

Professions and Public Health Subcommittee

Tuesday, January 25, 2022
9:00 AM – 11:00 AM
Webster Hall (212 Knott)

Meeting Packet

Chris Sprowls
Speaker

Will Robinson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Professions & Public Health Subcommittee

Start Date and Time: Tuesday, January 25, 2022 09:00 am

End Date and Time: Tuesday, January 25, 2022 11:00 am

Location: Webster Hall (212 Knott)

Duration: 2.00 hrs

Consideration of the following bill(s):

HB 105 Regulation of Smoking by Counties and Municipalities by Fine, Altman
HB 517 Dentistry and Dental Hygiene Examinations by Sirois
CS/HB 559 Occupational Licensure of Military Spouses by Regulatory Reform Subcommittee, Hunschofsky, Smith, D.
HB 747 Protections of Medical Conscience by Snyder
HB 861 Medical Specialty Designations by Massullo
HB 931 Alternate-site Testing by McClure
HB 953 Psychology Interjurisdictional Compact by Hunschofsky
HB 955 Pub. Rec. and Meetings/Psychology Interjurisdictional Compact by Hunschofsky

Consideration of the following proposed committee substitute(s):

PCS for HB 475 -- Alzheimer's Disease and Related Forms of Dementia Education and Public Awareness
PCS for HB 693 -- Department of Health

For information about attending or testifying at a committee meeting, please see the "Visiting the House" tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 01/21/2022 4:00PM by Osborne.Erin

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 105 Regulation of Smoking by Counties and Municipalities
SPONSOR(S): Fine and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Morris	McElroy
2) Environment, Agriculture & Flooding Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Florida Clean Indoor Air Act (FCIAA), implements Article X, Section 20 of the Florida Constitution. Article X, Section 20 of the Florida Constitution prohibits a person from smoking tobacco or using a vapor-generating electronic device in an enclosed indoor workplace, with certain exceptions.

The state preempts the regulation of smoking and does not allow counties or municipalities to regulate smoking. HB 105 amends the FCIAA to allow counties and municipalities to restrict smoking within the boundaries of any public beach or park they own.

The bill changes the title of the “Florida Clean Indoor Air Act” to the “Florida Clean Air Act” to account for the broader application of the act proposed in the bill.

The bill has no fiscal impact on state governments. The bill has an indeterminate, negative fiscal impact on local governments.

The bill provides and effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Smoking Regulation in Florida

While the Food and Drug Administration (FDA) regulates the manufacture, distribution, and marketing of tobacco and vaping products, it does not regulate smoking or vaping in public places – leaving that to the states.

In 1985, the Florida Legislature enacted the Florida Clean Indoor Air Act (FCIAA)[1] to protect the public health, comfort, and environment by creating areas in public places and at public meetings that were reasonably free from tobacco smoke. The FCIAA originally prohibited smoking[2] in certain indoor public places (*e.g.* government buildings, elevators, public transportation, hospitals, day care centers) or common areas of an indoor public place (*e.g.* lobby, hallway, stairwell, restrooms), but did permit designated smoking areas of specified indoor public places such as places of employment, retail stores, indoor arenas, and restaurants.

Article X, Section 20 of the Florida Constitution

In the November, 2002 General Election, Floridians voted to create Article X, Section 20 of the Florida Constitution, titled "Workplaces without tobacco smoke," which further restricted smoking indoors.[3] The purpose of this citizens' initiative was to protect people from the health hazards of secondhand tobacco smoke by prohibiting smoking in enclosed indoor workplaces, which are defined as:

> Any place where one or more persons engage in work,[4] and which place is predominantly or totally bounded on all sides and above by physical barriers, regardless of whether such barriers consist of or include uncovered openings, screened or otherwise partially covered openings; or open or closed windows, jalousies, doors, or the like.[5]

The provision also provided various other definitions and exceptions to the smoking ban, and required the Legislature to implement the section in law by the following legislative session. Accordingly, in 2003, the Legislature amended the FCIAA to conform existing law and implement the constitutional provision in a manner consistent with its broad purpose and stated terms.[6]

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[1] Ch. 386, Part II, F.S.; ch. 85-257, Laws of Fla.
[2] "Smoking" is defined as "inhaling, exhaling, burning, carrying, or possessing any lighted tobacco product, including cigarettes, cigars, pipe tobacco, and any other lighted product. S. 386.203(11), F.S.
[3] Text available at: https://dos.elections.myflorida.com/initiatives/fulltext/pdf/34548-1.pdf (last visited Dec. 15, 2021). The constitutional provision does not preclude the Legislature from enacting more restrictive regulation of tobacco smoking.
[4] "Work" is defined as "any persons providing any employment or employment-type service for or at the request of another individual or individuals or any public or private entity, whether for compensation or not, whether full or part-time, whether legally or not." Fla. Const., art. X, s. 20. "Work" includes, without limitation, any such service performed by an employee, independent contractor, agent, partner, proprietor, manager, officer, director, apprentice, trainee, associate, servant, volunteer, and the like. The term does not include noncommercial activities performed by members of a membership association. S. 386.203(12), F.S.
[5] The smoking ban applies to all enclosed indoor workplaces regardless of whether work is occurring at any given time, Fla. Const., art. X, s. 20.
[6] Ch. 2003-398, Laws of Fla.

In the November 2018, General Election, Floridians passed Amendment No. 9, which amended Article X, Section 20 of the Florida Constitution, banning the use of vapor-generating electronic devices, or vaping, in enclosed indoor workplaces, consistent with the prohibition on tobacco smoking.[7]

The FCIAA prohibits smoking and vaping in an enclosed indoor workplace, unless it is a:[8]

- Private residence that is not being used commercially to provide child care, adult care, or health care, or any combination thereof;
- Retail tobacco shop;
- Designated smoking guest room in a public lodging establishment;
- Stand-alone bar;[9]
- Smoking cessation program or medical or scientific research; or
- Customs smoking room in an airport.

However, an owner, lessee, or a person otherwise in control of an enclosed indoor workplace may further prohibit or limit smoking or vaping therein.[10]

Additionally, no one under the age of 18 years old may smoke tobacco or vape in, on, or within 1,000 feet of a public or private grade school between 6 a.m. and midnight.[11] Violators of this provision are subject to a citation from a law enforcement officer.[12]

Persons in charge of enclosed indoor workplaces are required to develop and implement smoking and vaping prohibition policies in line with the FCIAA requirements.[13] Persons in charge of a smoking or vaping cessation program, medical or scientific research, or an airport terminal that includes a customs smoking room must all post signs clearly stating that smoking is only permitted in the designated areas.[14] Additionally, public transportation carriers in certain locations are required to make regular announcements regarding the smoking and vaping prohibition.[15]

The Department of Health (DOH) and the Department of Business and Professional Regulation (DBPR) are each responsible for the enforcement of the FCIAA as it relates to their respective areas of regulatory authority.[16] If an enclosed indoor work place violates the FCIAA and does not correct the violation within 30 days, DOH or DBPR may impose fines against the owner and pursue compliance in circuit court, if necessary.[17] Additionally, any person who violates the FCIAA by smoking or vaping in an enclosed indoor work place commits a noncriminal violation and may be subject to a fine of up to $100 for the first violation and up to $500 for each subsequent violation.[18]

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[7] Text available at: p. 26-30 https://dos.myflorida.com/media/699824/constitutional-amendments-2018-general-election-english.pdf (last visited Dec. 15, 2021). Note: Amendment No. 9 also amended article II, section 7 of the Florida Constitution to ban offshore oil and gas drilling.
[8] Ss. 386.204 and 386.2045, F.S. Additionally, s. 386.203(5)(c), F.S., by definition of an "enclosed indoor workplace," excludes any facility owned or leased by and used exclusively for noncommercial activities performed by the members and guests of a membership association, including social gatherings, meetings, dining, and dances, if no person or persons are engaged in work.
[9] A stand-alone bar is a licensed premises that predominantly or totally serves alcoholic beverages and in which serving food is merely incidental to the sale of alcohol. Also, it must not share a common entryway or indoor area with a business that predominantly serves food during the hours the stand-alone bar is operating its business, s. 386.203(11), F.S. *See also* s. 561.695, F.S.
[10] Fla. Const., art X, sec. 20(b).
[11] S. 386.212(1), F.S.
[12] S. 386.212(2), F.S.
[13] S. 386.206(1), F.S.
[14] S. 386.206(2)-(3), F.S.
[15] S. 386.211, F.S.
[16] Ss. 386.207(1) and 561.695, F.S. DBPR enforces the FCIAA in restaurants, bowling centers, dog tracks, horse tracks, bars, billiards, bingo halls (with food service), and civic/fraternal organizations. DOH enforces the FCIAA in all facilities not regulated by DBPR. Florida Department of Health, *Florida Clean Indoor Air Act, Enforcement*, http://www.floridahealth.gov/PROGRAMS-AND-SERVICES/prevention/tobacco-free-florida/indoor-air-act/index.html (last visited Dec. 15, 2021).
[17] S. 386.207(3), F.S.
[18] S. 386.208, F.S.

Currently, the state preempts the regulation of smoking and does not allow counties or municipalities to regulate smoking, except school districts may further restrict smoking on school district property.[19] The state does not currently preempt the regulation of vaping. Thus, local governments impose more restrictive regulation on the use of vapor-generated electronic devices.[20]

County and Municipally Owned Parks

The Division of Recreation and Parks within the Florida Department of Environmental Protection maintains a comprehensive inventory of the existing park facilities and outdoor resources in Florida. The inventory provides details about the parks and recreation areas in the state and contains information on more than 13,000 outdoor recreational facilities in Florida, the majority of which are county and municipal parks.[21]

There are 67 county park systems and more than 400 municipal park systems in the state.[22] Such parks provide a wide variety of activities to the public, including nature trails, bird watching, youth and adult athletics, bike paths, horse trails, boat ramps, fishing piers, outdoor gyms, and outdoor pavilions.[23] For example, Orange County maintains and operates 118 county-owned parks, which consist of a wide array of available activities and facilities.[24] Additionally, municipalities within Orange County also own and operate parks and outdoor recreational facilities, For example, the City of Winter Park owns and operates 11 city parks, which offer similar recreational activities to county-owned parks.[25]

Public Beaches

Florida has 825 miles of sandy coastline, attracting over 18 million tourists each year.[26] A significant portion of Florida's beaches is publicly owned, including federally-owned areas managed by the National Park Service, parts of Florida's 175 state parks, and the many beaches owned and managed by local governments on the coast.[27] In general, access to these beaches is free through the numerous public access points along the coast however; some state parks, counties and municipalities charge an access fee.

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[19] S. 386.209, F.S.

[20] Id.; "Vapor-generating electronic devices" means any product that employs an electronic, a chemical, or a mechanical means capable of producing vapor or aerosol from a nicotine product or any other substance, including, but not limited to, an electronic cigarette, electronic cigar, electronic cigarillo, electronic pipe, or other similar device or product, any replacement cartridge for such device, and any other container of a solution or other substance intended to be used with or within an electronic cigarette, electronic cigar, electronic cigarillo, electronic pipe, or other similar device or product.

[21] Florida Division of Recreation and Parks*, Florida Outdoor Recreation Inventory, available at:* https://floridadep.gov/parks/florida-outdoor-recreation-inventory (last visited Dec. 15, 2021)

[22] Florida Department of Environmental Protection, Division of Recreation and Parks, *Frequently Asked Questions,* https://prodenv.dep.state.fl.us/DrpOrpcr/StaticFiles/FAQ.pdf (last visited Dec. 15, 2021).

[23] *Id.*

[24] Orange County Government Florida, *Parks,* http://www.orangecountyfl.net/CultureParks/Parks.aspx (last visited Dec. 15, 2021).

[25] City of Winter Park, *Parks*, https://cityofwinterpark.org/departments/parks-recreation/parks-playgrounds/parks/ (last visited Dec. 15, 2021).

[26] Department of Environmental Protection, *Beaches*, https://floridadep.gov/water/beaches (last visited at March 14, 2021).

[27] National Park Service, Canaveral National Seashore*, Nature and Science*, https://www.nps.gov/cana/learn/nature/index.htm (last visited Dec. 15, 2021). Canaveral National Seashore's 24 miles of undeveloped beach is the longest such stretch on the east coast of Florida; National Park Service, Gulf Islands National Seashore, *Things To Do*, https://www.nps.gov/guis/planyourvisit/things2do.htm (last visited Dec. 15, 2021). Gulf Islands National Seashore stretches for 160 miles along the coasts of both Florida and Mississippi; DEP, *Beaches and Coasts at Florida State Parks*, https://www.floridastateparks.org/learn/beaches-and-coasts-florida-state-parks (last visited Dec. 15, 2021). Florida's state parks include 100 miles of beaches; DEP, *Map of Florida's Coastal Counties*, https://floridadep.gov/fco/fcmp/documents/map-floridas-coastal-counties (last visited Dec. 15, 2021); Beaches in coastal counties are important for tourism and Florida's "brand"; DEP, Florida Coastal Management Program, *Final Assessment and Strategies*, *FY 2016 – FY 2020*, 30 (2015) *available at* https://floridadep.gov/sites/default/files/FCMP_FY2016-20_Assessment.pdf (last visited Dec. 15, 2021). Based on shoreline access sites, there are approximately 439 miles of public saltwater beach in Florida.

Health Concerns

In 2020, an estimated 15 percent of the adults in Florida were tobacco smokers.[28] Tobacco smoke contains over 7,000 chemicals, including hundreds that are toxic and up to 69 that are known to cause cancer.[29] More than 480,000 deaths annually in the United States are caused by cigarette smoking, with exposure to secondhand smoke causing an estimated 41,000 deaths each year.[30] Secondhand smoke is generally defined as smoke from burning tobacco products or smoke that is exhaled by a tobacco smoker.[31] Exposure to secondhand smoke can cause numerous health problems and has been causally linked to cancer and other fatal diseases.[32] Studies suggest that secondhand smoke in crowded outdoor areas can cause concentrations of air contaminants comparable to those caused by indoor smoking.[33]

Effect of Proposed Changes

The bill authorizes counties and municipalities to further restrict smoking within the boundaries of any public beaches and public parks they own. Municipalities may further restrict smoking within the boundaries of public beaches and public parks that are within their jurisdiction, but owned by the county, unless such restriction conflicts with county ordinance.

The bill changes the title of Part II of ch. 386, F.S., from "Indoor Air: Smoking and Vaping" to "Smoking and Vaping."

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Renames Part II of chapter 386, F.S., from "INDOOR AIR: SMOKING AND VAPING" to "SMOKING AND VAPING."
Section 2: Amends s. 386.201, F.S., relating to popular name.
Section 3: Amends s. 386.209, F.S., relating to regulation of smoking preempted to state.
Section 4: Amends s. 381.84, F.S., relating to Comprehensive Statewide Tobacco Education and Use Prevention Program.
Section 5: Amends s. 386.211, F.S., relating to public announcements in mass transportation terminals.
Section 6: Provides an effective date of July 1, 2022.

[28] United Health Foundation, America's Health Rankings, *Annual Report*, *available at:* https://www.americashealthrankings.org/explore/annual/measure/Smoking/state/FL (last visited Dec. 15, 2021).
[29] *Id.*; U.S. Department of Health and Human Services, *The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General*, 148 (2014), https://www.surgeongeneral.gov/library/reports/50-years-of-progress/full-report.pdf (last visited Dec. 15, 2021).
[30] Centers for Disease Control and Prevention, *Tobacco-Related Mortality,* https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm (last visited Dec. 15, 2021).
[31] Centers for Disease Control and Prevention, *Secondhand Smoke (SHS) Facts*, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/index.htm (last visited Dec. 15, 2021).
[32] Id.
[33] Nipapun Kungskulniti et al., *Secondhand Smoke Point-Source Exposures Assessed By Particulate Matter At Two Popular Public Beaches in Thailand*, 40 J. Public Health 3, 527–532 (2017), https://academic.oup.com/jpubhealth/article/40/3/527/4110319?guestAccessKey=5947c328-fd75-4b6c-acfe-28f989c4c639 (last visited Dec. 15, 2021); James Repace, *Benefits of Smoke-free Regulations in Outdoor Settings: Beaches, Golf Courses, Parks, Patios and in Motor Vehicles*, 34 WM Mitchell L. Rev. 1621, 1622–1624, 1638 (2008), https://open.mitchellhamline.edu/wmlr/vol34/iss4/15/ (last visited Dec. 15, 2021).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   To the extent that any imposed smoking restrictions deter or encourage visitation of county and municipal beaches and parks, local governments may experience and indeterminate fluctuation in revenues generated by any fees for beach and park admittance.

