - Termination of participation shall be imposed only after all means of compliance have been exhausted
Dispute Resolution	The commission shall attempt to resolve disputes that are subject to the compact and that may arise among member states or member boards when requested by a member state.
Coordinated Data System	Data system will include - practitioner identifying information; - licensure data; - significant investigatory information; - adverse actions against a license; - non-confidential information related to alternative program participation; - any denial of application for licensure and reasons for denial; and - other information that may facilitate compact administration.¹
Compact Withdrawal	A member state withdraws from a compact by enacting repealing statute. Withdrawal is effective 6 to 12 months after enacting the repealing statute.

¹ An alternative program is a non-disciplinary monitoring or practice remediation process approved by a licensing authority to address practitioners with an impairment. Impairment is a condition(s) that may impair a practitioner's ability to engage in full and unrestricted practice without an intervention and may include alcohol and drug dependence, mental health impairment, and neurological or physical impairments.

Source: OPPAGA analysis of compact model legislation.

Florida nurses' participation in the Nurse Licensure Compact has increased, while few physicians and psychologists have joined their respective compacts; OPPAGA could not determine whether Florida compact practitioners practice in other states

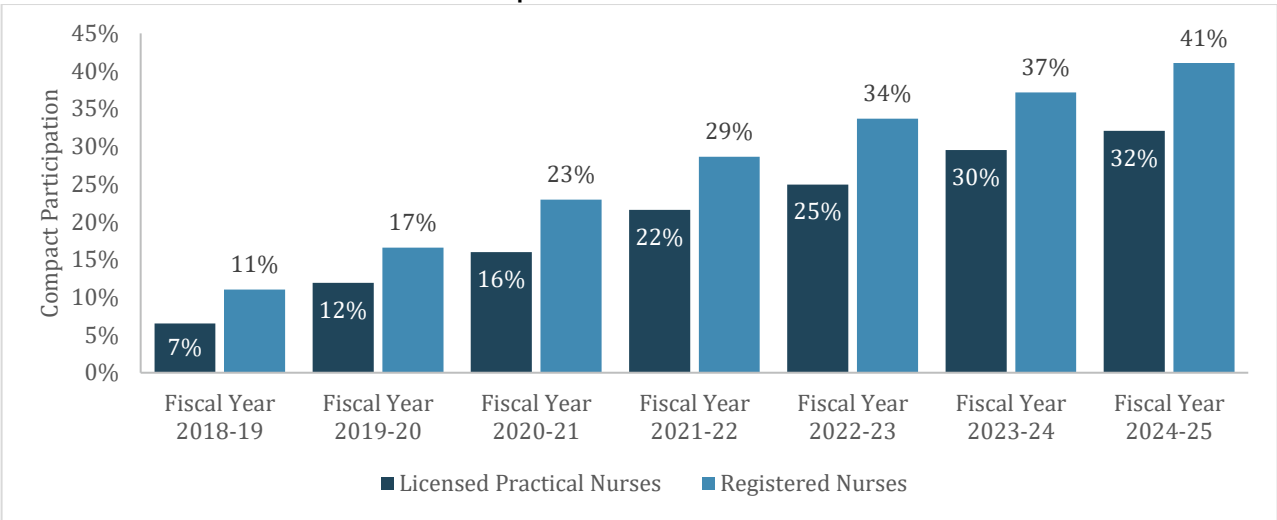
The number of licensed practical nurses and licensed registered nurses in Florida has increased, as has the percentage of nurses who have joined the Nurse Licensure Compact. The Nurse Licensure Compact (NLC) is a multistate agreement establishing a mutual recognition system for licensed practical or vocational nurses and registered nurses. Any nurse who is issued a multistate license from a member state is permitted to practice in any other member state. Florida adopted the NLC in statute in 2016 and became an active member in 2018. To join the compact, nurses apply within

their home state for a multistate license. Once issued a multistate license, nurses must comply with the scope of practice defined by the state where the client is located at the time the service is provided.

The total number of licensed practical nurses (LPNs) and registered nurses (RNs) licensed in Florida has increased by 15% since Fiscal Year 2018-19.¹⁶ In Fiscal Year 2018-19, there were 81,893 LPNs and 353,654 RNs. In Fiscal Year 2024-25, licensed LPNs and RNs increased to 77,745 and 423,104, respectively. The percentage of licensed Florida LPNs and RNs that joined the NLC also increased for both professions during this period. In Fiscal Year 2018-19, the first year Florida became active in the compact, 7% of Florida LPNs and 11% of RNs joined the NLC. By Fiscal Year 2024-25, the percentage of Florida LPNs and RNs that had joined the NLC increased to 32% and 41%, respectively. (See Exhibit 9.) However, OPPAGA could not determine whether these nurses use their license to practice in another state, because the NLC does not require nurses to report this information and DOH does not collect it.

Exhibit 9

Since Fiscal Year 2018-19, the Percentage of Licensed Practical Nurses and Licensed Registered Nurses in Florida That Joined the Nurse Licensure Compact Has Increased



Source: OPPAGA analysis of data from the Florida Department of Health.

