**South Carolina General Assembly**

126th Session, 2025-2026

**S. 669**

**STATUS INFORMATION**

General Bill

Sponsors: Senator Verdin

Document Path: SR-0072CEM25.docx

Introduced in the Senate on May 8, 2025

Currently residing in the Senate Committee on **Medical Affairs**

Summary: Team Based Health Care Act

**HISTORY OF LEGISLATIVE ACTIONS**

 Date Body Action Description with journal page number

 5/8/2025 Senate Introduced and read first time (Senate Journal‑page 4)

 5/8/2025 Senate Referred to Committee on **Medical Affairs** (Senate Journal‑page 4)

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**VERSIONS OF THIS BILL**

[05/08/2025](https://www.scstatehouse.gov/sess126_2025-2026/prever/669_20250508.docx)

A bill

TO AMEND THE SOUTH CAROLINA CODE OF LAWS SO AS TO ENACT THE “TEAM BASED HEALTH CARE ACT”; AND BY ADDING CHAPTER 48 TO TITLE 40, SO AS TO PROVIDE DEFINITIONS RELATED TO THE TEAM BASED HEALTH CARE ACT; TO REQUIRE APRNS, PAS, AND AAS TO PRACTICE AS A PART OF A PATIENT CARE TEAM, REGARDLESS OF PRACTICE SETTING, AND TO PROVIDE GUIDLINES FOR THE CARE TEAM; TO CREATE THE TEAM BASED HEALTH CARE COMMITTEE AS A COMMITTEE TO ASSIST THE BOARD OF MEDICAL EXAMINERS AND THE BOARD OF NURSING ON MATTERS RELATED TO TEAM‑BASED HEALTH CARE IN THIS STATE AND TO PROVIDE FOR HOW THE COMMITTEE WILL BE STRUCTURED; AND TO PROVIDE THAT THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (DEPARTMENT), IN COLLABORATION WITH THE SOUTH CAROLINA BOARD OF MEDICAL EXAMINERS, THE SOUTH CAROLINA BOARD OF NURSING, AND THE SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH, MUST ISSUE A REPORT WITH RECOMMENDATIONS REGARDING PROPOSED INCENTIVES FOR APRNS, PAS, AND PHYSICIANS TO PRACTICE AS A PART OF A PATIENT CARE TEAM.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. This act may be cited as the “Team Based Health Care Act”.

SECTION 2. Title 40 of the S.C. Code is amended by adding:

CHAPTER 48

Team Based Health Care Act

 Section 40‑48‑10. As used in this chapter:

 (1) “Advanced practice registered nurse” (APRN) means an individual licensed to practice with the support of a physician for a nurse practitioner (NP), certified nurse midwife (CNM) or clinical nurse specialist (CNS) or with physician supervision for a certified registered nurse anesthetist under Chapter 33 of this title.

 (2) “Anesthesiologist's assistant” means an individual licensed to practice under the supervision of an anesthesiologist under Title 40, Chapter 47.

 (3) “Collaboration” means the communication and decision‑making process among members of a patient care team related to the treatment and care of a patient and includes communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments, and the development of an appropriate plan of care, including decisions regarding the health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies.

 (4) “Consultation” means a process whereby a member of the patient care team seeks the advice or opinion of the patient care team physician regarding a patient diagnosis, condition, or treatment.

 (5) “Patient care team” means a multidisciplinary team of health care providers actively functioning as a unit with the leadership of and the collaboration or supervision, whichever is required by state law, of one or more patient care team physicians, in ratios in accordance with state and federal law, for the purposes of providing and delivering health care to a patient or group of patients.

 (6) “Patient care team physician” means a physician who is actively licensed to practice medicine in this State, who is actively practicing medicine within the geographic boundaries of this State, and who maintains responsibility, provides leadership, and is available for collaboration and consultation or supervision, as required by state law, in the care of all patients as part of a patient care team.

 (7) “Physician” means an individual licensed to practice medicine in this State under Title 40, Chapter 47.

 (8) “Physician assistant” (PA) means an individual licensed to practice under the supervision of a physician under Title 40, Chapter 47.

 (9) “Practice agreement” means a written agreement developed by a nurse practitioner, certified nurse midwife, or clinical nurse specialist and a physician pursuant to Section 40‑33‑20(45).

 (10) “Scope of practice guidelines” means a written agreement signed by a physician assistant and a physician pursuant to Section 40‑47‑960.