2. Expenditures:

   Counties and municipalities that opt to restrict smoking within the boundaries of public parks may incur indeterminate expenses related to enacting and enforcing such restrictions.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Visitors to county or municipal parks who violate smoking restrictions imposed by a county or municipality may be subject to any applicable fines or civil penalties for such violations.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Rulemaking authority is not needed to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the regulation of smoking by counties and municipalities; revising the title of part II of ch. 386, F.S.; amending s. 386.201, F.S.; revising a short title; amending s. 386.209, F.S.; authorizing counties and municipalities to further restrict smoking within the boundaries of public beaches and public parks under certain circumstances; amending ss. 381.84 and 386.211, F.S.; conforming provisions to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Part II of chapter 386, Florida Statutes, entitled "INDOOR AIR: SMOKING AND VAPING," is renamed "SMOKING AND VAPING."

Section 2. Section 386.201, Florida Statutes, is amended to read:

386.201 Short title ~~Popular name~~.—This part may be cited as ~~by the popular name~~ the "Florida Clean ~~Indoor~~ Air Act."

Section 3. Section 386.209, Florida Statutes, is amended to read:

386.209 Regulation of smoking preempted to state.—This part expressly preempts regulation of smoking to the state and

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

supersedes any county or municipal ~~municipal or county~~ ordinance on the subject; however, counties and municipalities may further restrict smoking within the boundaries of any public beaches and public parks that they own. A municipality may further restrict smoking within the boundaries of public beaches and public parks that are within its jurisdiction but are owned by the county, unless such restriction conflicts with a county ordinance. School districts may further restrict smoking by persons on school district property. This section does not preclude the adoption of county or municipal ~~municipal or county~~ ordinances that impose more restrictive regulation on the use of vapor-generating devices than is provided in this part.

Section 4. Paragraph (h) of subsection (3) of section 381.84, Florida Statutes, is amended to read:

381.84 Comprehensive Statewide Tobacco Education and Use Prevention Program.—

(3) PROGRAM COMPONENTS AND REQUIREMENTS.—The department shall conduct a comprehensive, statewide tobacco education and use prevention program consistent with the recommendations for effective program components contained in the 1999 Best Practices for Comprehensive Tobacco Control Programs of the CDC, as amended by the CDC. The program shall include the following components, each of which shall focus on educating people, particularly youth and their parents, about the health hazards of tobacco and discouraging the use of tobacco:

(h) *Enforcement and awareness of related laws.*—In coordination with the Department of Business and Professional Regulation, the program shall monitor the enforcement of laws, rules, and policies prohibiting the sale or other provision of tobacco to minors, as well as the continued enforcement of the Florida Clean ~~Indoor~~ Air Act prescribed in chapter 386. The advertisements produced in accordance with paragraph (a) may also include information designed to make the public aware of these related laws and rules. The departments may enter into interagency agreements to carry out this program component.

Section 5. Section 386.211, Florida Statutes, is amended to read:

386.211 Public announcements in mass transportation terminals.—Announcements about the Florida Clean ~~Indoor~~ Air Act shall be made regularly over public address systems in terminals of public transportation carriers located in metropolitan statistical areas with populations over 230,000 according to the latest census. These announcements shall be made at least every 30 minutes and shall be made in appropriate languages. Each announcement must include a statement to the effect that Florida is a clean ~~indoor~~ air state and that smoking and vaping are prohibited except as provided in this part.

Section 6. This act shall take effect July 1, 2022.

PCS for HB 475

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 475 Alzheimer's Disease and Related Forms of Dementia Education and Public Awareness
SPONSOR(S): Professions & Public Health Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Professions & Public Health Subcommittee		Guzzo	McElroy

SUMMARY ANALYSIS

Alzheimer's disease is the most prevalent form of dementia, a general term for memory loss. It is a progressive brain disorder that damages and eventually destroys brain cells, leading to memory loss and changes in the functions of the brain. Alzheimer's disease accounts for 60 to 80 percent of dementia cases. There are an estimated 5.8 million people in the United States with Alzheimer's disease, including 5.6 million people aged 65 and older and 200,000 individuals under age 65 who have younger-onset Alzheimer's disease.

Florida has several programs and initiatives under the oversight of the Department of Elder Affairs (DOEA) that provide resources and support for individuals suffering from Alzheimer's disease and other dementia-related disorders. The Florida Department of Health (DOH) licenses physicians, osteopathic physicians, and nursing professionals who provide care, among others, to patients with Alzheimer's disease and other dementia-related disorders.

The bill creates the Ramping up Education of Alzheimer's and Dementia for You (READY) Act which requires DOH, in partnership with DOEA and the Alzheimer's Association, to educate physicians and nursing professionals about Alzheimer's disease and related forms of dementia. This effort will occur through existing public health and community outreach programs and include education on:

- The importance of early detection and timely diagnosis of Alzheimer's disease and related forms of dementia;
- Utilization of a validated cognitive assessment tool;
- The value and effectiveness of Medicare annual wellness visits in detecting Alzheimer's disease and related forms of dementia;
- The use of Medicare billing codes for care planning for individuals with Alzheimer's disease and related forms of dementia; and
- Methods to reduce the risk of cognitive decline, particularly among individuals in diverse communities who are at greater risk of developing Alzheimer's disease and related forms of dementia.

The bill has no fiscal impact on state or local government.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Alzheimer's Disease

Alzheimer's disease is a form of dementia, a general term for memory loss. It is a progressive brain disorder that damages and eventually destroys brain cells, leading to memory loss and changes in the functions of the brain. Alzheimer's disease accounts for 60 to 80 percent of dementia cases. Alzheimer's disease is a progressive disease in which dementia symptoms worsen gradually over time. In the early stages of Alzheimer's disease, memory loss is mild; in late-stages, individuals lose the ability to carry on a conversation and respond to their environment. Currently, the disease has no cure, but treatment can temporarily slow the worsening of symptoms.[1]

There are an estimated 6.2 million people in the United States with Alzheimer's disease.[2] By 2050, the number of people age 65 and older with Alzheimer's disease in the U.S. is expected to double to a projected 12.7 million people.[3]

Florida has an increasing number of individuals with Alzheimer's disease. An estimated 580,000 Floridians have Alzheimer's disease.[4] The projected number of Floridians with Alzheimer's disease is estimated to increase by 24% to 720,000 individuals by 2025.[5]

Alzheimer's Disease Initiative

Section 430.503, F.S., creates the Alzheimer's Disease Initiative (ADI) within the Department of Elder Affairs (DOEA).[6] The Alzheimer's Disease Initiative is a statewide program that provides services to individuals and families affected by Alzheimer's disease. The ADI includes the following programs:[7]

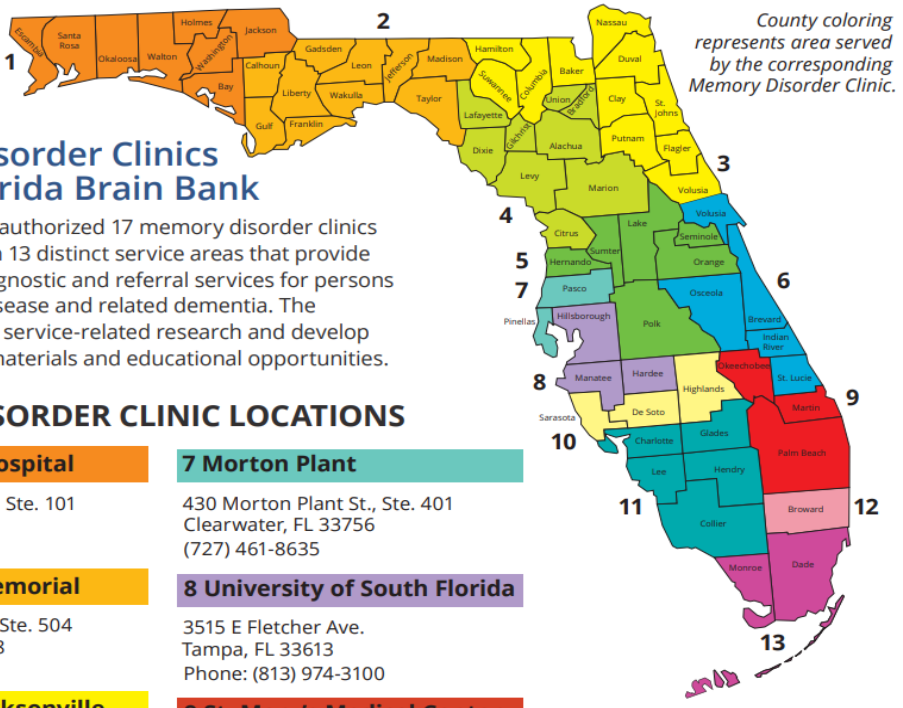
- Respite care and other support services for caregivers;
- Memory Disorder Clinics;
- Specialized Alzheimer's Adult Day Care Centers; and
- The Florida Alzheimer's Brain Bank, which is a service- and research-oriented network of regional sites which collect and study the brains of deceased dementia patients.[8]

Memory Disorder Clinics

[1] Alzheimer's Association, *2021 Alzheimer's Disease Facts and Figures*, available at https://www.alz.org/media/documents/alzheimers-facts-and-figures.pdf (last accessed January 20, 2022).
[2] Rajan KB, Weuve J, Barnes LL, McAninch EA, Wilson RS, Evans DA, *Population Estimate of People with Clinical AD and Mild Cognitive Impairment in the United States (2020-2060)*. Alzheimers Dement. 2021 Dec;17(12):1966-1975. doi: 10.1002/alz.12362. Epub 2021 May 27. PMID: 34043283.
[3] Id.
[4] Florida Department of Elder Affairs, *2021 Alzheimer's Disease Advisory Committee Annual Report*, available at https://elderaffairs.org/wp-content/uploads/ADAC-Report-2021_FINAL.pdf (last accessed January 20, 2022).
[5] Id.
[6] S. 430.503(1), F.S.
[7] Florida Department of Elder Affairs, *Alzheimer's Disease Initiative,* available at http://elderaffairs.state.fl.us/doea/alz.php (last accessed January 20, 2022).
[8] Florida Department of Elder Affairs, *The Florida Brain Bank*, available at http://elderaffairs.state.fl.us/doea/BrainBank/docs/BrainBank-brochure.pdf (last accessed January 20, 2022).

Section 430.502(1), F.S., designates 17 memory disorder clinics (MDCs)[9] that provide comprehensive assessments, diagnostic services, and treatment to individuals who exhibit symptoms of Alzheimer's disease and related memory disorders. The MDCs operate in 13 distinct service areas.[10]

MDC Service Areas and Locations[11]



MDCs also develop training programs and materials and conduct training for caregivers, respite service providers, and health care professionals in the care of persons with Alzheimer's disease and related memory disorders.[12] In addition, MDCs conduct service-related research projects through model day

[9] S. 430.502(1), F.S.
[10] Florida Department of Elder Affairs, *Summary of Programs and Services 2019*, available at http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/2019_SOPS_A.pdf (last accessed January 20, 2022).
[11] Id.
[12] *Supra* note 7.

care programs and respite care programs.[13] MDCs are established at medical schools, teaching hospitals, and public and private not-for-profit hospitals throughout the state in accordance with s. 430.502, F.S. MDCs served 9,753 clients in 2017-2018.[14]

Purple Ribbon Task Force and Alzheimer's Disease State Plan

Chapter 2012-172, Laws of Florida, created the Purple Ribbon Task Force. The task force was composed of 18 members with 6 members appointed by the Governor, 6 members appointed by the Speaker of the House of Representatives, and 6 members appointed by the President of the Senate.[15]

The law required the task force to conduct an interim study regarding Alzheimer's disease in the state and directed the Task Force to:[16]

- Assess the current and future impact of Alzheimer's disease on the state;
- Examine existing industries, services, and resources that address the needs of persons with Alzheimer's disease;
- Develop a strategy to mobilize a state response to Alzheimer's disease; and
- Gather information on state trends and policy regarding Alzheimer's disease.

Additionally, the law required the task force to submit a report in the form of an Alzheimer's disease state plan.[17] The 2013 completed report by the task force is the *State Plan on Alzheimer's Disease and Related Forms of Dementia.*[18] The state report included the task force's findings and recommendations. Upon submission of this report, pursuant to law, the Purple Ribbon Task Force terminated.

Current law requires DOEA to review and update the Alzheimer's disease state plan every three years. The state plan must include an assessment of the current and future impact of Alzheimer's disease, an examination of existing resources available to persons living with Alzheimer's disease, and other information regarding Alzheimer's disease trends and policies in the state.[19]

Alzheimer's Disease Advisory Committee

Section 430.501, F.S., establishes the Alzheimer's Disease Advisory Committee (Committee) to advise DOEA on legislative, programmatic, and administrative matters regarding individuals with Alzheimer's disease and their caretakers. The committee is established within DOEA and composed of 11 members appointed by the Governor, 2 members appointed by the Senate President (one of which must be a sitting Senator), and 2 members appointed by the Speaker of the House of Representatives (one of which must be a sitting Representative).[20] The Governor's appointments must reflect the following representation:[21]

- At least four members must be persons licensed pursuant to ch. 458 or 459, F.S., or hold a Ph.D. degree and be currently involved in research on Alzheimer's disease;
- At least four persons who have been caregivers of victims of Alzheimer's disease; and
- Whenever possible, a gerontologist, a geriatric psychiatrist, a geriatrician, a neurologist, a social worker, and a registered nurse.

Committee members are appointed to four-year staggered terms. The chair is elected by the Committee and serves a one-year term. The Committee may establish subcommittees as necessary to carry out the functions of the Committee. Currently, the Committee has four standing subcommittees

[13] Id.
[14] *Supra* note 10.
[15] Ch. 2012-172, Laws of Fla.
[16] Id.
[17] Id.
[18] Florida Department of Elder Affairs, *Purple Ribbon Task Force State Plan on Alzheimer's Disease and Related Forms of Dementia*, available at https://www.alz.org/media/Documents/florida-state-plan-august-2013.pdf (last accessed January 20, 2022).
[19] S. 430.501, F.S.
[20] Id.
[21] Id.

regarding clinical services, home- and community-based care, education and research, and legislative advocacy.[22]

The Committee is required to submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of Elder Affairs by September 1 of each year. The report must include recommendations on Alzheimer's disease policy, all state-funded Alzheimer's disease efforts, and proposed updates to the Alzheimer's disease state plan.

DOEA must use the report submitted by the Committee and collaborate with other organizations and professionals when updating the state plan. DOEA must submit the updated state plan every three years to the Governor, the President of the Senate, and the Speaker of the House of Representatives.[23]

Dementia Care and Cure Initiative

The DOEA announced the Dementia Care and Cure Initiative (DCCI) in 2015 to engage communities across the state to be more dementia-caring, promote better care for Floridians affected by dementia, and support research efforts to find a cure. In collaboration with Florida's 11 Area Agencies on Aging and 17 memory disorder clinics, participating DCCI communities organize task forces consisting of community professionals and stakeholders who work to bring about education, awareness of, and sensitivity regarding the needs of those affected by dementia.[24]

Health Care Licensure in Florida

Chapter 458, F.S., governs licensure and regulation of the practice of medicine by the Florida Board of Medicine in conjunction with the Florida Department of Health (DOH). Physicians holding a Doctor of Medicine (M.D.) degree are licensed under this chapter.

Chapter 459, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Osteopathic Medicine in conjunction with DOH. Osteopathic Physicians holding a Doctor of Osteopathic Medicine (D.O.) are licensed under this chapter.

Chapter 464, F.S., provides for the licensure and regulations of the practice of nursing by the Florida Board of Nursing in conjunction with DOH. Individuals licensed under this chapter include registered nurses (RN), advanced practice registered nurses (APRN), licensed practical nurses (LPN), and certified nursing assistants (CNA).