Very few Florida medical doctors and osteopathic physicians have been licensed through the Interstate Medical Licensure Compact. The Interstate Medical Licensure Compact (IMLC) is an agreement among states that allows compact states to collaborate to expedite the licensing process for physicians who want to practice in multiple states and U.S. territories. Florida adopted the IMLC into statute in 2024 and became an active member in Fall 2024. To join the IMLC, medical doctors and osteopathic physicians complete one application to become eligible to receive separate licenses from each compact member state where they intend to practice.

In Fiscal Year 2024-25, there were 99,475 medical doctors (MDs) and 14,011 osteopathic physicians (DOs) licensed in Florida. In the same fiscal year, the first year of Florida’s participation in the IMLC, approximately 1.2% (1,225) of MDs and 1.3% (187) of DOs licensed in Florida had received licenses to practice in other states via the IMLC.¹⁷

¹⁶ This reflects the number of nurses holding Florida licenses, regardless of whether the nurse is actively practicing in Florida. It does not include out-of-state nurses practicing in Florida through the compact because these nurses are not issued a Florida license.

¹⁷ The total count of licensed physicians includes physicians whose primary state of practice may not be Florida, which may result in an underrepresentation of the extent of participation in the IMLC by Florida licensed physicians. If physicians whose primary state of practice may

In addition to expediting the process for Florida physicians to practice in other states, the IMLC also allows physicians from other states to have a more streamlined process of applying for a license to practice in Florida. The IMLC allows physicians from other states to register their home state licensing board approved expedited license with the compact’s commission, which then allows the practitioner to select to receive a Florida license after paying any applicable fees. In Fiscal Year 2024-25, the first year that Florida became active in the compact, 1,005 MDs and 163 DOs had principal licensure in another IMLC state but had also applied for and received a license to practice in Florida.¹⁸ (See Exhibit 10.) OPPAGA could not determine whether Florida physicians use their IMLC license to practice in another state or whether physicians from other states use their IMLC license to practice in Florida because the IMLC does not require that compact practitioners report such information to state licensing authorities, such as DOH.

Exhibit 10
The Interstate Medical Licensure Compact Has Licensed More Florida Physicians to Practice Outside of Florida Than it Has Licensed Physicians From Other States to Practice in Florida

Physicians Seeking a Compact License	Compact Licensed Medical Doctors	Compact Licensed Osteopathic Physicians
Florida physicians seeking a license in other states	1,225	187
Other state physicians seeking a license in Florida	1,005	163

Source: OPPAGA analysis of data from the Florida Department of Health.

Some Florida psychologists have joined the Psychology Interjurisdictional Compact. The Psychology Interjurisdictional Compact (PSYPACT) authorizes the practice of telepsychology and temporary in-person psychology across compact states.¹⁹ Florida enacted the PSYPACT into statute and became an active member in 2023. To participate in the compact, licensed psychologists apply to the PSYPACT commission for authorization to practice telepsychology in other compact states or authorization to temporarily practice in-person psychology in compact states.

As of June 2025, there were 12,986 psychologists across 43 compact states with the authority to practice interjurisdictional telepsychology and 865 psychologists with temporary authorization to practice in-person psychology. As of September 2025, approximately 15.6% (1,235) of Florida-licensed psychologists could practice telepsychology in other compact states and 0.8% (66) could practice temporary in-person psychology in other compact states. DOH staff was unable to report how many psychologists from outside of Florida are authorized to practice via telepsychology or in-person in the state because there is no requirement for PSYPACT-participating psychologists to report this information to the compact states where they practice.

What are the advantages and disadvantages of joining health care compacts?

Health care compacts have several reported advantages and disadvantages for the state, practitioners, and the public; these advantages and disadvantages vary across compact models. Reported advantages include sharing disciplinary data among states, making multi-state licensure easier, and increasing practitioner supply. Disadvantages include cost and operational challenges and potential conflicts with existing state law. (See Exhibit 11.)

not be Florida are excluded from the total count of licensed physicians, then the percent of MDs and DOs licensed in Florida that have received licenses to practice in other states via the IMLC increases to 1.7% and 1.8%, respectively.

¹⁸ The IMLC defines state of principal licensure as a member state where a physician holds a license to practice medicine and that has been designated as such by the physician for purposes of registration and participation in the compact.

¹⁹ Telepsychology refers to the provision of psychological services using telecommunications technologies.

While some stakeholders reported that health care compacts increase a state's supply of practitioners, OPPAGA found little research evaluating how compacts affect state labor supply or labor mobility, and available research has some limitations. Stakeholders, including the Florida Department of Health and the National Center for Interstate Compacts, reported that data systems to evaluate health care compacts are still being developed and may provide useful information once completed.

Health care compacts have reported advantages and disadvantages for the state, practitioners, and the public; advantages and disadvantages vary across compact models

There are several advantages and disadvantages of health care compacts for the state. Stakeholders reported that health care compacts may facilitate licensure and disciplinary data sharing between states. According to national stakeholders and the Florida Department of Health, the benefit of sharing licensure and disciplinary data is that each state has full knowledge of each compact practitioner's disciplinary history, including information on adverse actions or other restrictions on a practitioner's license that may affect their ability to practice.