 (11) “Supervision of a PA” means overseeing the activities of, and accepting responsibility for, the medical services rendered by a PA as part of a physician‑led team in a manner approved by the board.

 (12) “Supervision of a CRNA” means that the licensed doctor of medicine, osteopathy, or dentistry is present during an operation or procedure or is immediately available to respond and provide patient care as needed.

 (13) “Supervision of an AA” means medically directing and accepting responsibility for the anesthesia services rendered by an anesthesiologist's assistant in a manner approved by the Board of Medical Examiners. The supervising anesthesiologist must be in the hospital and in the anesthetizing or operative area such that he can be immediately available to participate directly in the care of the patient with whom the anesthesiologist's assistant and the anesthesiologist are jointly involved.

 Section 40‑48‑20. (A) APRNs, PAs, and AAs must practice as a part of a patient care team, regardless of practice setting, corporate structure, or practice ownership, and in compliance with all requirements set forth in Title 40, Chapter 33 for APRNs and Title 40, Chapter 47 for PAs and AAs.

 (B) In addition to the requirements set forth in Section 40‑33‑20(45) and Section 40‑47‑960, practice agreements and scope of practice guidelines must contain the following to clearly delineate how the patient care team physician will fulfill his obligations of collaboration with NPs, CNSs, CNMs, or supervision of PAs on behalf of the patient care team:

 (1) method and frequency the patient care team physician will use to periodically review patient charts or electronic health records to ensure clinical quality delivered by a NP, CNS, CNM, or PA;

 (2) guidelines that set forth how the patient care team physician will be available to patients and available to the NP, CNS, or CNM for collaboration and consultation and supervision of PAs;

 (3) the frequency that visits by the patient care team physician will occur to the site where health care is delivered to patients by a NP, CNM, CNS, or PA if they do not practice in the same physical location as the physician; and

 (4) the method that will be used for regular joint evaluation and improvement of clinical quality and outcomes of the patient care team, including but not limited to periodic meetings between the patient care team physician and members of the patient care team to review such evaluations, outcomes, and improvements.

 (C) In order that patients treated as part of a patient care team are fully informed of all aspects of team‑based health care, the following requirements must be met:

 (1) except in cases of medical emergency, APRNs, PAs, and AAs practicing as part of a patient care team shall disclose to the patient or his or her legal representative at the initial encounter that he or she is a licensed CRNA, CNM, CNS, NP, PA, or AA;

 (2) APRNs, PAs, or AAs who have received a doctorate degree in their respective field of practice may not use the title doctor during a patient encounter without first informing and documenting in writing that they have advised the patient that they are not a physician; and

 (3) except in cases of medical emergency, a member of the patient care team shall disclose, in writing, to a patient or his legal representative at the initial encounter and at least annually, is applicable, the name of the patient care team physician and information regarding how to contact and follow‑up with the patient care team physician. In addition, the name and contact information of the patient care team physician must be posted in a conspicuous location, easily viewable by patients, on websites and in all sites where patients are treated by the patient care team.

 (D) Unless otherwise required by law, nothing herein requires the patient care team physician to be physically located at the same site where care is delivered by a NP, CNM, CNS, or PA on the patient care team. However, the patient care team physician or his designee must be available during all hours when care is offered to patients on the care team for collaboration or consultation or supervision, whichever is required, through telephone or other electronic means.

 (E) APRNs, PAs, or AAs who are employed by a health system, health care practice, or other corporate entity may not be charged a fee for the collaboration and consultation or supervision provided by a patient care team physician.

 (F) Practice agreements entered into by a physician for the collaboration and consultation with a NP, CNS, or CNM for a practice owned in whole or in part by that NP, CNS, or CNM must be reviewed by the team based health care committee to ensure that all requirements of this chapter and Title 40, Chapters 33 and 47 are met, including the ability to maintain team‑based health care. If requested, the review by the team based health care committee may include a review of the reasonableness of any fee that may be charged by the patient care team physician for his or her services.

 (G)(1) In the event a physician who is serving as a patient care team physician plans to retire from active practice or relocate his practice such that he is no longer able to serve, he must notify the team based health care committee at least ninety days in advance of such retirement or relocation, and if there is not a physician who will assume the role of the patient care team physician immediately upon the retirement or relocation, then the team based health care committee must appoint a physician to serve as the patient care team physician, using a process set forth in regulation, prior to such retirement or relocation for a period not to exceed sixty days to allow members of the patient care team to enter into practice agreements or scope of practice guidelines with another physician.