Medicare Program

Medicare is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, and people of any age with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).[25] The program is administered by the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services.
Medicare will pay for some services during every stage of Alzheimer's disease and dementia care, such as:[26]

- Cognitive assessments;
- Home safety evaluations

[22] Alzheimer's Disease Advisory Committee, *2009-2016 Summary of Accomplishments*, http://elderaffairs.state.fl.us/doea/alz/ADI_Accomplishments.pdf (last accessed January 20, 2022).
[23] S. 430.501(3)(b)8., F.S.
[24] Department of Elder Affairs, *Dementia Care and Cure Initiative*, http://elderaffairs.state.fl.us/doea/dcci.php (last accessed January 20, 2022).
[25] Medicare.gov, *What's Medicare*, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last accessed January 20, 2022).
[26] Centers for Medicare and Medicaid Services, *Medicare and Medicaid Benefits for People with Dementia*, August 2017, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Medicare-and-Medicaid-Benefits-for-People-with-Dementia.pdf (last accessed January 20, 2022).

- Planning for care;
- Hospital stays; and,
- Prescription drugs — Medicare Part D pays a portion of drug costs for individuals diagnosed with dementia.

Effect of Proposed Changes

The bill creates the Ramping up Education of Alzheimer's and Dementia for You (READY) Act. The bill requires DOH to use existing public health and community outreach programs to educate physicians and nursing professionals on a range of topics related to the diagnosis and treatment of Alzheimer's disease and related forms of dementia. Specifically, the bill requires DOH to educate physicians and nursing professions on:

- The importance of early detection and timely diagnosis of Alzheimer's disease and related forms of dementia;
- Utilization of a validated cognitive assessment tool;
- The value and effectiveness of Medicare annual wellness visits in detecting Alzheimer's disease and related forms of dementia;
- The use of Medicare billing codes for care planning for individuals with Alzheimer's disease and related forms of dementia; and
- Methods to reduce the risk of cognitive decline, particularly among individuals in diverse communities who are at greater risk of developing Alzheimer's disease and related forms of dementia.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.825, F.S., relating to Alzheimer's disease and dementia-related disorders education.

Section 2: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No rule-making authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Alzheimer's disease and related forms of dementia education and public awareness; creating s. 381.825, F.S.; providing a short title; requiring the Department of Health to educate certain licensed health care providers regarding specified information related to Alzheimer's disease and related forms of dementia; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.825, Florida Statutes, is created to read:

381.825 Education and public awareness relating to Alzheimer's disease and related forms of dementia.—

(1) This section may be cited as the "Ramping up Education of Alzheimer's and Dementia for You (READY) Act."

(2) The Department of Health shall, through existing, relevant public health and community outreach programs, educate health care providers licensed under chapters 458, 459, and 464 regarding all of the following information:

(a) The importance of early detection and timely diagnosis of Alzheimer's disease and related forms of dementia.

(b) Using a validated cognitive assessment tool.

(c) The value and effectiveness of the Medicare annual

CODING: Words stricken are deletions; words underlined are additions.

wellness visit in detecting Alzheimer's disease and related forms of dementia.

(d) Using Medicare advance care planning billing codes for persons with Alzheimer's disease and related forms of dementia.

(e) Reducing the risk of cognitive decline, particularly among persons in diverse communities who are at greater risk of developing Alzheimer's disease and related forms of dementia.

Section 2. This act shall take effect July 1, 2022.

HB 517

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 517 Dentistry and Dental Hygiene Examinations
SPONSOR(S): Sirois
TIED BILLS: **IDEN./SIM. BILLS:** SB 926

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Rahming	McElroy
2) Health & Human Services Committee			

SUMMARY ANALYSIS

The Board of Dentistry, within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants under the Dental Practice Act. A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures. A dental hygienist provides education and preventive and delegated therapeutic dental services.

Currently, all applicants for licensure as a dentist or dental hygienist must pass a practical or clinical examination developed by the American Board of Dental Examiners, Inc. (ADEX), in addition to meeting other qualifications. A live patient must be used during the clinical examination.

In response to the COVID-19 pandemic, on March 31, 2021, the State Surgeon General issued Emergency Order 21-001, which suspended the prohibition against the use of manikins or simulated patients in lieu of live patients during the administration of the ADEX examinations. The Emergency Order expired on June 30, 2021.

HB 517 requires the use of the CompeDont DTX manufactured tooth for the restorative and periodontal skills portions on the dental clinical examination and for the dental hygiene clinical examination. This eliminates the requirement for dental and dental hygienist applicants to perform clinical examination components on a live patient. The bill also removes the following provisions that are unnecessary because the examination is no longer on live patients:

- The requirement for dental students to obtain, and the Board of Dentistry's authority to require, specified medical malpractice insurance;
- The requirement for dental schools to make arrangements for patients who require follow-up dental care as a result of procedures performed during the clinical examination; and
- The requirement that dental schools ensure that a student's academic record does not include any evidence that the student poses an unreasonable risk to a patient during the clinical examination.

The bill has an insignificant, negative fiscal impact on the DOH, which current resources are adequate to absorb. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Dentistry

The Board of Dentistry, within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants under the Dental Practice Act.[1] A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[2] A dental hygienist provides education, preventive and delegated therapeutic dental services.[3]

Dental Licensure

Any person wishing to practice dentistry in this state must apply to the DOH and meet specified requirements. Section 466.006, F.S., requires dentistry licensure applicants to sit for and pass the following licensure examinations:

- The National Board of Dental Examiners dental examination (NBDE);
- A written examination on Florida laws and rules regulating the practice of dentistry; and
- The American Dental Licensing Examination, a practical or clinical examination developed by the American Board of Dental Examiners.[4]

To qualify to take the Florida dental licensure examination, an applicant must be 18 years of age or older, be a graduate of a dental school accredited by the American Dental Association Commission on Dental Accreditation or be a student in the final year of a program at an accredited institution, and have successfully completed the NBDE dental examination.[5]

Dental Hygiene Licensure

Any person wishing to be licensed as a dental hygienist must apply to DOH and meet the following qualifications:[6]

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school;[7] and
- Obtain a passing score on the:
    - National Board Dental Hygiene Examination;
    - Dental Hygiene Examination, a practical or clinical examination developed by the American Board of Dental Examiners, Inc.; and
    - A written examination on Florida laws and rules regulating the practice of dental hygiene.

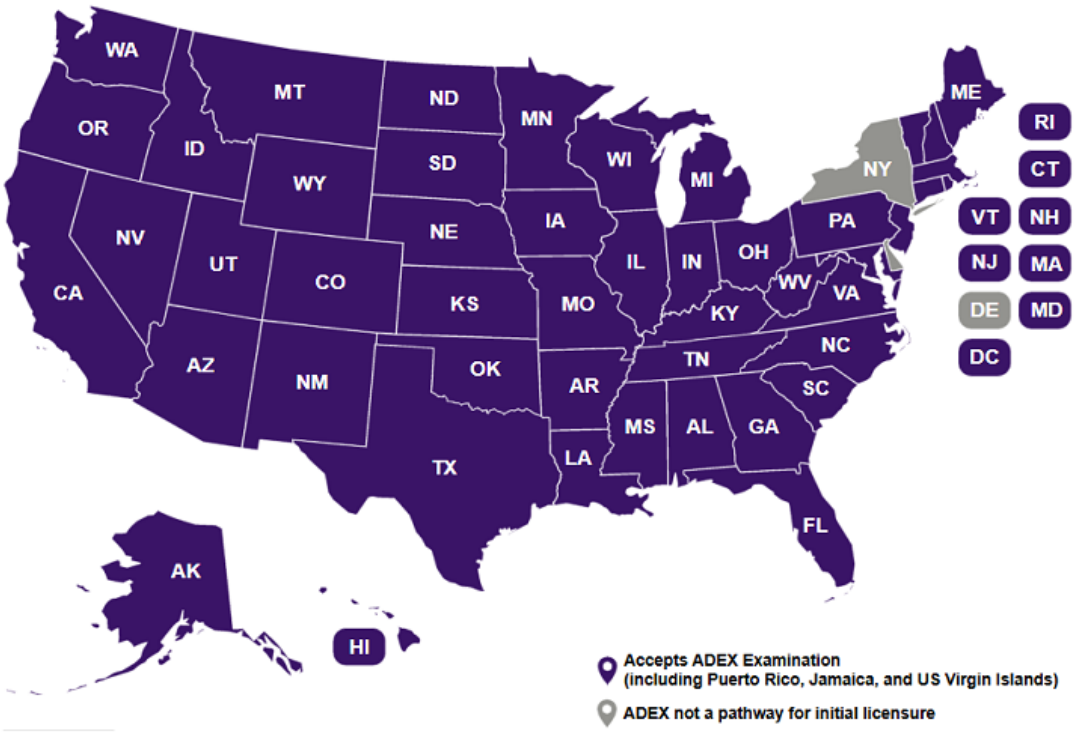
A dental hygienist may also apply to be certified to administer local anesthesia, under the direct supervision of a dentist, to a non-sedated, adult patient if the dental hygienist is certified in basic or advanced cardiac life support and successfully completes an accredited course that includes a

[1] S. 466.004, F.S.
[2] S. 466.003(3), F.S.
[3] Ss. 466.003(4)-(5), F.S.
[4] A passing score is valid for 365 days after the date the official examination results are published. The same is true for a passing score on the American Dental Licensing Examination administered in another state on or after Oct. 1, 2011.
[5] S. 466.006(2), F.S.
[6] S. 466.007, F.S.
[7] If the school is not accredited, the applicant must have completed a minimum of 4 years of postsecondary dental education and received a dental school diploma, which must be reviewed and approved by the Board of Dentistry.

minimum of 30 hours of didactic training, 30 hours of clinical experience, and additional training in specified areas.[8]

American Board of Dental Examiners

The American Board of Dental Examiners, Inc. (ADEX) is an organization of state and regional dental boards that provides for the ongoing development of uniform national dental and dental hygiene licensure examinations.[9] The ADEX examination is widely used: 48 states accept the ADEX for dental licensure.[10]



The Commission on Dental Competency Assessment (CDCA), formerly known as the Northeast Regional Board, and the Council of Interstate Testing Agencies (CITA) administers the ADEX dental licensure examination to graduates of accredited dental schools and students in their senior year at an accredited dental school.[11]

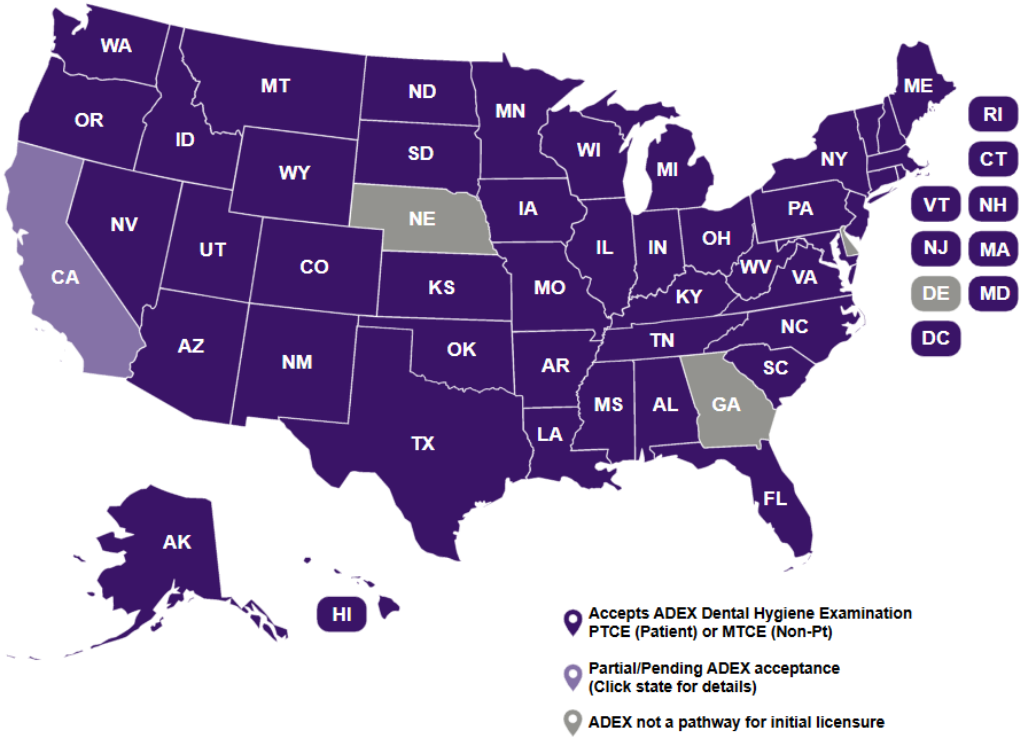
The ADEX dental examination consists of three portions: a computer-based examination, simulated clinical examinations, and clinical examinations on live patients.[12] The simulated clinical examinations assesses skills related to endodontics and fixed prosthodontics. The clinical examinations on live patients assesses skills related to restorative and periodontal procedures. As of December 2021, only four states require live patient-based examinations: Florida, Nevada, Oklahoma, and Wyoming.[13]

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[8] S. 466.017(5), F.S.
[9] American Board of Dental Examiners, Inc., *About ADEX*, https://adexexams.org/about-adex/ (last visited Dec. 22, 2021).
[10] CDCA/WREB, *2021 ADEX Acceptance Map*, https://www.cdcaexams.org/adex-acceptance-map/ (last visited Dec. 22, 2021).
[11] Commission on Dental Competency Assessments (CDCA), *Registration and DSE OSCE Manual: 2021 ADEX Dental Examination Series*, https://www.cdcaexams.org/wp-content/uploads/2021/03/Dental_DSE_OSCE2021-2.pdf (last visited Dec. 22, 2021).The cost of the ADEX dental examinations is $2,295; however, additional fees may be assessed, such as a facility or score report fee. The fee is reduced for partial exams and retakes. *See* CDCA, *Dental (ADEX)*, https://www.cdcaexams.org/dental-exams/ (last visited Dec. 22, 2021).
[12] CDCA, *supra* note 11, at 4. The simulated clinical examinations assesses skills related to endodontics and fixed prosthodontics. The clinical examinations on live patients assesses skills related to restorative and periodontal procedures.
[13] Email from Andrew Love, Director of Legislative Affairs, Florida Department of Health, RE: HB 517 Data Inquiry, regarding states that require live patient ADEX examinations (Dec. 22, 2021).

As with the dental examination, CDCA and CITA administer the ADEX dental hygiene examination.[14] The ADEX dental hygiene examination consists of two portions: a computer-simulated examination and a clinical examination on live patients.[15] The computer-simulated examination assesses various levels of diagnosis and treatment planning knowledge, skills, and abilities. The clinical examinations on live patients evaluates the applicants ability to detect and remove calculus, measure periodontal pocket depths, and present the case for evaluation of calculus removal and soft and/or hard tissue damage.[16] Only nine states require live patient-based examinations: Alaska, Florida, Idaho, Missouri, Nevada, New Mexico, Oklahoma, Utah, and Wyoming.[17]

The ADEX examination is widely used: 47 states accept the ADEX for dental hygiene licensure.[18]



The DOH contracts with the CDCA to administer the ADEX examinations, as well as the jurisprudence examinations.[19] In Fiscal Year 2020-2021, 1,196 dentists and 1,392 dental hygienists applied to the take the ADEX examinations.[20]

In April 2020, the ADEX approved the use of CompeDont™ DTX, a new manikin tooth technology developed by the CDCA[21] that allows dental licensure candidates to choose a non-patient-based restorative examination option to demonstrate readiness for practice. The CompeDont™ accurately represents infected, affected and sclerotic dentin.[22] According to CDCA Director of Examinations, Dr. Ellis Hall, "[b]oth examiners and students reported that the tooth mimics decay, stickiness and tug-back and can be restored as if it were a natural tooth in this way."[23] The CompeDont™'s new technology

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[14] CDCA, *Candidate Registration and CSCE OSCE Manual: 2021 ADEX Dental Hygiene Examination*, available at https://www.cdcaexams.org/documents/manuals/Dental_Hygiene_Candidate_Registration2021.pdf (last visited Dec. 22, 2021). The cost of the ADEX dental hygiene examinations is $995; however, additional fees may be assessed, such as a facility or score report fee. *See* CDCA, *Dental Hygiene (ADEX)*, https://www.cdcaexams.org/dental-hygiene-adex-exam/ (last visited Dec. 22, 2021).
[15] *Id.*
[16] DOH, *2022 Agency Legislative Bill Analysis for HB 517*, p. 2 (Nov. 19, 2021).
[17] Email, supra note 13.
[18] CDCA, *supra* note 10.
[19] DOH, *2021 Agency Legislative Bill Analysis for HB 497*, p. 3 (Feb. 24, 2021).
[20] DOH, *2022 Agency Legislative Bill Analysis for HB 517*, p. 3 (Nov. 19, 2021).
[21] The CDCA partnered with Acadental, Inc. for the development and production of the CompeDont™ DTX. See, CDCA, *ADEX Approves CompeDont(TM) Non-Patient Based Exam Alternative*, https://www.cdcaexams.org/adex-approves-compedont/ (last visited Jan. 11, 2022).
[22] *Id.*
[23] *Id.*

provides an option to many state dental boards seeking to address public health concerns in the wake of COVID-19 without reducing existing licensure standards.[24]

In response to the COVID-19 pandemic, on March 31, 2021, the State Surgeon General issued Emergency Order 21-001, which suspended the prohibition against the use of manikins or simulated patients in lieu of live patients during the administration of the ADEX examinations. This expired on June 30, 2021.