In addition, stakeholders reported that compacts are important in certain circumstances, such as during times of crisis, for large hospital systems in the state, and for large state-border populations. For example, stakeholders noted that compacts can efficiently increase the number of practitioners in the state during emergency response following hurricanes and public health emergencies. DOH reported that compacts could benefit multi-state hospital systems in the state, such as Mayo Clinic, that want to bring out-of-state expert practitioners into the state from another hospital. Finally, a stakeholder reported that compacts could benefit states that have large populations on borders with other states, because the compact would allow the state to easily draw on a nearby pool of practitioners.

While all states may benefit from sharing disciplinary data, state authority over disciplinary actions varies by model. In an expedited licensure model, in which each state licenses the practitioner, state boards can take disciplinary action against physicians holding a license in the board's state. In contrast, in a mutual recognition model, only the home state has exclusive power to impose discipline on a compact practitioner; if another state wants to take disciplinary action against a compact practitioner, it reports to the licensure information system and the licensee's home state handles the disciplinary action as if the disciplinary issue occurred in the home state. A remote state can take disciplinary action against a practitioner's authorization to practice only within that remote state, which does not affect the practitioner's multistate license authorizations granted by other member states. This process may take more time to provide discipline since cooperation between two states is needed and the remote state does not have control over the disciplinary action that the home state takes.

In addition, some stakeholders reported that health care compacts may present cost and operational challenges. For example, each health care compact commission can collect an annual assessment from each participating state to fund operational costs and commission activities. Stakeholders, including DOH, also reported that states must invest resources to conform with compact requirements—such as implementing and maintaining the required data system—which may require developing technological infrastructure and providing staff resources. Moreover, a disadvantage for the state with some mutual recognition model compacts (i.e., those that allow a practitioner to practice in any compact member state by gaining recognition through a compact approved home state license) is revenue loss when the state no longer collects licensure fees from out-of-state practitioners.

Compacts may also allow practitioners to circumvent a state's scope of practice. Generally, scopes of practice are described in state law, but compact model legislation may also detail a scope of practice that could, if enacted, conflict with existing state law. For example, the Advanced Practice Registered Nurse (APRN) Compact, of which Florida is not a member, has language that conflicts with Florida's practice and prescribing laws by permitting compact APRNs to practice and prescribe noncontrolled substances without physician supervision. Physician supervision of APRNs is a requirement in 32 states, including Florida.²⁰ The American Medical Association noted lack of supervision as a disadvantage of the compact to states, reporting that it could undermine physician-led care and threaten patient care and safety.

Compacts can be advantageous to health care practitioners because of licensure portability, application ease, and for some compacts, streamlined continuing education requirements and lower licensure costs across multiple states. Some stakeholders reported that health care compacts increase licensure portability, which makes practitioners more mobile. For example, DOH reported that licensure portability is an advantage, particularly for military spouses who may move frequently. Health care compacts also enable practitioners to upload one application and supporting documentation to be licensed across multiple states, making the multistate license process easier. Moreover, some compacts include a unified group of continuing education requirements, which means that applicable practitioners do not need to satisfy varied continuing education requirements across multiple states. Several mutual recognition health care compacts that allow a practitioner to practice in any member state using their compact approved home state license—including compacts for emergency management services personnel, psychologists, nurses, and advanced practice registered nurses—do not require licensees to pay a fee to each state where they intend to practice.²¹

In addition, many health care compacts were created, in part, to support spouses of relocating active-duty military personnel. Health care compacts may allow individuals to retain their home state license during military service periods and obtain practice authorization in a new state. Therefore, a compact reduces the burden of applying for a new state-specific license each time military service personnel spouses relocate. Health care compacts may also waive or reduce some fees for active-duty personnel and their spouses.