 (2) In the event a patient care team physician’s license is suspended or revoked by the South Carolina Board of Medical Examiners, the board must set forth as a part of the order suspending or revoking such license the appointment of another patient care team physician and the process going forward for physician collaboration or supervision to be maintained on behalf of the patient care team.

 (3) In the event that a patient care team physician dies, becomes disabled, or otherwise encounters a circumstance that abruptly renders the patient care team physician unable to serve and a NP, CNS, CNM, or PA is unable to immediately enter into another practice agreement or scope of practice guideline or does not have an alternate patient care team physician, he must immediately notify the team based health care committee and the team based health care committee must hold a specially called meeting within five business days of such notification to appoint a physician to serve as the patient care team physician, using the process set forth in regulation, for a period not to exceed sixty days to allow members of the patient care team to enter into practice agreements or scope of practice guidelines with another physician. During the interim period between the circumstance that renders the patient care team physician unable to fulfill his duties and appointment of another patient care team physician by the team based health care committee, not to exceed ten days, the NP, CNS, CNM, or PA may continue to provide care to patients on the patient care team within the parameters of the practice agreement or scope of practice guideline, on an as needed basis, if he provides evidence to the team based health care committee that he has access to physician input and a process to refer patients for further follow‑up, evaluation, or care, if needed.

 (H) Requirements set forth in this section are in addition to those set forth in Section 40‑47‑195.

 (I) Violations of this chapter constitute misconduct and may be grounds for discipline under the applicable licensing laws of this State.

 Section 40‑48‑30. (A)(1) There is created the team based health care committee as a committee to assist the Board of Medical Examiners and the Board of Nursing on matters related to team‑based health care in this State. The committee is composed of thirteen members of whom:

 (a) two must be licensed APRNs, appointed by the Board of Nursing who are licensed to practice in this State and must have a minimum of three years of clinical experience as an APRN in this State;

 (b) five must be physicians, appointed by the Board of Medical Examiners who are licensed to practice in this State and who currently employs or collaborates with an NP, CNS, or CNM or supervises a PA, CRNA, or AA;

 (c) two must be PAs appointed by the Board of Medical Examiners who are licensed to practice in this State and must have a minimum of three years of clinical experience as a PA in this State;

 (d) one must be an AA, appointed by the Board of Medical Examiners who is licensed to practice in this State and must have a minimum of three years of clinical experience as an AA in this State;

 (e) one must be a physician of the Board of Medical Examiners, serving ex officio;

 (f) one must be a member of the Board of Nursing, serving ex officio; and

 (g) one must be a member of the public who is to be appointed by the Governor.

 (2) The ex officio members are voting members.

 (3) All organizations, groups, or interested individuals may submit recommendations to the boards of individuals for each position to be filled on the committee.

 (B) The members shall serve for terms of four years and until their successors are appointed and qualify, except the initial terms of one APRN member, two physician members, and one PA member are for two years. Vacancies must be filled in the manner of the original appointment for the unexpired portion of the term. The appointing board or authority, after notice and opportunity for hearing, may remove a member of the committee for negligence, neglect of duty, incompetence, revocation, suspension of license, or other dishonorable conduct. Members of the committee must receive mileage, subsistence, and per diem as provided by law for members of state boards, commissions, and committees for each meeting attended. No member may serve more than two full four‑year terms consecutively, but may be eligible for reappointment four years from the date the last full four‑year term expired.

 (C) The committee shall meet at least two times annually and at other times as may be required by statute or as necessary. A quorum for all meetings consists of eight members. At its initial meeting, and at the beginning of each year thereafter, the committee shall elect from its membership a chairman who must be a physician member of the committee, vice chairman, and secretary to serve for a term of one year from the date of election.

 (D) The committee has the powers and duties to:

 (1) recommend regulations to the Board of Nursing and the Board of Medical Examiners to carry out the provisions of this article, provided the committee must make recommendations regarding a process for this committee to conduct random audits of practice relationships under Section 40‑48‑50(D)(3) and a process for appointing an alternate patient care team physician under Section 40‑48‑40(G) no later than four months after the effective date of this article;

 (2) recommend the issuance of joint advisory opinions to the Board of Nursing and the Board of Medical Examiners related to issues or interpretations of this chapter;

 (3) conduct random audits of practice relationships to determine whether compliant written practice agreements or scope or practice guidelines are in place and whether they are being followed to ensure safe practice, which must be done following a process set forth in regulation at least once a year, and to report deficiencies to the Board of Nursing and Board of Medical Examiners;