Malpractice Insurance

Under current law, dental students must possess medical malpractice insurance to take the licensure examinations.[25] Additionally, the Board of Dentistry may require dental and dental hygiene applicants to maintain medical malpractice insurance to cover any harmful incident to a patient during the clinical examination.[26] The CDCA has a blanket malpractice insurance policy that covers all dental and dental hygiene applicants for ADEX examinations.[27] This means that applicants are not required to obtain additional insurance.[28]

Patient Care

Under current law, dental schools must ensure that a student's academic record does not include any evidence that the student poses an unreasonable risk to a patient during the clinical examination.[29] The schools must inform patients in writing of their right to follow-up dental care before the examination and also make arrangements for patients who require follow-up care as a result of performed procedures.[30]

Effect of Proposed Changes

Dentistry

HB 517 requires the use of the CompeDont DTX manufactured tooth for the restorative and periodontal skills portions on the dental clinical examination and for the dental hygiene clinical examination. This eliminates the requirement for dental and dental hygienist applicants to perform clinical examination components on a live patient.

The bill also removes the following provisions that are unnecessary because the examination is no longer on live patients:

- The requirement for dental students to obtain, and the Board of Dentistry's authority to require, specified medical malpractice insurance;
- The requirement for dental schools to make arrangements for patients who require follow-up dental care as a result of procedures performed during the clinical examination; and
- The requirement that dental schools ensure that a student's academic record does not include any evidence that the student poses an unreasonable risk to a patient during the clinical examination.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amends s. 466.006, F.S., relating to examination of dentists.
Section 2: Amends s. 466.0065, F.S., relating to regional licensure examinations.
Section 3: Amends s. 466.007, F.S., relating to examination of dental hygienists.

[24] *Id. See* statement of CDCA Chair, Dr. Harvey Weingarten.
[25] S. 466.0065 (c), F.S.
[26] S. 466.0075, F.S.
[27] DOH, 2022 Agency Legislative Bill Analysis for HB 517, p. 3 (Nov. 19, 2021).
[28] *Id*.
[29] S. 466.0065 (j), F.S.
[30] S. 466.0065 (e). F.S.

Section 4: Repeals s. 466.0075. F.S., relating to applicants for examination; medical malpractice insurance.
Section 5: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The DOH will incur non-recurring costs for rulemaking, which current resources can absorb.[31]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Board of Dentistry has sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

[31] DOH, 2022 Agency Legislative Bill Analysis for HB 517, p. 4 (Nov. 19, 2021).

A bill to be entitled

An act relating to dentistry and dental hygiene examinations; amending ss. 466.006 and 466.007, F.S.; authorizing the use of a specified nonpatient dental device during a licensure examination of a dentist or dental hygienist in lieu of a live patient; amending s. 466.0065, F.S.; conforming provisions to changes made by the act; repealing s. 466.0075, F.S., relating to required medical malpractice insurance for applicants for examination; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (5) of section 466.006, Florida Statutes, is amended to read:

466.006 Examination of dentists.—

(5)(a) The practical examination required under subsection (4) shall be the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., or its successor entity, if any, provided the board finds that the successor entity's clinical examination complies with the provisions of this section, and shall include, at a minimum:

1. A comprehensive diagnostic skills examination covering the full scope of dentistry and an examination on applied

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

clinical diagnosis and treatment planning in dentistry for dental candidates.~~;~~

2. Two restorations using the CompeDont DTX manufactured tooth approved by the Commission on Dental Competency Assessments ~~on a live patient or patients~~. The board by rule shall determine the class of such restorations.~~;~~

3. A demonstration of periodontal skills using the CompeDont DTX manufactured tooth approved by the Commission on Dental Competency Assessments. ~~on a live patient;~~

4. A demonstration of prosthetics and restorative skills in complete and partial dentures and crowns and bridges and the utilization of practical methods of evaluation, specifically including the evaluation by the candidate of completed laboratory products such as, but not limited to, crowns and inlays filled to prepared model teeth.~~;~~

5. A demonstration of restorative skills on a manikin ~~mannequin~~ which requires the candidate to complete procedures performed in preparation for a cast restoration.~~;~~

6. A demonstration of endodontic skills.~~; and~~

7. A diagnostic skills examination demonstrating ability to diagnose conditions within the human oral cavity and its adjacent tissues and structures from photographs, slides, radiographs, or models pursuant to rules of the board. If an applicant fails to pass the diagnostic skills examination in three attempts, the applicant shall not be eligible for

reexamination unless she or he completes additional educational requirements established by the board.

The department shall require a mandatory standardization exercise for all examiners prior to each practical or clinical examination and shall retain for employment only those dentists who have substantially adhered to the standard of grading established at such exercise.

Section 2. Subsection (2) of section 466.0065, Florida Statutes, is amended to read:

466.0065 Regional licensure examinations.—

(2) Each school of dentistry in this state which is accredited by the Commission on Accreditation of the American Dental Association or its successor agency may, upon written approval by the Board of Dentistry, offer regional licensure examinations only to dental students in the final year of a program at an approved dental school, if the board has approved the hosting school's written plan to comply with the following conditions:

(a) A member of the regional examination body's board of directors or equivalent thereof must be a member of the American Association of Dental Examiners.

(b) The student must have successfully passed parts I and II of the National Board of Dental Examiners examination within 2 years before taking the regional examination.

~~(c) The student must possess medical malpractice insurance in amounts not less than the amounts required to take the Florida licensure examinations.~~

(d) At least one of the examination monitors must be a dentist licensed in this state who has completed all necessary standardization exercises required by the regional examination body. Recruitment of examination monitors is the responsibility of the regional examination body.

~~(e) Adequate arrangements, as defined by the regional examination body and as otherwise required by law, must be made, when necessary, for patients who require followup care as a result of procedures performed during the clinical portion of the regional examination. The regional examination body must inform patients in writing of their right to followup care in advance of any procedures performed by a student.~~

(f) The board chair or the chair's designee must be allowed to observe testing while it is in progress.

(g) Each student, upon being deemed eligible by the dental school to apply to the regional examination body to take the regional examination, must receive written disclosure in at least 12-point boldface type that states: "This examination does not meet the licensure requirements of chapter 466, Florida Statutes, for licensure in the State of Florida. Persons wishing to practice dentistry in Florida must pass the Florida licensure examinations."

(h) The student must be enrolled as a dental student in the student's final year of a program at an approved dental school that is accredited by the Commission on Accreditation of the American Dental Association or its successor agency.

(i) The student must have completed all coursework deemed necessary by the dental school to prepare the student to perform all clinical and diagnostic procedures required to pass the regional examination.

~~(j) The student's academic record must not include any evidence suggesting that the student poses an unreasonable risk to any live patients who are required for the clinical portion of the regional examination. In order to protect the health and safety of the public, the dental school may request additional information and documents pertaining to the candidate's mental and physical health in order to fully assess the candidate's fitness to engage in exercises involving a live patient.~~

Section 3. Subsection (4) of section 466.007, Florida Statutes, is amended to read:

466.007 Examination of dental hygienists.—

(4) Effective July 1, 2012, to be licensed as a dental hygienist in this state, an applicant must successfully complete the following:

(a) A written examination on the laws and rules of this state regulating the practice of dental hygiene.

(b) A practical or clinical examination approved by the

board. The examination shall be the Dental Hygiene Examination produced by the American Board of Dental Examiners, Inc., (ADEX) or its successor entity, if any, if the board finds that the successor entity's clinical examination meets or exceeds the provisions of this section. The board shall approve the ADEX Dental Hygiene Examination if the board has attained and continues to maintain representation on the ADEX House of Representatives, the ADEX Dental Hygiene Examination Development Committee, and such other ADEX Dental Hygiene committees as the board deems appropriate through rulemaking to ensure that the standards established in this section are maintained organizationally. The ADEX Dental Hygiene Examination or the examination produced by its successor entity is a comprehensive examination in which an applicant must demonstrate skills within the dental hygiene scope of practice using the CompeDont DTX manufactured tooth approved by the Commission on Dental Competency Assessments ~~on a live patient~~ and any other components that the board deems necessary for the applicant to successfully demonstrate competency for the purpose of licensure.

Section 4. Section 466.0075, Florida Statutes, is repealed.

Section 5. This act shall take effect July 1, 2022.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee

Representative Sirois offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (a) of subsection (5) of section 466.006, Florida Statutes, is amended to read:

466.006 Examination of dentists.—

(5)(a) The practical examination required under subsection (4) is ~~shall be~~ the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc., or its successor entity, if any, provided the board finds that the successor entity's clinical examination complies with the provisions of this section, and must ~~shall~~ include, at a minimum:

1. A comprehensive diagnostic skills examination covering the full scope of dentistry and an examination on applied clinical diagnosis and treatment planning in dentistry for dental candidates;

2. Two restorations on a manikin that has typodont teeth with simulated caries as approved by the Commission on Dental Competency Assessments ~~live patient or patients~~. The board by rule shall determine the class of such restorations;

3. A demonstration of periodontal skills on a manikin that has typodont teeth with simulated calculus as approved by the Commission on Dental Competency Assessments ~~live patient~~;

4. A demonstration of prosthetics and restorative skills in complete and partial dentures and crowns and bridges and the utilization of practical methods of evaluation, specifically including the evaluation by the candidate of completed laboratory products such as, but not limited to, crowns and inlays filled to prepared model teeth;

5. A demonstration of restorative skills on a manikin ~~mannequin~~ which requires the candidate to complete procedures performed in preparation for a cast restoration;

6. A demonstration of endodontic skills; and

7. A diagnostic skills examination demonstrating ability to diagnose conditions within the human oral cavity and its adjacent tissues and structures from photographs, slides, radiographs, or models pursuant to rules of the board. If an

applicant fails to pass the diagnostic skills examination in three attempts, the applicant is ~~shall~~ not ~~be~~ eligible for reexamination unless she or he completes additional educational requirements established by the board.

The department shall require a mandatory standardization exercise for all examiners prior to each practical or clinical examination and shall retain for employment only those dentists who have substantially adhered to the standard of grading established at such exercise.

Section 2. Paragraphs (c), (e), and (j) of subsection (2) of section 466.0065, Florida Statutes, are amended to read:

466.0065 Regional licensure examinations.—

(2) Each school of dentistry in this state which is accredited by the Commission on Accreditation of the American Dental Association or its successor agency may, upon written approval by the Board of Dentistry, offer regional licensure examinations only to dental students in the final year of a program at an approved dental school, if the board has approved the hosting school's written plan to comply with the following conditions:

~~(c) The student must possess medical malpractice insurance in amounts not less than the amounts required to take the Florida licensure examinations.~~

~~(e) Adequate arrangements, as defined by the regional examination body and as otherwise required by law, must be made, when necessary, for patients who require followup care as a result of procedures performed during the clinical portion of the regional examination. The regional examination body must inform patients in writing of their right to followup care in advance of any procedures performed by a student.~~

~~(j) The student's academic record must not include any evidence suggesting that the student poses an unreasonable risk to any live patients who are required for the clinical portion of the regional examination. In order to protect the health and safety of the public, the dental school may request additional information and documents pertaining to the candidate's mental and physical health in order to fully assess the candidate's fitness to engage in exercises involving a live patient.~~

Section 3. Paragraph (b) of subsection (4) of section 466.007, Florida Statutes, is amended to read:

466.007 Examination of dental hygienists.—

(4) Effective July 1, 2012, to be licensed as a dental hygienist in this state, an applicant must successfully complete the following:

(b) A practical or clinical examination approved by the board. The examination shall be the Dental Hygiene Examination produced by the American Board of Dental Examiners, Inc., (ADEX) or its successor entity, if any, if the board finds that the

successor entity's clinical examination meets or exceeds the provisions of this section. The board shall approve the ADEX Dental Hygiene Examination if the board has attained and continues to maintain representation on the ADEX House of Representatives, the ADEX Dental Hygiene Examination Development Committee, and such other ADEX Dental Hygiene committees as the board deems appropriate through rulemaking to ensure that the standards established in this section are maintained organizationally. The ADEX Dental Hygiene Examination or the examination produced by its successor entity is a comprehensive examination in which an applicant must demonstrate skills within the dental hygiene scope of practice on a manikin that has typodont teeth with simulated dentition and calculus as approved by the Commission on Dental Competency Assessments ~~live patient~~ and any other components that the board deems necessary for the applicant to successfully demonstrate competency for the purpose of licensure.

Section 4. Section 466.0075, Florida Statutes, is repealed.

Section 5. This act shall take effect July 1, 2022.

T I T L E A M E N D M E N T

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to licensure examinations for dental practitioners; amending s. 466.006, F.S.; revising licensure examination requirements for dentists to require applicants to demonstrate certain clinical skills on a manikin rather than a live patient; amending s. 466.0065, F.S.; revising requirements for regional licensure examinations offered by dental schools to dental students; amending s. 466.007, F.S.; revising licensure examination requirements for dental hygienists to require applicants to demonstrate certain clinical skills on a manikin rather than a live patient; repealing s. 466.0075, F.S., relating to a requirement that applicants for dental practitioner licensure examinations maintain medical malpractice insurance to cover any incident of harm to a patient during the clinical examination; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 559 Occupational Licensure of Military Spouses
SPONSOR(S): Regulatory Reform Subcommittee, Hunschofsky and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 562

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Regulatory Reform Subcommittee	17 Y, 0 N, As CS	Thompson	Anstead
2) Professions & Public Health Subcommittee		Rahming	McElroy
3) Appropriations Committee			
4) Commerce Committee			

SUMMARY ANALYSIS

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners in Florida. The MQA works in conjunction with 22 boards and four councils to license and regulate ten types of health care facilities and more than 200 licenses in over 40 health care professions. Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.

DOH provides expedited health care professional licensing to applicants who are a spouse or surviving spouse of a U.S. Armed Forces active duty member through the Florida Veterans Application for Licensure Online Response System (VALOR). Veterans and spouses who apply through the VALOR process receive a waiver of most licensing fees. In Florida, spouses of active duty members are authorized to receive a temporary license to practice certain health care professions upon submission of specified information and a $65 licensure application fee.

The bill makes several revisions to temporary licensure requirements for the spouse of an active duty member. The bill:

- Requires DOH to issue a full professional license, rather than a temporary license, to applicants who satisfy submission requirements;
- Requires the board, or DOH if there is no board, to expedite all applications submitted by an active duty member's spouse and issue him or her a temporary professional license that is valid for the duration of the application review process under specified conditions;
- Allows military spouse licensees to renew the license, which is prohibited under current law; and
- Requires DOH to waive the $65 application fee.

The bill will likely have an insignificant, negative fiscal impact on DOH and has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Licensure of Health Care Practitioners

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners in Florida.[1] The MQA works in conjunction with 22 boards and four councils to license and regulate ten types of health care facilities and more than 200 licenses in over 40 health care professions.[2] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.