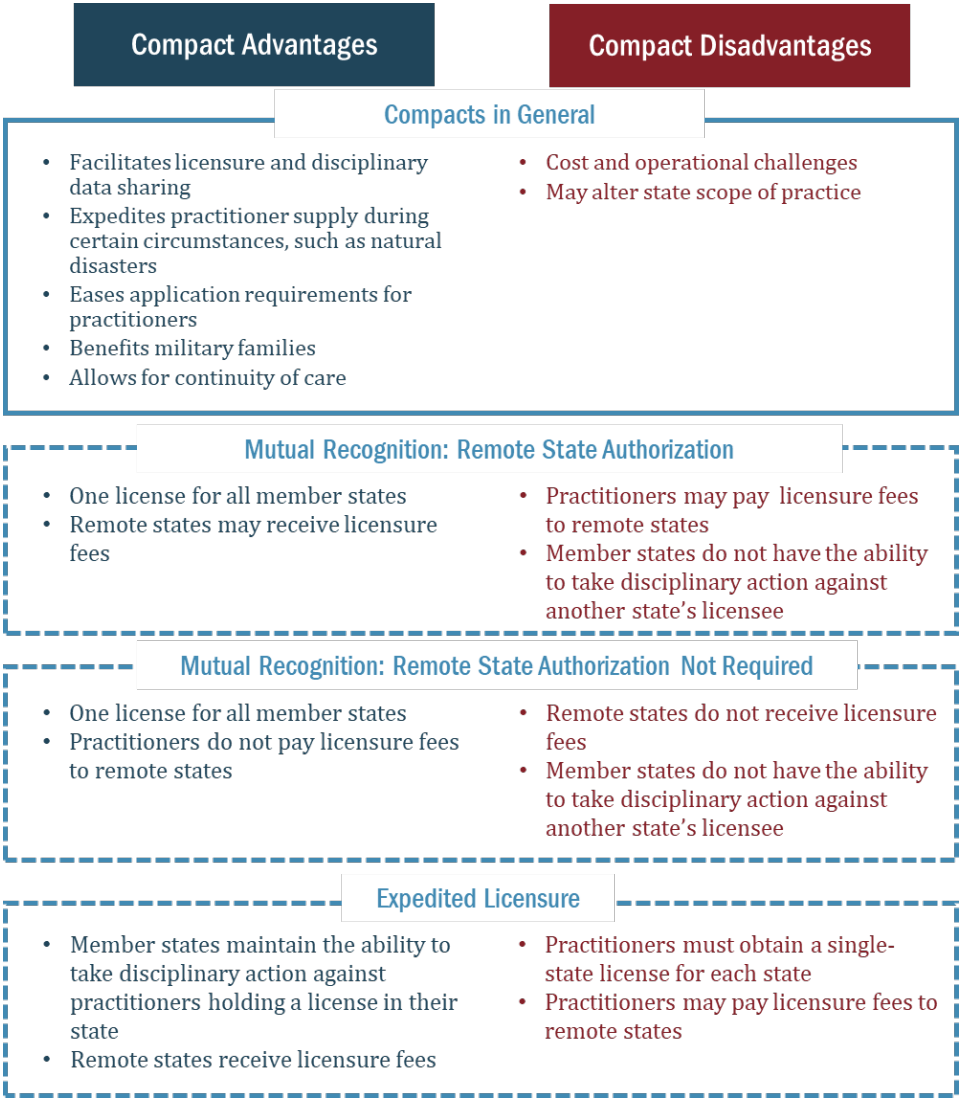
Several stakeholders also reported that health care compacts can have advantages for the public. Stakeholders reported that patients can benefit from an increased supply of practitioners within a state. The American Medical Association noted that the Interstate Medical Licensure Compact would potentially reduce access to care challenges in rural areas of Florida because of new physicians practicing in Florida through the compact.

In addition, stakeholders reported that compacts encourage continuity of patient care because compacts may allow practitioners to continue serving patients when patients move out of state. For example, a stakeholder reported that the Counseling Compact, of which Florida is a member, would allow licensed counselors in Florida to continue to provide counseling services to patients who move to another compact member state.

²⁰ Some states may require a physician relationship for a short-term transition period or as a requirement for nurse practitioners to prescribe or practice in general.

²¹ A medical association reported that a potential disadvantage for practitioners is that physicians are required to pay a fee to the IMLC, as well as each state where they are seeking additional licensure, potentially making the overall process costly.

Exhibit 11
Compacts Have General Advantages and Disadvantages and Those That Vary According to the Compact Model



Source: OPPAGA analysis of information from stakeholders and compact model literature.

OPPAGA did not find reliable evidence to support claims that health care compacts reduce workforce shortages and increase access to providers; national stakeholders reported ongoing efforts to evaluate compact impact

Existing research evaluating the effect of compacts on a state's health care practitioner labor supply or mobility has methodological concerns. Available literature is limited to research related to two compacts—nurse licensure and interstate medical licensure—and is hampered by data or methodological limitations. For example, one study found that Nurse Licensure Compact member states had slightly greater use of telemedicine from out-of-state nurses, but the differences were small and not statistically significant. Further, this study included out-of-state telemedicine use by all practitioners rather than only telemedicine provided by nurses, therefore limiting the ability to draw specific conclusions about the impact of the NLC on nurses' use of telemedicine.²² Two additional

²² Norris et al. "The Nurse Licensure Compact's Effect on Telemedicine Usage." *Journal of Patient Experience* 10, (2023): 1-4. <https://doi.org/10.1177/23743735231179060>.

studies suggest that the NLC is associated with the relocation of nurses across states.^{23,24} Specifically, the research suggests that states that join the NLC may experience an increase in the share of nurses who move to other compact states instead of moving to non-compact states. However, both studies have data limitations. In the first study, only 17% of the population examined were registered nurses or licensed practical nurses—the rest were health care professionals who cannot utilize the NLC. The second study used data from the Centers for Medicare and Medicaid Services, which represents a small and potentially unrepresentative subset of nurses, so the findings may not apply to all nurses.