 (4) review practice agreements pursuant to Section 40‑48‑40(F) and make recommendations, if necessary, to the Board of Nursing and Board of Medical Examiners;

 (5) conduct hearings on violations of this chapter and to issue a report to the Board of Nursing and Board of Medical that includes recommended findings of fact and conclusions of law and, if warranted, recommended sanctions;

 (6) keep records and minutes of its proceedings;

 (7) provide notice of all meetings and hearings authorized under this article pursuant to the Administrative Procedures Act and Freedom of Information Act;

 (8) report annually to the Board of Nursing and the Board of Medical Examiners on duties performed, actions taken, and recommendations; and

 (9) perform such duties and tasks as may be delegated to the committee by the Board of Nursing and the Board of Medical Examiners.

 (E) The Board of Nursing and the Board of Medical Examiners jointly may review any decision of the committee pursuant to subsections (D)(3) and (4) at the request of the Board of Nursing, the Board of Medical Examiners, or an affected party.

 (F) A board member serving ex officio on the committee must recuse himself from participating in any disciplinary proceeding:

 (1) that concerns or relates to the licensee's actions or activities pursuant to a written practice agreement for which the board member participated in the approval process or as a result of an audit in which the board member participated; or

 (2) in which he otherwise has a conflict of interest.

 (G) Other committee members must follow conflict of interest rules and recusal rules adopted by the committee.

 (H) The South Carolina Department of Labor, Licensing and Regulation must provide adequate staff to assist and advise the team based health care committee, and the licensing fees collected on behalf of the Board of Nursing and the Board of Medical Examiners may be used to fund such staff.

 Section 40‑48‑40. (A) Within six months of the effective date of this act, the South Carolina Department of Health and Human Services (Department), in collaboration with the South Carolina Board of Medical Examiners, the South Carolina Board of Nursing, and the South Carolina Department of Public Health, must issue a report with recommendations regarding proposed incentives for APRNs, PAs, and physicians to practice as a part of a patient care team, particularly in primary care in rural and underserved areas of this State, to include but not limited to the examination of:

 (1) loan repayment or grant programs;

 (2) payment models that encourage active use of data and quality metrics to manage and improve patient care and system performance;

 (3) payment models that integrate primary health care with public health, social services, and behavioral health;

 (4) increased use of telehealth services, where appropriate;

 (5) increased Graduate Medical Education funding;

 (6) tax policy to encourage APRN, PA, AA, medical school graduates and residents, and physicians to practice in this State, particularly in rural and underserved areas of the State;

 (7) incentives to make South Carolinians healthier and reduce the demand for health care services in this State;

 (8) increased funding for mobile health units, where appropriate;

 (9) incentives to APRN, PA, AA programs and medical schools to accept students from rural areas of the State;

 (10) incentives to residency programs to accept graduates of South Carolina medical schools;

 (11) incentives to APRN, PA, AA programs and medical schools and residency programs for graduates who choose to practice in South Carolina, particularly in rural and underserved areas;

 (12) tax policy to enable and encourage physicians, APRNs, PAs, and AAs to provide charity health care to underserved populations in the setting of specified, qualified practice settings; and

 (13) creation and support of pipeline programs in South Carolina high schools and college and universities to enter into needed healthcare professions.

 (B) All organizations, groups, or interested individuals, including but not limited to the South Carolina Office of Rural Health and the South Carolina Area Health Education Consortium, may submit recommendations to the Department for consideration. Upon completion, the Department must submit this report to the Governor, President of the Senate, Chairman of the Senate Medical Affairs Committee, Chairman of the Senate Finance Committee, Speaker of the House of Representatives, Chairman of the House of Representatives 3M Committee, and Chairman of the House of Representatives Ways and Means Committee.

SECTION 3. If any section, subsection, paragraph, subparagraph, sentence, clause, phrase, or word of this act is for any reason held to be unconstitutional or invalid, such holding shall not affect the constitutionality or validity of the remaining portions of this act, the General Assembly hereby declaring that it would have passed this act, and each and every section, subsection, paragraph, subparagraph, sentence, clause, phrase, and word thereof, irrespective of the fact that any one or more other sections, subsections, paragraphs, subparagraphs, sentences, clauses, phrases, or words hereof may be declared to be unconstitutional, invalid, or otherwise ineffective.

SECTION 4. This act takes effect upon approval by the Governor. All Practice Agreements and Written Scope of Practice Guidelines must be in compliance with the requirements set forth in this act and other requirements of state law within six months of the effective date.

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