Military and Veteran Licensure

Florida offers expedited licensing and fee waivers to a person who serves or has served as a health care practitioner[3] in the United States Armed Forces, United States Reserve Forces, or the National Guard[4]. To qualify for the expedited licensure and fee waivers, the person must have actively practiced the profession for which he or she is applying during the preceding 3 years and must:[5]

- Submit a complete application;
- Submit proof that he or she has received an honorable discharge within 6 months before, or will receive an honorable discharge within 6 months after, the date of submission of the application;
- Submit proof that he or she holds an active, unencumbered license issued by another state, the District of Columbia, or a possession or territory of the United States and who has not had disciplinary action taken against him or her in the 5 years preceding the date of submission of the application;
- Attest that he or she is not, at the time of submission of the application, the subject of a disciplinary proceeding in a jurisdiction in which he or she holds a license or by the U.S. Department of Defense for reasons related to the practice of the profession for which he or she is applying; and
- Submit a set of fingerprints for a background screening, if required for the profession for which he or she is applying.

DOH is required to develop an application form,[6] and each board, or DOH if there is no board, is required to waive the application fee, licensure fee, and unlicensed activity fee for such applicants.[7]

Military Spouse Temporary Licensure

[1] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[2] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2020-2021*, http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1617.pdf (last visited Jan. 3, 2022).
[3] Health care practitioner means a health care practitioner as defined in s. 456.001, F.S., and a person licensed under part III of ch. 401, F.S., or part IV of ch. 468, F.S.
[4] Includes the United States Army, Navy, Air Force, Marine Corps, and Coast Guard. 10 U.S.C. § 101(a)(4).
[5] S. 456.024(3)(b), F.S.
[6] R. 64B-9.003, F.A.C.
[7] S. 456.024(3)(a), F.S.

Each board, or DOH if there is no board, is also authorized to issue temporary licenses to military spouses to practice his or her health care profession in Florida.[8] A temporary license is valid for one year and is not renewable.[9] To be eligible for a temporary license, a military spouse must:[10]

- Submit a completed application and a $65 application fee;[11]
- Provide proof that he or she is married to an active duty member of the U.S. Armed Forces assigned to a duty station in Florida pursuant to official military orders;
- Provide proof of a valid license from another state or jurisdiction to practice the health profession for which he or she is applying and that such license is not subject to any disciplinary proceeding;
- Provide proof that he or she would otherwise be entitled to full licensure and is eligible to take the respective licensure examination as required in this state; and
- Pass a criminal background screening.

DOH provides expedited health care professional licensing to honorably discharged veterans and their spouses through the Florida Veterans Application for Licensure Online Response System (VALOR).[12] Veterans and spouses who apply through the VALOR process receive a waiver of most licensing fees.[13]

Since its inception in 2016, there have been approximately 1,669 health care licensure applications submitted by and approved for active duty service members, military veterans, and their spouses through the VALOR expedited licensing process. There were 352 applications approved for health care licensure of military spouses and honorably discharged veterans in FY 2020-2021, which accounted for approximately 1.38% of all DOH issued licenses during this time period.[14]

Effect of Proposed Changes

The bill makes several revisions to temporary licensure requirements for the spouse of an active duty member. The bill:

- Requires DOH to issue a full professional license, rather than a temporary license, to applicants who satisfy submission requirements;
- Requires the board, or DOH if there is no board, to expedite all applications submitted by an active duty member's spouse and issue him or her a temporary professional license that is valid for the duration of the application review process under specified conditions;
- Allows military spouse licensees to renew the license, which is prohibited under current law; and
- Requires DOH to waive the $65 application fee.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.024, F.S., relating to members of Armed Forces in good standing with administrative boards or the department; spouses; licensure.
Section 2: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[8] S. 456.024(4), F.S.
[9] S. 456.024(4)(f), F.S.
[10] S. 456.024(4)(a)-(d), F.S.
[11] R. 64B-4.007, F.A.C.
[12] DOH operates the Veterans Application for Licensure Online Response System (VALOR) to provide expedited licensing for active duty military members, honorably discharged veterans, and spouses of active duty military members with an active license in another state. *See* http://www.flhealthsource.gov/valor (last visited Jan. 4, 2021).
[13] Florida Department of Health, Agency Analysis of 2022 HB 559, p. 2 (12/14/2021).
[14] *Id.*

1. Revenues:

   The Division of Medical Quality Assurance will experience a recurring loss of revenue with implementation of the bill, but anticipates that any reduction in licensing fees will have an insignificant impact on their trust fund.[15]

2. Expenditures:

   DOH will incur costs associated with implementing the bill, which current resources are adequate to absorb. [16]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill removes the $65 DOH licensure fee for a spouse of a U.S. Armed Force active duty member.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Current law provides sufficient rulemaking authority for DOH to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 12, 2021, the Regulatory Reform Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The committee substitute removed provisions related to the Department of Business and Professional Regulation from the bill.

[15] Florida Department of Health, Agency Analysis of 2022 HB 559, p. 4 (12/14/2021).
[16] *Id*.

A bill to be entitled

An act relating to occupational licensure of military spouses; amending s. 456.024, F.S.; requiring the Department of Health or the applicable board to issue a professional license to spouses of active duty members of the Armed Forces of the United States if certain requirements are met; requiring the department to waive the application fee for such license applications; authorizing applicants issued such licenses to renew their licenses if certain requirements are met; providing construction; requiring the department or applicable board to expedite applications for such licenses; requiring the department or applicable board to issue a temporary professional license under certain circumstances; conforming provisions to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraphs (a), (c), (e), (f), (g), (h), and (i) of subsection (4) of section 456.024, Florida Statutes, are amended, and paragraph (j) is added to that subsection, to read:

456.024 Members of Armed Forces in good standing with administrative boards or the department; spouses; licensure.—

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

(4)(a) The board, or the department if there is no board, shall ~~may~~ issue a ~~temporary~~ professional license to the spouse of an active duty member of the Armed Forces of the United States who submits to the department:

1. A completed application upon a form prepared and furnished by the department in accordance with the board's rules;

2. ~~The required application fee;~~

~~3.~~ Proof that the applicant is married to a member of the Armed Forces of the United States who is on active duty;

3.~~4.~~ Proof that the applicant holds a valid license for the profession issued by another state, the District of Columbia, or a possession or territory of the United States, and is not the subject of any disciplinary proceeding in any jurisdiction in which the applicant holds a license to practice a profession regulated by this chapter;

4.~~5.~~ Proof that the applicant's spouse is assigned to a duty station in this state pursuant to the member's official active duty military orders; and

5.~~6.~~ Proof that the applicant would otherwise be entitled to full licensure under the appropriate practice act, and is eligible to take the respective licensure examination as required in Florida.

(c) Each board, or the department if there is no board, shall review the results of the state and federal criminal

history checks according to the level 2 screening standards in s. 435.04 when granting an exemption and when granting or denying the ~~temporary~~ license.

(e) The department shall waive the applicant's licensure ~~set an~~ application fee~~, which may not exceed the cost of issuing the license~~.

(f) An applicant issued a license under this subsection may renew such license upon completion of the conditions for renewal required of licenseholders under the applicable practice act, including, without limitation, continuing education requirements. This paragraph does not limit waiver of initial licensure requirements under this subsection ~~A temporary license expires 12 months after the date of issuance and is not renewable~~.

(g) An applicant for a ~~temporary~~ license under this subsection is subject to the requirements under s. 456.013(3)(a) and (c).

(h) An applicant shall be deemed ineligible for a ~~temporary~~ license pursuant to this section if the applicant:

1. Has been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;

2. Has had a health care provider license revoked or suspended from another of the United States, the District of Columbia, or a United States territory;

3. Has been reported to the National Practitioner Data Bank, unless the applicant has successfully appealed to have his or her name removed from the data bank; or

4. Has previously failed the Florida examination required to receive a license to practice the profession for which the applicant is seeking a license.

(i) The board, or the department if there is no board, may revoke a ~~temporary~~ license upon finding that the individual violated the profession's governing practice act.

(j) The board, or the department if there is no board, shall:

1. Expedite all applications submitted by a spouse of an active duty member of the Armed Forces of the United States pursuant to this section; and

2. Issue a temporary professional license valid for the duration of the application review process to such spouse once the board or department verifies the information provided by the spouse pursuant to paragraph (a) is accurate.

Section 2. This act shall take effect July 1, 2022.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	___ (Y/N)
ADOPTED AS AMENDED	___ (Y/N)
ADOPTED W/O OBJECTION	___ (Y/N)
FAILED TO ADOPT	___ (Y/N)
WITHDRAWN	___ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee

Representative Hunschofsky offered the following:

Amendment (with title amendment)

Remove lines 85-93 and insert:

(j) The board, or the department if there is no board, shall expedite all applications submitted by a spouse of an active duty member of the Armed Forces of the United States pursuant to this section and that satisfy the requirements of paragraph (a).

T I T L E A M E N D M E N T

Remove lines 13-15 and insert:

expedite applications for such licenses;

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 693 Department of Health
SPONSOR(S): Professions & Public Health Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Professions & Public Health Subcommittee		Morris	McElroy

SUMMARY ANALYSIS

PCS for HB 693 makes numerous changes to programs under the Department of Health (DOH) and health care professions regulated by the Division of Medical Quality Assurance (MQA) within DOH.

DOH administers the Targeted Outreach for Pregnant Women Act (TOPWA) Program which supports high risk pregnant women to prevent heath issues for themselves and their newborns. The bill updates the TOPWA to account for current medication options, information on HIV, and mental health issues that may lead to a pregnancy being high risk.

DOH is responsible for ensuring medical marijuana products are safe for human consumption and meet THC and CBD potency and labeling requirements. The bill requires medical marijuana treatment centers to recall all marijuana that fails to meet the safety and potency requirements, authorizes DOH to test samples of all forms of marijuana from MMTCs, and immunizes DOH staff from prosecution for possessing marijuana for this purpose.

MQA regulates health care practitioners in this state. MQA works in conjunction with 22 boards and 4 councils to license and regulate 7 types of health facilities and 40 health care professions. Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory authority and licensure authority for MQA. The bill:

- Updates institutional accreditation references for chiropractic medicine, clinical laboratory personnel, and mental clinical social workers and marriage and family therapists;
- Authorizes DOH to deny a nursing application or discipline a nurse licensed under ch. 464, F.S. under certain circumstances;
- Removes obsolete references to DOH-issued licensure examinations for clinical social workers and marriage and family therapists;
- Revises education, training, and temporary certification requirement for midwives;
- Removes obsolete form and fee requirements for fingerprinting of orthotists and prosthetists;
- Revises educational requirements for psychologists applying for licensure by endorsement; and
- Allows DOH to continue to issue licenses to marriage and family therapy graduates until July 1, 2026, while such programs seek accreditation.

The Florida Birth-Related Neurological Injury Compensation Association (NICA) is an independent association created by the Legislature to manage the Florida Birth-Related Neurological Injury Compensation Plan (Plan). The Plan pays for the care of infants born with certain neurological injuries. NICA is authorized by law to collect annual assessments from physicians to finance the Plan, though many physicians are delinquent on payments. The bill requires allopathic and osteopathic physicians to provide proof of payment of NICA assessments as a condition of licensure.

Current law establishes DOH as the lead agency for coordination of staffing special needs shelters during an emergency or disaster. DOH's Division of Children's Medical Services (CMS) is specifically charged with carrying out such duties, though programmatic and organizational changes within CMS in recent years has impacted the ability of CMS to effectively do so. The bill designates DOH, rather than CMS specifically, as the lead for the coordination of local medical and health care providers in developing a plan for the staffing and medical management of pediatric special needs shelters. Additionally, the bill requires DOH to determine who is responsible for the medical supervision of each special needs shelter.

The bill has an insignificant, negative fiscal impact on DOH, which current resources are adequate to absorb. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Targeted Outreach for Pregnant Women

Current Situation

The Targeted Outreach for Pregnant Women Act (TOPWA) supports targeted outreach programs that aim to prevent vertical HIV transmission and other health issues by linking high-risk pregnant women with services that can help them have healthier pregnancies and deliveries and can aid them in ensuring their newborn gets a healthy start.[1] TOPWA programs aim to provide outreach and linkage services to pregnant women who may not seek proper prenatal care, who suffer from substance-use disorders, or who are living with HIV or are at increased risk for HIV acquisition.

In 2021, there were eight funded TOPWA programs in Florida. TOPWA programs provided services to 7,292 women from January 2018 to December 2021. Black women represented 49 percent of enrollees, Hispanic women represented 40 percent, and white women represented 8 percent. Women living with HIV made up just over 9 percent of TOPW enrollments.[2]

If a pregnant woman tests positive for HIV, medical interventions like antiretroviral (ARV) medication and delivery by caesarian section can greatly reduce her risk of transmitting the virus to her baby during childbirth. Prevention methods, like avoiding breastfeeding, can reduce her risk of transmitting the virus to her child post childbirth. Providing ARV medication to the newborn also decreases the chances of seroconversion in the event of an HIV-exposed birth. DOH has developed a program, Baby Rxpress, which provides a six-week course of ARV medication to HIV-exposed newborns at no cost to the mother. In 2021, this program filled 330 prescriptions to 232 HIV-exposed newborns.[3]

Many of the women targeted by TOPWA programs would not otherwise receive prenatal care or know their HIV status. In 2020, there were 439 HIV-exposed births in Florida and four reported cases of perinatal HIV transmission. TOPWA programs aim to engage women into care who very likely do not already have knowledge of or access to these interventions. Without these types of interventions, a mother's chances of transmitting HIV to her newborn can be up to 45 percent. With these interventions, the chances of transmission are less than 2 percent.[4]

Effect of Proposed Changes – Targeted Outreach for Pregnant Women

The bill adds pregnant women who are suffering from mental health problems to the list of outreach targets. It also includes mental health services as a linkage option.

The bill revises the duties of DOH's administration of the TOPWA and the information and services DOH provides to the women it serves. The bill requires DOH to encourage high-risk pregnant women to be tested for other sexually transmitted diseases, in addition to HIV, as specified by rule. The bill requires DOH to give pregnant women who have HIV information on the need for ARV medication for their newborn, their medication options, and how to access medication after hospital discharge. The bill removes a reference to a specific type of ARV medication DOH may provide information on and incorporates more general information on ARV medications, allowing for additional options. The bill requires DOH to educate pregnant women who have HIV on the importance of engaging in and continuing HIV care. Lastly, the bill requires DOH to conduct additional follow up for HIV-exposed newborns to ensure final HIV status is known and necessary linkages to care are made.

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[1] Department of Health, *Targeted Outreach for Pregnant Women Act,* http://stlucie.floridahealth.gov/programs-and-services/infectious-disease-services/hiv-aids/topwa.html (last visited Jan. 20, 2022).
[2] Email from Gangul Gabadage, Legislative Planning Coordinator, Department of Health, TOPWA Numbers (Jan. 24, 2022).
[3] Id.
[4] Id.

Institutional Accreditation

Current Situation

Accreditation is the recognition from an accrediting agency that an institution maintains a certain level of educational standards. Institutional accreditation normally applies to an entire institution and indicates that each entity of a school contributes to the achievement of the school's objectives. This does not necessarily mean that all parts of the school have the same quality level of education.[5]

Accrediting agencies issue accreditations.[6] Institutions or programs that request an agency's evaluation and that meet an agency's criteria are then accredited by that agency.[7] Accrediting agencies are organizations made up of educational professionals that:[8]

- Establish the operating standards for educational or professional institutions and programs;
- Determine if a school meets those standards; and
- Publically announce their findings through the issuance of accreditations.

While the United States Department of Education (DOE) does not issue accreditations, it does hold agencies accountable by ensuring that such agencies enforce their accreditation standards effectively. As part of DOE oversight, the Secretary of Education is required by law to publish a list of nationally recognized accrediting agencies that the Secretary determines to be reliable authorities as to the quality of education or training provided by the institutions of higher education and the higher education programs they accredit.[9]

The DOE issued finalized regulations in the Federal Register in October 2019 relating to institutional accrediting agencies.[10] DOE issued a letter of guidance on February 26, 2020, specifying that final regulations omit references to "regional" and "national" accreditation.[11] The letter specifies, "[b]ecause the Department holds all accrediting agencies to the same standards, distinctions between regional and national accrediting agencies are unfounded." Provisions implemented in 34 C.F.R. § 602.32(d), relating to the recognition of accrediting agencies, became effective January 1, 2021.

However, the education requirements in current Florida law distinguish regional from institutional accrediting agencies for chiropractic medicine, clinical laboratory directors, and orthotists and prosthetists, which does not align with the federal guidance.