Similarly, stakeholders referenced one study, which has not been peer reviewed, that considers patient access to care and growth in physician practice subsequent to the Interstate Medical Licensure Compact.²⁵ The study found a 3% increase in the number of new out-of-state physician practices following adoption of the IMLC, with most growth concentrated in IMLC states. The study also found that the IMLC increased the number of states where physicians practiced. However, the study's lack of peer review means that experts in the field have not attested to its quality, accuracy, and methodological soundness.

National stakeholders reported that data systems to evaluate health care compacts are still being developed. While a national stakeholder reported that compacts do not currently require reporting that would identify where practitioners work, limiting the ability to determine compacts' effect on labor supply, some stakeholders reported that evaluative efforts are underway. For example, the National Council of State Boards of Nursing developed a database—Nursys E-Notify—that is shared across states; the database has two main components.

- **E-Notify for institutions** acts as a nurse licensure notification system, enabling institutions (e.g., hospital or other health care facilities) to receive real-time notifications about employed nurses. The system provides licensure and publicly available discipline data directly to institutions as such information is entered into the database by participating boards of nursing.
- **E-Notify for nurses** helps nurses easily manage their licenses at no cost. Once enrolled, nurses get automatic notifications about license status, license expiration, license renewal, and publicly available disciplinary actions.

Department of Health officials reported that E-Notify for nurses could allow DOH to determine the number of compact nurses working in Florida, if nurses were required to use E-Notify. For example, a nurse from Alabama who uses the NLC to practice in Florida to assist during an emergency response could use their E-Notify for nurses account to report that they are currently practicing in Florida. However, Nursys E-Notify is a voluntary system, so it may not contain reliable and comprehensive information about where nurses practice. To improve reporting, a state may require that nurses licensed in that state participate in Nursys E-Notify for nurses.²⁶

The National Center for Interstate Compacts also reported that data systems for several compacts—including counseling, speech pathology and audiology, and occupational therapy—are still being developed and are anticipated to be completed in Fiscal Year 2025-26. Once developed, the national center reports that the data systems will allow for more insight into where compact practitioners are

²³ Ghani, Aimi Abdul. "The Impact of the Nurse Licensing Compact on Inter-State Job Mobility in the United States." In OECD Economic Survey of the United States: Key Research Findings, 103-119. Paris: OECD Publishing, 2019. <https://doi.org/10.1787/9789264310278-en>.

²⁴ Shakya, Shishir, et al. "Nurse Licensure Compact and Mobility." Journal of Labor Research (June 2022):260-274. <https://doi.org/10.1007/s12122-022-09333-2>.

²⁵ Deyo, Darwynn, et al. "Access to Care and Physician-Practice Growth after the Interstate Medical Licensure Compact." Preprint, SSRN (March 2024):1-38. <https://dx.doi.org/10.2139/ssrn.4755497>.

²⁶ Delaware, Missouri, Nebraska, and Washington require that nurses licensed in each state maintain a Nursys E-Notify for nurses account.

working, which could then be used to determine where compact practitioners practice as well as how compact practitioners use their licenses. For example, data systems, as well as surveys of compact practitioners, could be used to determine whether compact practitioners use compact licenses to practice via telehealth or in rural areas.

What are key considerations when contemplating participation in health care compacts?

Florida has not joined 11 of the 17 existing health care compacts, including compacts for advanced practice registered nurses, dentists and dental hygienists, dietitians, emergency medical services (EMS) personnel, physician assistants, and respiratory care practitioners. Most recently, the state has considered legislation to join three compacts—Interstate Compact for School Psychologists, Occupational Therapy Licensure, and Social Work Licensure. If contemplating Florida’s participation in additional health care compacts, the Legislature should focus on key compact provisions, including those related to public safety, quality of care, licensure portability, and administrative efficiencies. In addition, the Legislature should consider financial and operational characteristics necessary for compact implementation and participation.

If contemplating participation in additional health care compacts, the Legislature should focus on provisions related to public safety, quality of care, access and continuity of care, licensure portability, and administrative efficiencies

As Florida contemplates joining additional health care compacts, there are key elements in each compact that policymakers should consider. (See Appendix A for details on key provisions.) The 11 health care compacts that Florida has not joined have provisions that support public safety, quality of care, licensure portability, and administrative efficiencies. For example, the compacts address practitioner scope of practice, state roles related to disciplinary action, decreasing administrative burdens through member state cooperation, and use of data systems to organize licensure information, which could reduce practitioner application burdens and allow for the sharing of interstate disciplinary actions.

However, two health care compacts—advanced practice registered nurse and emergency medical services personnel—have provisions that may conflict with the current scope of practice for APRNs and EMS personnel in Florida, which could affect quality of care standards. For example, Florida law currently requires APRNs to practice under a supervisory agreement with a physician.²⁷ While the APRN compact requires that APRNs practicing in member states comply with the state practice laws of the state where the client is located, the compact also explicitly excludes state laws, rules, and regulations that require supervision or collaboration with a health care professional, except for those laws regarding prescribing controlled substances, from its definition of state practice laws. If Florida joined the APRN compact, the compact could allow APRNs from other states to practice in Florida without supervision, thereby exempting compact APRNs from Florida’s practice requirements under current state law. The EMS personnel compact could also conflict with a state’s scope of practice because, unlike other compacts in which the scope of practice is consistent with the scope of practice in the state where the patient is treated, it allows EMS clinicians to practice in remote states within the scope of practice of their home state.²⁸

²⁷ Section [464.012, F.S.](#)

²⁸ The EMS personnel compact does allow appropriate authorities in member states to modify visiting EMS clinician’s scopes of practice and may require additional education or training or a demonstration of competency.