[5] U.S. Department of Homeland Security – Study in the States, *The Basics of School Accreditation,* https://studyinthestates.dhs.gov/the-basics-of-school-accreditation (last visited Jan. 20, 2022).
[6] Id. *See also* U.S. Department of Education, *Database of Accredited Postsecondary Institutions and Programs,* https://ope.ed.gov/dapip/#/home (last visited March 20, 2021).
[7] U.S. Department of Education, *Database of Accredited Postsecondary Institutions and Programs,* https://ope.ed.gov/dapip/#/home (last visited Jan. 20, 2022).
[8] *Supra,* note 5.
[9] *Supra,* note 7.
[10] 84 C.F.R § 58834 (2020). The new regulations delayed implementation of changes to DOE staff's review of accrediting agency applications for initial or renewal of recognition under 34 C.R.R. § 602.32(d) until January 1, 2021. The new regulations also delayed implementation of changes to DOE staff's process for responding to accrediting agency applications and allowing agency responses within 180 days under 34 C.F.R. § 602.32(h) until July 1, 2021.
[11] U.S. Department of Education, Re: Final Accreditation and State Authorization Regulations (February 26, 2021) https://sacscoc.org/app/uploads/2020/03/State-Authorization-Letter-w-Diane-Signature-2.26.19.pdf (last visited Jan. 20, 2022).

Effect of Proposed Changes – Institutional Accreditation

The bill removes all references to "regional" accreditation in the practice acts for chiropractic medicine, clinical laboratory directors, orthotists and prosthetists, clinical social workers, and marriage and family therapists. The bill replaces the references with "institutional" accreditation throughout.

Nursing

Current Situation

The Board of Nursing (Board) within DOH, oversees the licensure and regulation of certified nursing assistants (CNA), licensed practical nurses (LPN), registered nurses (RN), and advanced practice registered nurses (APRN). The Board has the authority to adopt rules to implement ch. 464, F.S., which regulates the practice of nursing in this state.[12] Additionally, the Board is responsible for administratively disciplining a CNA, LPN, RN, and APRN who commits an act prohibited under s. 464.018 or s. 456.072, F.S.

Current law specifies that being found guilty of any offense prohibited by s. 435.04, F.S., or an act of domestic violence, regardless of adjudication, or entering a plea of nolo contendere or guilty to, is ground for denial of a nursing license application or disciplinary action against a nursing licensee.[13] However, entering a guilty plea, or pleading nolo contendere, to these crimes is only grounds for licensure denial if there is a conviction. Other practice acts authorize license denial and discipline for pleading guilty or nolo contendere regardless of adjudication.[14]

Effect of Proposed Changes – Nursing

The bill moves "regardless of adjudication" after "or entered a plea of nolo contendere or guilty to" which allows DOH to deny a nursing licensure application or discipline a licensed CNA, LPN, RN, or APRN who is found guilty of, or pleads guilty or no contest to an offense prohibited in ch. 435, F.S., or domestic violence under s. 741.28, F.S.

Midwifery

Current Situation

Chapter 467, F.S., is the practice act for midwifery (Act). DOH licenses and regulates the practice of midwifery in this state. Midwifery is the practice of supervising a normal labor and childbirth, with the informed consent of the parent, advising the parents as to the progress of childbirth, and rendering prenatal and postpartal care.[15] The Council of Licensed Midwifery assists and advises DOH on midwifery, including the development of rules relating to regulatory requirements. These regulations include training requirements, the licensure examination, responsibilities of midwives, emergency care plans, and reports and records to be filed by licensed midwives.[16]

Licensure

An individual must graduate from an approved midwifery program and pass a licensure examination to be eligible for licensure as a midwife.[17] A licensed midwife must submit a general emergency care plan to DOH, which addresses consultation with other health care providers, emergency transfer protocols, and access to neonatal intensive care units and obstetrical units or other patient care areas with his or

[12] Section 464.006, F.S.
[13] Section 464.018(1)(e), F.S.
[14] Examples of other practice acts include allopathic physicians under in s. 458.331(1)(c), F.S., osteopathic physicians in s. 459.015(1)(c), F.S., pharmacists in s. 465.016(1)(f), F.S., and dentists and dental hygienists in s. 466.028(1)(c), F.S.
[15] Section 467.003(8), F.S.
[16] Section 467.004, F.S.
[17] Section 467.011, F.S. Section 467.0125, F.S. DOH no longer administers licensure examinations.

her application for licensure and licensure renewal.[18] A licensed midwife must also submit proof of professional liability coverage of at least $100,000, with an annual aggregate of at least $300,000.[19]

DOH may issue a license by endorsement for midwifery applicants who:[20]

- Holds a valid certificate or diploma from a foreign institution of medicine or from midwifery program in another state provided the requirements for licensure or certification in another country or another state are equivalent to or exceed that which is required for licensing in Florida; or
- Holds a valid certificate or license to practice midwifery in another state provided the requirements for licensure or certification in another state are equivalent to or exceed that which is required for licensing in Florida; and
- Has completed a 4-month prelicensure course conducted by an approved program; and
- Has successfully passed the licensed midwifery examination.

Areas of Critical Need

DOH may also issue a temporary certificate to a midwife who qualifies for licensure by endorsement to practice in areas of critical need.[21] Currently, a temporary certificate issued to practice in areas of critical need valid as long as an area for which it's issued remains an area of critical need, but not longer than two years, and the certificate is not renewable.[22] Currently, if the area in which a midwife is practicing ceases to be an area of critical need, DOH must immediately initiate disciplinary action to revoke his or her temporary certificate.[23]

Midwifery Students

The Act uses the terms "applicant" and "student midwife" interchangeably. It also sets standards for admission, education, and clinical training in the context of student requirements, which, according to DOH, may cause confusion.[24] As an example, current law requires a student midwife to have a high school diploma or the equivalent to enroll in an education program, but the act does not clearly state that a high school diploma is a requirement for licensure.[25]

According to DOH, the use of the undefined term "student midwife" has led to unlicensed persons attempting to work with clients and complete clinical requirements without enrolling in or being educated by an approved midwifery program, as well as midwives attempting to serve as preceptors who are not affiliated with an approved midwifery program.[26]

[18] Section 467.017, F.S.
[19] Rule 64B24-7.013, F.A.C. An applicant does not have to submit proof of professional liability insurance if the applicant practices exclusively as an officer, employee, or agent of the federal government, practices only in conjunction with teaching duties at an approved midwifery school that provides such coverage on the applicant's behalf, or who does not practice midwifery in this state and provides proof of such.
[20] Section 467.0125(1), F.S.
[21] Section 467.0125(2), F.S.
[22] Id.
[23] Department of Health Agency Analysis of 2022 House Bill 693, (Jan. 7, 2022)
[24] Id.
[25] Section 467.009, F.S. *See also Supra,* note 23.
[26] *Supra*, note 2. In general, health care practitioners do not start seeing clients in a clinical setting until they have completed prerequisite portions of a course of study and are near the end of their educational program.

Midwifery Education Programs

Any accredited or state-licensed institution of higher learning may provide midwifery education and training. Midwifery education programs may apply to DOH to obtain approved program status.[27] Approval may be obtained if a program meets requirements for accreditation, faculty, curriculum, and clinical training.[28] Current law requires nonpublic educational institutions be accredited by the Commission on Recognition of Postsecondary Accreditation (CRPA) in order to be approved as a midwifery program.[29] However, CRPA has been succeeded by the Council for Higher Education Accreditation, which is not recognized in current law.[30]

Currently, the Act does not address midwifery programs which are seeking accreditation and are provisionally approved while awaiting their first graduating class.

Current law allows DOH to place a midwifery educational program on probationary status if it no longer meets required standards; if the program fails to correct these conditions, DOH may rescind its approval.[31] However, statutes provide no guidance regarding notification to the program or length of time a school may remain in probationary status. Additionally, the circumstances under which DOH may rescind the approval of a midwifery education program under the Act is unclear as it does not provide a definitive timeline for a non-compliant program to come back into compliance before DOH may rescind its approval. Current law allows a non-compliant program to correct itself "within a specified period of time"[32]; however no timeline is provided in statute or rule.

Effect of Proposed Changes – Midwifery

The bill makes numerous changes to the midwifery practice act.

Licensure

The bill prohibits endorsement without a license or certification in another state, territory or jurisdiction and creates a pathway to licensure by examination for applicants who have completed education equivalent to or exceeds that which is required for licensing in Florida in a state, territory, or jurisdiction that does not license midwives. These revisions do not change what is actually required to qualify for a midwifery license, but instead help applicants better understand those requirements.[33]

The bill allows midwifery programs to be provisionally approved for five years. This change conforms to the five-year period that such programs can be provisionally licensed by the U.S. Department of Education's Commission for Independent Education when seeking accreditation status. DOH will be able to give provisional approval to a new program which has met all requirements except for showing their students have an 80% passage rate on the national exam. Programs provisionally approved will have five years to demonstrate the required exam approval rate after they are preliminarily approved. This time period allows completion of the three-year education program for at least one cohort of students, and for those students to take the exam before the Department tries to determine the passing rate.[34]

The bill removes obsolete references to the DOH-issued exam for midwifery licensure as DOH no longer administers licensure examinations.

[27] Section 467.205, F.S.
[28] Rule 64B24-4.002, F.A.C.
[29] Section 467.009(8), F.S.
[30] *Supra*, note 23.
[31] Section 467.205, F.S.
[32] Id.
[33] *Supra*, note 23.
[34] Id.

Areas of Critical Need

When a practice area is no longer designated as an area of critical need, the bill requires a certified midwife who practices in an area of critical need to relinquish his or her certificate within 30 days, or move his or her practice to another area of critical need, rather than being immediately subject to disciplinary action. Only if the midwife holding the temporary certificate fails to act within those thirty days will DOH initiate disciplinary action to revoke the certificate.[35]

Midwifery Students

The bill prohibits a preceptor from supervising a midwifery student unless the student has been enrolled in an approved midwifery program. This means that an individual cannot begin their clinical practice before enrolling in an approved midwifery program and will explicitly conform midwifery training with the requirements of other medical professions, with students having to complete the majority of their classroom training before working with patients in a clinical setting.

Midwifery Education Programs

The bill updates the accreditation requirement for private educational institutions by replacing the defunct Commission on Recognition of Postsecondary Accreditation with the Council for Higher Education Accreditation or provisional licensing by the Commission for Independent Education. The bill also allows DOH to approve midwifery programs at private educational institutions which are accredited by an agency recognized and approved by the U.S. Department of Education.

The bill authorizes DOH to grant provisional approval of a new midwifery education program which is seeking accreditation for up to 5 years.

Lastly, the bill authorizes DOH to place a midwifery program on probationary status for up to 3 years if such program fails to maintain the requirements of an approved program or has lost accreditation. If a program in probationary status fails to come into compliance with the requirements of an approved program or does not regain its accreditation, DOH may rescind the program's approval.

Orthotists and Prosthetists

Current Situation

The Board of Orthotists and Prosthetists oversees licensure and regulation of orthotists[36] and prosthetists.[37] A person applying for licensure must first apply to DOH to take the appropriate licensure examination. The board may accept the exam results of a national orthotic or prosthetic, standards organization in lieu of administering the state exam.[38] The board must verify that an applicant for licensure examination meets the following requirements:[39]

- Has completed the application form and paid all applicable fees;
- Is of good moral character;
- Is 18 years of age or older;
- Has completed the appropriate educational preparation, including practical training requirements; and
- Has successfully completed an appropriate clinical internship in the professional area for which the license is sought.

[35] *Supra*, note 23.
[36] An orthotist is a health care professional who evaluates, formulates treatment, measures, designs, fabricates, assembles, fits, adjusts, services, or provides necessary training to accomplish the fitting of an orthosis or a pedorthic device (s. 468.80(9)-(10), F.S.)
[37] An prosthetist is a health care professional who evaluates, formulates treatment, measures, designs, fabricates, assembles, fits, adjusts, services, or provides necessary training to accomplish the fitting of a prosthesis (s. 468.80(15)-(16), F.S.)
[38] Section 468.803(4), F.S. The Board has approved the American Board for Certification in Orthotics, Prosthetics, and Pedorthics (ABC) exam for orthotist and prosthetist applicants (r. 64B14-4.001, F.A.C.)
[39] Section 468.803(2), F.S.

Background Screening

Chapter 435, F.S., establishes standard procedures and requirements for criminal history background screening of prospective employees. There are two levels of background screening: level 1 and level 2. Level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[40] and may include criminal records checks through local law enforcement agencies. A level 2 background screening includes, but, is not limited to, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[41]

Every person required by law to be screened pursuant to ch. 435, F.S., must submit a complete set of information necessary to conduct a screening to his or her employer.[42] Such information for a level 2 screening includes fingerprints, which are taken by a vendor that submits them electronically to FDLE.[43]

Effect of Proposed Changes – Orthotists and Prosthetists

The bill removes obsolete references to form and fee requirements for background screening of orthotists, prosthetists, and pedorthists which are no longer collected by DOH.

Psychologists

Current Situation

The Board of Psychology oversees the licensure and regulation of psychologists.[44] To receive a license to practice psychology, an individual must:[45]

- Meet one of the following educational requirements:
  - Received a doctoral-level psychological education from an institution that had institutional accreditation from an agency recognized by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada, and had programmatic accreditation from the American Psychological Association (APA);[46] or
  - Received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology.
- Complete 2 years or 4,000 hours of supervised experience;
- Pass the Examination for Professional Practice in Psychology;[47] and
- Pass an examination on Florida laws and rules.

[40] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited Jan. 20, 2022).
[41] Section 435.04, F.S.
[42] Section 435.05(1)(a), F.S.
[43] Sections 435.03(1) and 435.04(1)(a), F.S.
[44] Section 490.004, F.S.
[45] Section 490.005(1), F.S.
[46] Section 490.003(3), F.S., defines doctoral-level education as a Psy.D, an Ed.D., or a Ph.D in psychology.
[47] Rule 64B19-11.001, F.A.C.

Applicants for licensure by endorsement must:[48]

- Be a diplomate in good standing with the American Board of Professional Psychology;
- Hold a doctoral degree in psychology with at least 10 years of experience as a licensed psychologist in any jurisdiction or territory of the U.S. within the 25 years preceding the date of application.

The APA is recognized by the U.S. Department of Education and the Council for Higher Education Accreditation as the national accrediting authority for professional education and training in psychology.[49] To be licensed as a psychologist in this state, an applicant with a Doctoral degree must have received that degree from a program accredited by the APA. Lack of APA accreditation is grounds for licensure denial under the licensure by endorsement method.[50]

Effect of Proposed Changes – Psychologists

The bill allows a psychologist applying by endorsement to obtain a license regardless of whether the doctoral program was APA accredited. This will allow applicants who did not graduate from an APA accredited program to be licensed by endorsement while maintaining the needed accreditation and educational standards for licensure by examination.[51]

Marriage and Family Therapy and Mental Health Counseling

Current Situation

Marriage and Family Therapists

Marriage and family therapy incorporates marriage and family therapy, psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients.[52] An applicant seeking licensure as a mental health counselor must:[53]

- Possess a master's degree from:
  - An institution of higher learning accredited by a regional accrediting body recognized by the Commission on Recognition of Postsecondary Accreditation (CRPA); and
  - A program accredited by the Commission on Accreditation for Marriage and Family Therapy Education; or
  - A Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs and board-approved graduate courses.[54]
- Complete two years of post-master's supervised experience under the supervision of a licensed marriage and family therapist with five years of experience or the equivalent who is a qualified supervisor as determined by the board;
- Pass a board-approved examination; and
- Demonstrate knowledge of laws and rules governing the practice.

Current law requires licensure applicants to hold a master's degree from an institution of higher learning accredited by a regional accrediting body recognized by the CRPA. The CRPA has been

[48] Section 490.006, F.S.
[49] American Psychological Association, *Understanding APA Accreditation*, http://www.apa.org/ed/accreditation/about/index.aspx (last visited Jan. 20, 2022).
[50] *Supra*, note 23
[51] Id.
[52] American Association for Marriage and Family Therapy, *About Marriage and Family Therapists,* https://www.aamft.org/About_AAMFT/About_Marriage_and_Family_Therapists.aspx (last visited Jan. 20, 2022).
[53] Section 491.005(3), F.S. An individual may qualify for a dual license in marriage and family therapy if he or she passes an examination in marriage and family therapy and has held an active license for at least three years as a psychologist, clinical social worker, mental health counselor, or advanced registered nurse practitioner who is determined by the Board of Nursing to be a specialist in psychiatric mental health (s. 491.0057, F.S.)
[54] Ch. 2020-133, Laws of Fla, required applicants for licensure as a marriage and family therapist to graduate from an accredited program or an accredited Florida university program.

succeed by the Council for Higher Education Accreditation, which is not recognized in current law. Additionally, current board rule requires licensure applicants to pass the board-approved examination developed by the Examination Advisory Committee of the Association of Marital and Family Therapy Regulatory Board.[55] This conflicts with current law, which requires applicants to pass an exam administered by DOH.[56] However, DOH no longer administers licensure examinations.

DOH must verify that an applicant's education matches the specified courses and hours as outlined in statute. However, there are organizations that accredit marriage and family therapy education programs, including the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) and the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) that establish the minimum standards to meet the requirements to practice the profession.[57]

In 2020, the Legislature passed HB 713, which, among other things, revised licensure requirements for marriage and family therapists. Beginning on July 1, 2020, applicants for licensure must possess a master's degree from an a program accredited by COAMFTE or from a Florida university program accredited by CACREP and board-approved graduate courses.[58] However, a window of time was not granted for education programs which were unaccredited at the time to apply for and obtain such accreditation, meaning students who graduate on or after July 1, 2020, from such programs do not meet the accreditation qualifications for licensure in Florida.[59] Currently, six universities in Florida have a marriage and family therapy program that is not accredited by either COAMFTE or CACREP.[60]

Mental Health Counselors

A mental health counselor is an individual who uses scientific and applied behavioral science theories, methods, and techniques to describe, prevent, and treat undesired behavior and enhance mental health and human development and is based on research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation.[61] To qualify for licensure as a mental health counselor, an individual must:[62]

- Have a master's degree from a mental health counseling program accredited by CACREP, or a program related to the practice of mental health counseling that includes coursework and a 700-hour practicum, internship, or fieldwork of which at least 280 hours must be in direct client services;
- Have at least two years of post-master's supervised clinical experience in mental health counseling;
- Pass an examination from the Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors; and
- Pass an eight-hour course on Florida laws and rules approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.[63]

Current board rule requires licensure applicants to pass the board-approved examination from the National Clinical Mental Health Counseling Examination.[64] This conflicts with current law, which

[55] Rule 64B4-3.003(2)(c), F.A.C.
[56] Section 491.005(3)(d), F.S.
[57] *See* Commission on Accreditation for Marriage and Family Therapy Education, *What Are the Benefits of COAMFTE Accreditation*, https://www.coamfte.org/COAMFTE/Accreditation/About_Accreditation.aspx (last visited Jan. 20, 2022), and Council for the Accreditation of Counseling and Related Educational Programs, *About CACREP*, https://www.cacrep.org/about-cacrep/ (last visited Jan. 20, 2022).
[58] Section 491.005, F.S. (2020).
[59] *Supra*, note 23.
[60] Id.
[61] Sections 491.003(6) and (9), F.S.
[62] Section 491.005(4), F.S.
[63] Section 491.005(4), F.S., and r. 64B4-3.0035, F.A.C.
[64] Rule 64B4-3.003(2)(b), F.A.C.

requires applicants to pass an exam administered by DOH.[65] However, DOH no longer administers licensure examinations.

Ch. 2020-133, L.O.F, also revised licensure requirements for mental health counselors. Beginning July 1, 2025, applicants for licensure as a mental health counselor must hold a master's degree from a program accredited by CACREP.[66] The CACREP accreditation standards require 60 credits of specified educational content and a 700-hour practicum requiring face-to-face psychotherapy.[67] There are currently sixteen universities in this state accredited by CACREP.[68] The University of West Florida's (UWF) mental health counselor program is the only program accredited by the Masters in Psychology and Counseling Accreditation Council in this state.[69] Thus, beginning in 2025, UWF's current accreditation for its mental health counselor program will not be sufficient for graduates to meet licensure requirements in this state.

Effect of the Bill – Marriage and Family Therapy and Mental Health Counseling

Marriage and Family Therapists

The bill allows DOH to continue to issue licenses to graduates of otherwise qualified Florida marriage and family therapy programs until July 1, 2027, while such programs seek accreditation.

The bill also updates the accreditation requirement for institutions of higher education by replacing the defunct Commission on Recognition of Postsecondary Accreditation with the Council for Higher Education Accreditation.

Additionally, the bill removes obsolete references to DOH-issued licensure examinations.

Mental Health Counselors

The bill adds the Masters in Psychology and Counseling Accreditation Council, or an equivalent body, as an authorized accrediting body for mental health counselor education programs beginning on July 1, 2025. This will allow UWF to continue to graduate students who are eligible for licensure in this state.

Florida Birth-Related Neurological Injury Compensation Association

Current Situation

Florida Birth-Related Neurological Injury Compensation Plan

The Florida Birth-Related Neurological Injury Compensation Plan (Plan) was created by the Legislature to manage both rising medical malpractice costs and diminishing availability of liability insurance by creating a hybrid no-fault and tort medical liability system.[70] The Plan was created to pay for the care of infants born with certain neurological injuries and is available to eligible families without the need for litigation. By eliminating costly legal proceedings, the Plan aims to ensure that birth-injured infants receive the care they need while reducing the financial burden on both medical providers and families.

[65] Section 491.005(4)(d), F.S.
[66] Section 491.005(4)(b), F.S.
[67] *Supra*, note 23.
[68] Council for Accreditation for Counseling and Related Educational Programs, *Find a Program,* https://www.cacrep.org/directory/ (last visited Jan. 20, 2022).
[69] Masters in Psychology and Counseling Accreditation Council, *Accredited Programs*, http://mpcacaccreditation.org/accredited-programs/ (last visited Jan. 20, 2022).
[70] Id.

Florida Birth-Related Neurological Injury Compensation Association

In 1988, the Legislature created the Florida Birth-Related Neurological Injury Compensation Association (NICA) to manage the Plan.[71] NICA is an independent association. Although it is not a state agency, NICA is subject to regulation and oversight by the Office of Insurance Regulation (OIR) and the Joint Legislative Auditing Committee. Directors on NICA's board are appointed by the Chief Financial Officer (CFO) for staggered terms of 3 years or until their successors are appointed, but there is no limit on the number of terms a director may serve.[72] The board of directors is composed of:[73]

- One citizen representative;
- One representative of participating physicians;
- One representative of hospitals;
- One representative of casualty insurers; and
- One representative of physicians other than participating physicians.

The board of directors may:[74]

- Administer the Plan;
- Administer the funds collected on behalf of the Plan;
- Administer the payment of claims on behalf of the Plan;
- Direct the investment and reinvestment of any surplus funds over losses and expenses, provided that any investment income generated thereby remains credited to the Plan;
- Reinsure the risks of the Plan in whole or in part;
- Sue, be sued, appear, and defend in all actions relating to the Plan;
- Exercise all powers necessary to effect any of the purposes for which the Plan is created.;
- Enter into such contracts as are necessary or proper to administer the Plan;
- Employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the Plan'
- Take such legal action as may be necessary to avoid payment of improper claims; and
- Indemnify any person acting on behalf of the Plan in an official capacity, provided that such person acted in good faith.

Annually, NICA must furnish audited financial reports to any Plan participant upon request, OIR and the Joint Legislative Auditing Committee.[75]

The reports must be prepared in accordance with accepted accounting procedures. OIR or the Joint Legislative Auditing Committee may conduct an audit of the Plan at any time.[76]

Assessments

In July 1988, the Legislature authorized a transfer of $20 million to NICA from the Department of Insurance (the predecessor agency to OIR)[77] to provide initial funding to administer the Plan. Currently, the Plan is funded by a combination of physician fees and hospital assessments.[78] A participating physician is required to pay a $5,000 fee each year for coverage which runs January 1 through December 31.[79] All licensed Florida physicians pay a mandatory fee of $250, regardless of specialty. Hospitals pay $50 for each live birth during the previous calendar year. Certain exemptions apply to all of these categories, including resident physicians, retired physicians, government physicians, and

[71] Section 766.315, F.S. and ch. 88-1, s. 74, Laws of Fla.
[72] Id.
[73] Id.
[74] Id.
[75] Id.
[76] Id.
[77] Ch. 88-277, s. 41, Laws of Fla.
[78] Section 766.314, F.S.
[79] Id.

facilities.[80] Initial assessments are collected by DOH, though current law states initial assessments are to be collected by the Department of Business and Professional Regulation (DBPR), which has not had regulatory authority over health care practitioners since 2000.[81]

Between July 2018 and June 2020, NICA's audited financial statements showed a total of $54,755,762 in assessments was collected.[82] However, a 2021 Auditor General report showed an increase in delinquent assessments between 2016 and 2021, totaling $14.4 million.

Active Non-Participating Physician Assessments Paid and Delinquent, 2016 – 2021[83]

	Assessments Paid[a]		Delinquent Assessments			
Assessment Year	Amount	Number of Physicians	Amount	Number of Physicians	Total Assessment Amount	Delinquent Assessments as Percentage of Total Assessment Amount
2021	$13,791,926	56,362	$ 4,836,553	19,242	$ 18,628,479	26%
2020	16,035,537	64,372	3,118,420	12,043	19,153,957	16%
2019	16,209,715	65,209	2,291,303	8,336	18,501,018	12%
2018	16,132,917	64,487	1,765,173	6,123	17,898,090	10%
2017	16,159,869	64,043	1,356,025	4,506	17,515,894	8%
2016	14,486,458	58,316	999,719	3,215	15,486,177	6%
Totals	**$92,816,422**	**372,789**	**$14,367,193**	**53,465**	**$107,183,615**	**13%**

[a] Includes late payments and pre-payment amounts applicable to the assessment year.

NICA is authorized to enforce collection of unpaid assessments by filing suit in county court and may recover attorney fees, costs and interest related if it obtains a final judgment.[84] DOH is prohibited from renewing a physician's license if NICA notifies DOH that the physician has unpaid assessments and that there is an unsatisfied final judgment against the physician.[85]

Effect of the Bill – NICA

The bill addresses unpaid assessments by requiring allopathic and osteopathic physicians to provide proof of payment of NICA assessments as a condition of licensure. This may potentially increase timely payment of the assessment and reduce the need for NICA to seek judicial remedy for unpaid assessments. The bill also requires NICA to notify DOH and applicable boards of any unpaid final judgment within seven days of the final judgement.

The bill also updates references from DBPR to DOH throughout.

[80] Id.
[81] Section 766.134, F.S. The Department of Business and Professional Regulation previously licensed health care practitioners in Florida when NICA was created. The Legislature moved this responsibility to the Division of Medical Quality Assurance within DOH in 2000. *See* ch. 2000-160, L.O.F. and *supra*, note 23.
[82] *Florida Birth-Related Neurological Injury Compensation Association*, State of Florida Auditor General – Operational Audit, August 2021.
[83] Id.
[84] Section 766.314(6)(b), F.S.
[85] Id.

Medical Marijuana Testing

Current Situation

Presently, processed marijuana products must be tested for contaminants that are harmful for human consumption and to ensure that products meet the THC and CBD potency requirements.[86] The DOH must adopt rules determining what contaminants must be tested for and at what levels such contaminants are unsafe for human consumption, as well as rules for the treatment of marijuana products that fail the safety and potency requirements.[87]

Current law authorizes the DOH to select random samples of edible products available for purchase for testing to determine whether the THC and CBD potency level on the label is accurate and whether the edible is safe for human consumption. DOH does not have express authority to sample all other types of medical marijuana or medical marijuana delivery devices. Additionally, current law does not provide an exception to criminal law to allow DOH, and its employees acting within the scope of their employment, to acquire, possess, test, transport, and lawfully dispose of marijuana.

A medical marijuana treatment center (MMTC) must recall all edibles that fail to meet safety and potency requirements.[88] DOH does not have express authority to require MMTCs to recall other types of medical marijuana or medical marijuana delivery devices that fail to meet safety and potency requirements.

Each MMTC is required to contract with a certified marijuana testing laboratory (CMTL) to test processed marijuana before it is dispensed. [89] Testing results must indicate that the low-THC cannabis meets the statutory definition; THC potency meets statutory requirements; THC and CBD are labeled accurately; and the marijuana is safe for human consumption and free from contaminants that are unsafe for human consumption.[90]

Effect of the Bill – Medical Marijuana Testing

The bill requires MMTCs to test all forms of its marijuana, not only processed marijuana, to ensure that it meets safety and potency requirements before it is dispensed. The bill requires MMTCs to recall all forms of marijuana that fail to meet the safety and potency requirements, rather than only edibles.

The bill authorizes the DOH to select available samples of all forms of marijuana available in a medical marijuana treatment center for testing to determine that the marijuana is safe for human consumption and that the THC and CBD potency level on the label is accurate or to verify medical marijuana testing laboratory results. The bill also authorizes the DOH to sample marijuana delivery devices from a marijuana treatment center to determine that the marijuana delivery device is safe for use by qualified patients. The bill permits the DOH, including employees acting within the scope of their employment, to acquire, possess, test, transport, and lawfully dispose of marijuana. The bill requires MMTCs to recall all forms of medical marijuana and marijuana delivery devices that fail to meet safety and potency requirements.

[86] Section 381.986(8)(e)11.d., F.S.
[87] Id.
[88] Id.
[89] Id.
[90] Id.

Special Needs Shelters

Current Situation

Special needs shelters ensure persons with special needs have a safe and secure location during an emergency or disaster. In 2000, the Legislature established a system to recruit health care practitioners to staff special needs shelters in times of emergencies or disasters, and required DOH to be the lead agency for these responsibilities.[91]

Current law establishes DOH's Division of Children's Medical Services (CMS) as the lead for the coordination of local medical and health care providers to develop a plan for the staffing and medical management of pediatric special needs shelters and to participate in local decision-making regarding the medical supervision of special needs shelters.[92] CMS's workforce consists of local health care practitioners with specialized training and experience in the provision of services for children with special needs.[93] However, through a series of program and organizational changes toward more effective operation and costs, the CMS workforce has been reduced by more than 70% since 2018.[94] Due to this change in workforce, CMS can no longer support the charges of the statute.[95]

Effect of the Bill – Special Needs Shelters

The bill designates DOH, rather than CMS specifically, as the lead for the coordination of local medical and health care providers in developing a plan for the staffing and medical management of pediatric special needs shelters. Additionally, the bill require DOH to determine who is responsible for the medical supervision of each special needs shelter.

Finally, the bill makes various conforming changes.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.0045, F.S., relating to targeted outreach for pregnant women.
Section 2: Amends s. 381.0303, F.S., relating to special needs shelters.
Section 3: Amends s. 381.986, F.S., relating to medical use of marijuana.
Section 4: Amends s. 456.039, F.S., relating to designated health care professionals; information required for licensure.
Section 5: Amends s. 460.406, F.S., relating to licensure by examination.
Section 6: Amends s. 464.008, F.S., relating to licensure by examination.
Section 7: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 8: Amends s. 467.003, F.S., relating to definitions.
Section 9: Amends s. 467.009, F.S., relating to midwifery programs; education and training requirements.
Section 10: Amends s. 467.011, F.S., relating to licensure by examination.
Section 11: Amends s. 467.0125, F.S., relating to licensure by endorsement.
Section 12: Amends s. 467.205, F.S., relating to approval of midwifery programs.
Section 13: Amends s. 468.803, F.S., relating to license, registration, and examination requirements.
Section 14: Amends s. 483.824, F.S., relating to qualifications of clinical laboratory director.
Section 15: Amends s. 490.003, F.S., relating to definitions.
Section 16: Amends s. 490.005, F.S., relating to licensure by examination.
Section 17: Amends s. 490.0051, F.S., relating to provisional licensure; requirements.
Section 18: Amends s. 491.005, F.S., relating to licensure by examination.
Section 19: Amends s. 766.314, F.S., relating to assessments; plan of operation.
Section 20: Provides an effective date of July 1, 2022.