The Legislature may also need to consider allocating funds and staff to join health care compacts; states should also anticipate the potential loss of licensing revenue

Joining health care compacts may require states to dedicate additional funds and resources to implement compact provisions and operate effectively. Each health care compact commission, regardless of compact model, can collect an annual assessment from each participating state to cover the cost of the operations and activities of the commission and its staff. There are no limits or restrictions on the amount of the assessment specified in each compact's model legislation. For the compacts that Florida has joined, the state has paid \$6,000 annually for Nurse Licensure Compact membership since Fiscal Year 2019-20 and \$6,000 annually for Psychology Compact membership since Fiscal Year 2023-24. Compacts for audiology and speech-language pathologists, counselors, and physicians have not charged Florida for participation.

In addition, states may need to hire additional staff and invest in technology to implement compacts. For example, in 2025, the Legislature considered a bill that would facilitate Florida joining the Social Work Licensure Compact. According to a Florida Department of Health bill analysis, joining the social work compact would increase costs for the state. Specifically, DOH estimated a total cost of \$208,776 (\$117,177 of non-recurring funds and \$91,599 of recurring funds) to fully implement the compact, which includes one full-time equivalent position, information technology resources, travel costs and related expenses for a compact commission delegate, and contracted services.

Licensing revenue is a major source of funds to support health care practitioner regulation. Typically, states charge fees for a license; however, Florida may lose licensing revenue from joining mutual recognition health care compacts that do not have provisions for a remote state to charge a fee for a multistate license. Of the 11 health care compacts that Florida has not joined, compacts for APRNs, nurses, psychologists, social workers, and EMS personnel do not allow remote states to collect fees from licensees.

APPENDIX A

Health Care Compact Provisions

Florida has not joined 11 of 17 existing health care compacts. Compacts are designed with the intent to benefit the state, health care practitioners, and the public. Each of the 11 compacts have elements that could support public safety, facilitate licensure portability, and ease administrative efficiencies. (See Exhibit A-1.)

Exhibit A-1

The 11 Health Care Compacts That Florida Has Not Joined Have Provisions That Support Public Safety, Access and Continuity of Care, Licensure Portability, and Administrative Efficiencies

	Interstate Compact for School Psychologists	Occupational Therapy Licensure Compact	Social Work Licensure Compact	Advanced Practice Registered Nurse Compact	Dentist and Dental Hygienist Compact	Dietician Licensure Compact	Emergency Medical Services Compact	Physician Assistant Licensure Compact	Respiratory Care Interstate Compact	Athletic Trainer Compact	Interstate Massage Therapy Compact
Ensuring Public Safety											
Criminal Background Checks ¹	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Authority to Investigate a Licensee for Adverse Action	Any member state	Home state	Home state	Any member state	Any member state	Home state	Home state	Any member state	Any member state	Any member state	Any member state
Any Member State Can Revoke Practice Authorization	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Disciplinary Authority ²	Home state	Home state	Home state	Home state	Home state	Home state	Home state	Home state	Home state	Home state	Home state
Maintaining Quality of Care											
Educational Requirements	Graduated from accredited program	Licensed in home state	Accredited or candidate by accrediting agency	Accredited graduate-level education	Graduated from accredited program	Applicable education, experience, examination	Licensed under practice model	Graduated from accredited program	Holds a credential and license	Holds a certification or a bachelor's degree	Applicable educational experience, examination

	Interstate Compact for School Psychologists	Occupational Therapy Licensure Compact	Social Work Licensure Compact	Advanced Practice Registered Nurse Compact	Dentist and Dental Hygienist Compact	Dietician Licensure Compact	Emergency Medical Services Compact	Physician Assistant Licensure Compact	Respiratory Care Interstate Compact	Athletic Trainer Compact	Interstate Massage Therapy Compact
Maintaining Quality of Care											
Location Where Scope of Practice Law Is Followed	Member state where services are being provided	Member state where the patient is located at time of care	Member state where the patient is located at time of care	Member state where the patient is located at time of care, except as provided in the compact ³	Member state where services are being provided	Member state where services are being provided	Home state ⁴	Member state where the patient is located at time of care	Member state where services are being provided	Member state where the patient is located at time of care	Member state where services are being provided
Supervision Levels	✖	Occupational therapist assistants in a remote state shall be supervised by an occupational therapist	✖	Collaboration with a health care professional only for prescribing controlled substance	✖	✖	Practice under supervision of a medical director	✖	✖	If required by a remote state's scope of practice	✖
Licensure Portability											
Remote state is allowed to charge a fee for license	✓	✖	✖	✖	✓	✓	✖	✓	✓	✓	✓
Support for Military Members and Spouses	Retain home state during active duty	Retain home state during active duty	Retain home state during active duty	✖	Reduced or no compact authorization fee	Retain home state during active duty	Consideration at minimum requirements and expedite applications	Only need an unrestricted member state license	Reduced or no compact authorization fee; retain home state during active duty	Reduced or no compact authorization fee	Retain home state during active duty

	Interstate Compact for School Psychologists	Occupational Therapy Licensure Compact	Social Work Licensure Compact	Advanced Practice Registered Nurse Compact	Dentist and Dental Hygienist Compact	Dietician Licensure Compact	Emergency Medical Services Compact	Physician Assistant Licensure Compact	Respiratory Care Interstate Compact	Athletic Trainer Compact	Interstate Massage Therapy Compact
Administrative Efficiencies											
Data Sharing Across States ⁵	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Requiring only one application process in home state	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

¹ Criminal background checks require submission of fingerprints or other biometric information.

² Disciplinary authority is when a member state holds the power to hold a practitioner accountable for abiding by their state's laws and take adverse action against practitioners who do not uphold professional standards established within that state. For these compacts, remote states cannot take action against a practitioner's license, although states can revoke authorization to practice in the remote state. Remote states must report the disciplinary action to the home state for the home state to take action against the practitioner's license

³ The APRN compact excludes from its definition of state practice laws any state law that requires supervision or collaboration with a health care professional except for laws, rules, and regulations regarding prescribing controlled substances.

⁴ When providing care in a remote state, the EMS clinician must practice only through an EMS agency that is authorized to operate in the remote state. If the modified scope of practice differs from or exceeds that of the home state, the remote state appropriate authority may require additional education or training; and/or mandate a demonstration of competency; and/or restrict the EMS clinician's scope of practice. An EMS clinician providing patient care in a remote state under the authorization to practice is responsible for adhering to the scope of practice modifications or limitations for that remote state, as may be modified by a remote state appropriate authority.

⁵ Licensure information required to report may include identifying information; licensure data; adverse action against a licensee; alternative program participation; denial of application for licensure and reasons; investigative information; other information that may facilitate compact administration.

Source: OPPAGA analysis of compact model legislation.



OPPAGA

Office of Program Policy Analysis and Government Accountability

OPPAGA provides performance and accountability information about Florida government in several ways.

- [Reports](#) deliver program evaluation and policy analysis to assist the Legislature in overseeing government operations, developing policy choices, and making Florida government more efficient and effective.
- [Government Program Summaries](#) (GPS), provides descriptive information on Florida state agencies, including funding, contact information, and references to other sources of agency information.
- [PolicyNotes](#), an electronic newsletter, delivers brief announcements of research reports, conferences, and other resources of interest for Florida's policy research and program evaluation community.
- Visit [OPPAGA's website](#).

OPPAGA supports the Florida Legislature by providing data, evaluative research, and objective analyses that assist legislative budget and policy deliberations. This project was conducted in accordance with applicable evaluation standards. Copies of this report in print or alternate accessible format may be obtained by telephone (850/488-0021), in person, or by mail (OPPAGA, 111 W. Madison St., Room 312, Tallahassee, FL 32399-1475).

Project supervised by Wendy Scott (850/717-0500)
Project conducted by Daphne Holden (850/717-0546),
Jason D'Amours, Dan Dunleavy, and Taylor Yanchuk
Kara Collins-Gomez, Coordinator

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Presenter Tab 5
Bill Number or Topic

Amendment Barcode (if applicable)

11/18/25
Meeting Date
Senate Health Policy
Committee

Name Wendy Scott Phone 850 717-0500

Address _____ Email scott.wendy@oppage.fl.gov
Street

City State Zip

Speaking: ☐ For ☐ Against ☒ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without
compensation or sponsorship.

☐ I am a registered lobbyist,
representing:

☐ I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022 Joint Rules.pdf \(flsenate.gov\)](#)

This form is part of the public record for this meeting.

S-001 (08/10/2021)



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Education Postsecondary, *Chair*
Education Pre-K - 12, *Vice Chair*
Appropriations Committee on Higher Education
Appropriations Committee on Pre-K - 12 Education
Fiscal Policy
Health Policy
Regulated Industries

JOINT COMMITTEE:

Joint Committee on Public Counsel Oversight

SENATOR ALEXIS CALATAYUD

38th District

November 14, 2025

The Honorable Colleen Burton
Chair, The Committee on Health Policy
305 The Capitol
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Burton,

Senator Calatayud respectfully requests an excused absence from the November 18th Committee on Health Policy.

I appreciate your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Nicole Fumarola".

Nicole Fumarola

REPLY TO:

- ☐ Kendall Campus, 11011 SW 104th Street, Suite 5101, Miami, Florida 33176 (305) 596-3002
- ☐ 305 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5038

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Commerce and Tourism, *Chair*
Appropriations Committee on Higher Education
Appropriations Committee on Transportation,
Tourism, and Economic Development
Community Affairs
Fiscal Policy
Health Policy
Judiciary

JOINT COMMITTEE:

Joint Administrative Procedures Committee

SENATOR TOM LEEK

7th District

November 12, 2025

The Honorable Colleen Burton
Chair of Committee on Health Policy
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Honorable Chair Burton:

Please excuse my absence from the Committee on Health Policy scheduled for Tuesday,
November 18th, 2025.

Thank you for understanding, if you have any questions, please feel free to contact me.

Sincerely,

A handwritten signature in blue ink, appearing to read "Tom Leek", written over a horizontal line.

Sen. Tom Leek
Florida Senator, District 7

REPLY TO:

- ☐ 4475 US 1 South, Suite 404, St. Augustine, Florida 32086 (386) 446-7610
- ☐ 310 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5007

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

CourtSmart Tag Report

Room: KB 412

Case No.:

Type:

Caption: Senate Committee on Health Policy

Judge:

Started: 11/18/2025 10:07:38 AM

Ends: 11/18/2025 11:45:08 AM

Length: 01:37:31

10:07:43 AM	Call to Order
10:07:48 AM	Roll Call
10:07:52 AM	Quorum present
10:08:18 AM	Opening Remarks-Chair Burton
10:08:39 AM	Tab 2 - SB 68
10:08:58 AM	Senator Harrell
10:12:25 AM	Senator Passidomo
10:13:07 AM	Senator Harrell
10:14:08 AM	Senator Gaetz
10:14:22 AM	Senator Harrell
10:14:46 AM	Senator Passidomo
10:15:35 AM	Senator Harrell
10:16:22 AM	Public Testimony
10:16:35 AM	Waives Read into Record
10:16:47 AM	Senator Passidomo
10:17:31 AM	Senator Harrell
10:18:47 AM	Roll call on SB 68
10:19:03 AM	Reported Favorably
10:19:10 AM	Tab 3 - SB 154
10:19:15 AM	Senator Harrell
10:21:17 AM	Public Testimony
10:21:19 AM	Dr. David Boden, FL Dental Association - waives time in support
10:21:25 AM	Joe Ann Hart, FL Dental Association - waives time in support
10:21:30 AM	Leslie Dughi, FL Dental Hygienists Assn - waives time in support
10:21:49 AM	Senator Berman
10:22:33 AM	Senator Harrell
10:23:05 AM	Roll call on SB 154
10:23:17 AM	Reported Favorably
10:23:26 AM	Tab 4 - SB 254
10:23:45 AM	Senator Harrell
10:36:11 AM	Senator Passidomo
10:37:10 AM	Senator Harrell
10:37:52 AM	Senator Passidomo
10:38:14 AM	Senator Harrell
10:38:45 AM	Senator Gaetz
10:40:34 AM	Senator Harrell
10:41:25 AM	Senator Berman
10:41:41 AM	Senator Harrell
10:42:05 AM	Public Testimony
10:42:14 AM	Jack Cory, Florida Nurses Association
10:44:30 AM	Bob Harris, Florida Association of Independent Nursing Schools
10:50:49 AM	Senator Davis
10:51:09 AM	Bob Harris
10:51:49 AM	Senator Davis
10:52:25 AM	Bob Harris
10:54:13 AM	Senator Davis
10:55:00 AM	Bob Harris
10:55:59 AM	Senator Osgood
10:56:29 AM	Bob Harris
10:57:47 AM	Senator Osgood
10:58:53 AM	Bob Harris
11:02:32 AM	Senator Osgood

11:03:06 AM Bob Harris
11:03:32 AM Allen Morthom, Florida Association of Postsecondary Schools and Colleges
11:04:41 AM Public testimony
11:04:54 AM Ivonne Fernandez, AARP - waives time in support
11:06:05 AM Jill Puckett, FL Association of Nurse Practitioners - waives time in support
11:08:33 AM Senator Passidomo
11:09:45 AM Senator Berman
11:10:33 AM Senator Harrell
11:16:47 AM Roll call on SB 254
11:17:16 AM Reported Favorably
11:17:23 AM Tab 1 - SB 40
11:17:36 AM Senator Sharief
11:18:44 AM Public Testimony
11:18:47 AM Jill Puckett, FL Association of Nurse Practitioners - waives time in support
11:18:52 AM Ivonne Fernandez, AARP - waives time in support
11:19:04 AM Senator Osgood
11:19:45 AM Roll call on SB 40
11:19:58 AM Reported Favorably
11:20:17 AM Tab 5 - Review of Health Care Practitioner Interstate Licensure Compacts by the Office of Program Policy
Analysis and Government Accountability (OPPAGA)
11:20:25 AM OPPAGA Presentation by Wendy Scott
11:41:34 AM Senator Berman
11:41:59 AM Wendy Scott
11:42:35 AM Senator Berman
11:43:03 AM Wendy Scott
11:43:07 AM Senator Berman
11:43:18 AM Wendy Scott
11:43:33 AM Chair Burton
11:44:32 AM Recorded votes
11:44:36 AM Senator Davis
11:44:58 AM Closing Remarks
11:45:01 AM Adjourned