[91] Ch. 2000-140, L.O.F. *See also supra,* note 23.
[92] Section 381.0303, F.S.
[93] *Supra*, note 23.
[94] Id.
[95] Id.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

DOH may experience an increase in workload to conduct rulemaking and updating online application websites to implement the provisions of the bill, the impact of which can be absorbed within current resources.[96]

DOH may also experience an increase in expenditures relating to medical marijuana sampling and testing, the impact of which can be absorbed within current resources.[97]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law provides sufficient rule-making authority to implement the provisions of the bill.

[96] Id.
[97] Id.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Department of Health; amending s. 381.0045, F.S.; revising the purpose of the department's targeted outreach program for certain pregnant women; requiring the department to encourage high-risk pregnant women of unknown status to be tested for sexually transmissible diseases; requiring the department to provide specified information to pregnant women who have human immunodeficiency virus (HIV); requiring the department to link women with mental health services when available; requiring the department to educate pregnant women who have HIV on certain information; requiring the department to provide, for a specified purpose, continued oversight of newborns exposed to HIV; amending s. 381.0303, F.S.; removing the Children's Medical Services office from parties required to coordinate in the development of local emergency management plans for special needs shelters; amending s. 381.986, F.S.; authorizing the department to select samples of marijuana from medical marijuana treatment center facilities for certain testing; authorizing the department to select samples of marijuana delivery devices from medical marijuana treatment centers to determine whether the device is safe for use; requiring medical marijuana treatment

centers to recall marijuana and marijuana delivery devices, instead of just edibles, under certain circumstances; exempting the department and its employees from criminal provisions if they acquire, possess, test, transport, or lawfully dispose of marijuana and marijuana delivery devices under certain circumstances; amending s. 456.039, F.S.; requiring applicants to provide certain proof of payment; amending s. 460.406, F.S.; revising provisions related to chiropractic physician licensing; amending s. 464.008, F.S.; deleting a requirement that certain nursing program graduates complete a specified preparatory course; amending s. 464.018, F.S.; revising grounds for disciplinary action against licensed nurses; amending s. 467.003, F.S.; revising and defining terms; amending s. 467.009, F.S.; revising provisions related to approved midwifery programs; amending s. 467.011, F.S.; revising requirements for licensure of midwives; amending s. 467.0125, F.S.; revising requirements for licensure by endorsement of midwives; revising requirements for temporary certificates to practice midwifery in this state; amending s. 467.205, F.S.; revising provisions relating to approval, continued monitoring, probationary status, provisional approval, and

approval rescission of midwifery programs; amending s. 468.803, F.S.; revising provisions related to orthotist and prosthetist registration, examination, and licensing; amending s. 483.824, F.S.; revising educational requirements for clinical laboratory directors; amending s. 490.003, F.S.; defining the terms "doctoral degree from an American Psychological Association accredited program" and "doctoral degree in psychology"; amending ss. 490.005 and 490.0051, F.S.; revising education requirements for psychologist licensure and provisional licensure, respectively; amending s. 491.005, F.S.; revising requirements for licensure of clinical social workers, marriage and family therapists, and mental health counselors; amending s. 766.314, F.S.; deleting obsolete language and updating provisions to conform to current law; revising the frequency with which the department must submit certain reports to the Florida Birth-Related Neurological Injury Compensation Association; revising the content of such reports; requiring the Florida Birth-Related Neurological Injury Compensation Association to notficy the department and the applicable board of any unpaid final judgements against a physician; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (2) and (3) of section 381.0045, Florida Statutes, are amended to read:

381.0045 Targeted outreach for pregnant women.—

(2) It is the purpose of this section to establish a targeted outreach program for high-risk pregnant women who may not seek proper prenatal care, who suffer from substance abuse or mental health problems, or who have acquired ~~are infected with~~ human immunodeficiency virus (HIV), and to provide these women with links to much-needed ~~much needed~~ services and information.

(3) The department shall:

(a) Conduct outreach programs through contracts with, grants to, or other working relationships with persons or entities where the target population is likely to be found.

(b) Provide outreach that is peer-based, culturally sensitive, and performed in a nonjudgmental manner.

(c) Encourage high-risk pregnant women of unknown status to be tested for HIV and other sexually transmissible diseases as specified by department rule.

(d) Educate women not receiving prenatal care as to the benefits of such care.

(e) Provide ~~HIV-infected~~ pregnant women who have HIV with information on the need for antiretroviral medication for their

newborn, their medication options, and how they can access the medication after their discharge from the hospital ~~so they can make an informed decision about the use of Zidovudine (AZT)~~.

(f) Link women with substance abuse treatment and mental health services, when available, and act as a liaison with Healthy Start coalitions, children's medical services, Ryan White-funded providers, and other services of the Department of Health.

(g) Educate pregnant women who have HIV on the importance of engaging in and continuing HIV care.

(h) Provide continued oversight of any newborn exposed to HIV to determine the newborn's final HIV status and ensure continued linkage to care if the newborn is diagnosed with HIV ~~to HIV-exposed newborns~~.

Section 2. Paragraphs (a) and (c) of subsection (2) of section 381.0303, Florida Statutes, are amended to read:

381.0303 Special needs shelters.—

(2) SPECIAL NEEDS SHELTER PLAN; STAFFING; STATE AGENCY ASSISTANCE.—If funds have been appropriated to support disaster coordinator positions in county health departments:

(a) The department shall assume lead responsibility for the coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of special needs shelters and~~. The local Children's Medical Services offices~~

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~~shall assume lead responsibility for the coordination of local medical and health care providers, the American Red Cross, and other interested parties in developing a plan for the staffing and medical management of~~ pediatric special needs shelters. Plans must conform to the local comprehensive emergency management plan.

(c) The appropriate county health department~~, Children's Medical Services office,~~ and local emergency management agency shall jointly decide who has responsibility for medical supervision in each special needs shelter.

Section 3. Present paragraphs (e) through (h) of subsection (14) of section 381.986, Florida Statutes, are redesignated as paragraphs (f) through (i), respectively, a new paragraph (e) is added to that subsection, and paragraph (e) of subsection (8) of that section is amended, to read:

381.986 Medical use of marijuana.—

(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(e) A licensed medical marijuana treatment center shall cultivate, process, transport, and dispense marijuana for medical use. A licensed medical marijuana treatment center may not contract for services directly related to the cultivation, processing, and dispensing of marijuana or marijuana delivery devices, except that a medical marijuana treatment center licensed pursuant to subparagraph (a)1. may contract with a single entity for the cultivation, processing, transporting, and

dispensing of marijuana and marijuana delivery devices. A licensed medical marijuana treatment center must, at all times, maintain compliance with the criteria demonstrated and representations made in the initial application and the criteria established in this subsection. Upon request, the department may grant a medical marijuana treatment center a variance from the representations made in the initial application. Consideration of such a request shall be based upon the individual facts and circumstances surrounding the request. A variance may not be granted unless the requesting medical marijuana treatment center can demonstrate to the department that it has a proposed alternative to the specific representation made in its application which fulfills the same or a similar purpose as the specific representation in a way that the department can reasonably determine will not be a lower standard than the specific representation in the application. A variance may not be granted from the requirements in subparagraph 2. and subparagraphs (b)1. and 2.

1. A licensed medical marijuana treatment center may transfer ownership to an individual or entity who meets the requirements of this section. A publicly traded corporation or publicly traded company that meets the requirements of this section is not precluded from ownership of a medical marijuana treatment center. To accommodate a change in ownership:

a. The licensed medical marijuana treatment center shall

notify the department in writing at least 60 days before the anticipated date of the change of ownership.

b. The individual or entity applying for initial licensure due to a change of ownership must submit an application that must be received by the department at least 60 days before the date of change of ownership.

c. Upon receipt of an application for a license, the department shall examine the application and, within 30 days after receipt, notify the applicant in writing of any apparent errors or omissions and request any additional information required.

d. Requested information omitted from an application for licensure must be filed with the department within 21 days after the department's request for omitted information or the application shall be deemed incomplete and shall be withdrawn from further consideration and the fees shall be forfeited.

e. Within 30 days after the receipt of a complete application, the department shall approve or deny the application.

2. A medical marijuana treatment center, and any individual or entity who directly or indirectly owns, controls, or holds with power to vote 5 percent or more of the voting shares of a medical marijuana treatment center, may not acquire direct or indirect ownership or control of any voting shares or other form of ownership of any other medical marijuana treatment

center.

3. A medical marijuana treatment center may not enter into any form of profit-sharing arrangement with the property owner or lessor of any of its facilities where cultivation, processing, storing, or dispensing of marijuana and marijuana delivery devices occurs.

4. All employees of a medical marijuana treatment center must be 21 years of age or older and have passed a background screening pursuant to subsection (9).

5. Each medical marijuana treatment center must adopt and enforce policies and procedures to ensure employees and volunteers receive training on the legal requirements to dispense marijuana to qualified patients.

6. When growing marijuana, a medical marijuana treatment center:

a. May use pesticides determined by the department, after consultation with the Department of Agriculture and Consumer Services, to be safely applied to plants intended for human consumption, but may not use pesticides designated as restricted-use pesticides pursuant to s. 487.042.

b. Must grow marijuana within an enclosed structure and in a room separate from any other plant.

c. Must inspect seeds and growing plants for plant pests that endanger or threaten the horticultural and agricultural interests of the state in accordance with chapter 581 and any

rules adopted thereunder.

d. Must perform fumigation or treatment of plants, or remove and destroy infested or infected plants, in accordance with chapter 581 and any rules adopted thereunder.

7. Each medical marijuana treatment center must produce and make available for purchase at least one low-THC cannabis product.

8. A medical marijuana treatment center that produces edibles must hold a permit to operate as a food establishment pursuant to chapter 500, the Florida Food Safety Act, and must comply with all the requirements for food establishments pursuant to chapter 500 and any rules adopted thereunder. Edibles may not contain more than 200 milligrams of tetrahydrocannabinol, and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may have a potency variance of no greater than 15 percent. Edibles may not be attractive to children; be manufactured in the shape of humans, cartoons, or animals; be manufactured in a form that bears any reasonable resemblance to products available for consumption as commercially available candy; or contain any color additives. To discourage consumption of edibles by children, the department shall determine by rule any shapes, forms, and ingredients allowed and prohibited for edibles. Medical marijuana treatment centers may not begin processing or dispensing edibles until after the effective date of the rule.

The department shall also adopt sanitation rules providing the standards and requirements for the storage, display, or dispensing of edibles.

9. Within 12 months after licensure, a medical marijuana treatment center must demonstrate to the department that all of its processing facilities have passed a Food Safety Good Manufacturing Practices, such as Global Food Safety Initiative or equivalent, inspection by a nationally accredited certifying body. A medical marijuana treatment center must immediately stop processing at any facility which fails to pass this inspection until it demonstrates to the department that such facility has met this requirement.

10. A medical marijuana treatment center that produces prerolled marijuana cigarettes may not use wrapping paper made with tobacco or hemp.

11. When processing marijuana, a medical marijuana treatment center must:

a. Process the marijuana within an enclosed structure and in a room separate from other plants or products.

b. Comply with department rules when processing marijuana with hydrocarbon solvents or other solvents or gases exhibiting potential toxicity to humans. The department shall determine by rule the requirements for medical marijuana treatment centers to use such solvents or gases exhibiting potential toxicity to humans.

c. Comply with federal and state laws and regulations and department rules for solid and liquid wastes. The department shall determine by rule procedures for the storage, handling, transportation, management, and disposal of solid and liquid waste generated during marijuana production and processing. The Department of Environmental Protection shall assist the department in developing such rules.

d. Test the processed marijuana using a medical marijuana testing laboratory before it is dispensed. Results must be verified and signed by two medical marijuana treatment center employees. Before dispensing, the medical marijuana treatment center must determine that the test results indicate that low-THC cannabis meets the definition of low-THC cannabis, the concentration of tetrahydrocannabinol meets the potency requirements of this section, the labeling of the concentration of tetrahydrocannabinol and cannabidiol is accurate, and all marijuana is safe for human consumption and free from contaminants that are unsafe for human consumption. The department shall determine by rule which contaminants must be tested for and the maximum levels of each contaminant which are safe for human consumption. The Department of Agriculture and Consumer Services shall assist the department in developing the testing requirements for contaminants that are unsafe for human consumption in edibles. The department shall also determine by rule the procedures for the treatment of marijuana that fails to

meet the testing requirements of this section, s. 381.988, or department rule. The department may select samples of marijuana ~~a random sample~~ from ~~edibles available for purchase in~~ a medical marijuana treatment center ~~dispensing~~ facility which shall be tested by the department to determine whether ~~that~~ the marijuana ~~edible~~ meets the potency requirements of this section, is safe for human consumption, and is accurately labeled with ~~the labeling of~~ the tetrahydrocannabinol and cannabidiol concentration or to verify the result of marijuana testing conducted by a marijuana testing laboratory. The department may also select samples of marijuana delivery devices from a medical marijuana treatment center to determine whether the marijuana delivery device is safe for use by qualified patients ~~is accurate~~. A medical marijuana treatment center may not require payment from the department for the sample. A medical marijuana treatment center must recall marijuana ~~edibles~~, including all marijuana and marijuana products ~~edibles~~ made from the same batch of marijuana, that fails ~~which fail~~ to meet the potency requirements of this section, that is ~~which are~~ unsafe for human consumption, or for which the labeling of the tetrahydrocannabinol and cannabidiol concentration is inaccurate. A medical marijuana treatment center must also recall all marijuana delivery devices determined to be unsafe for use by qualified patients. The medical marijuana treatment center must retain records of all testing and samples of each

homogenous batch of marijuana for at least 9 months. The medical marijuana treatment center must contract with a marijuana testing laboratory to perform audits on the medical marijuana treatment center's standard operating procedures, testing records, and samples and provide the results to the department to confirm that the marijuana or low-THC cannabis meets the requirements of this section and that the marijuana or low-THC cannabis is safe for human consumption. A medical marijuana treatment center shall reserve two processed samples from each batch and retain such samples for at least 9 months for the purpose of such audits. A medical marijuana treatment center may use a laboratory that has not been certified by the department under s. 381.988 until such time as at least one laboratory holds the required certification, but in no event later than July 1, 2018.

e. Package the marijuana in compliance with the United States Poison Prevention Packaging Act of 1970, 15 U.S.C. ss. 1471 et seq.

f. Package the marijuana in a receptacle that has a firmly affixed and legible label stating the following information:

(I) The marijuana or low-THC cannabis meets the requirements of sub-subparagraph d.

(II) The name of the medical marijuana treatment center from which the marijuana originates.

(III) The batch number and harvest number from which the

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marijuana originates and the date dispensed.

(IV) The name of the physician who issued the physician certification.

(V) The name of the patient.

(VI) The product name, if applicable, and dosage form, including concentration of tetrahydrocannabinol and cannabidiol. The product name may not contain wording commonly associated with products marketed by or to children.

(VII) The recommended dose.

(VIII) A warning that it is illegal to transfer medical marijuana to another person.

(IX) A marijuana universal symbol developed by the department.

12. The medical marijuana treatment center shall include in each package a patient package insert with information on the specific product dispensed related to:

a. Clinical pharmacology.

b. Indications and use.

c. Dosage and administration.

d. Dosage forms and strengths.

e. Contraindications.

f. Warnings and precautions.

g. Adverse reactions.

13. In addition to the packaging and labeling requirements specified in subparagraphs 11. and 12., marijuana in a form for

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smoking must be packaged in a sealed receptacle with a legible and prominent warning to keep away from children and a warning that states marijuana smoke contains carcinogens and may negatively affect health. Such receptacles for marijuana in a form for smoking must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol.

14. The department shall adopt rules to regulate the types, appearance, and labeling of marijuana delivery devices dispensed from a medical marijuana treatment center. The rules must require marijuana delivery devices to have an appearance consistent with medical use.

15. Each edible shall be individually sealed in plain, opaque wrapping marked only with the marijuana universal symbol. Where practical, each edible shall be marked with the marijuana universal symbol. In addition to the packaging and labeling requirements in subparagraphs 11. and 12., edible receptacles must be plain, opaque, and white without depictions of the product or images other than the medical marijuana treatment center's department-approved logo and the marijuana universal symbol. The receptacle must also include a list of all the edible's ingredients, storage instructions, an expiration date, a legible and prominent warning to keep away from children and pets, and a warning that the edible has not been produced or

inspected pursuant to federal food safety laws.

16. When dispensing marijuana or a marijuana delivery device, a medical marijuana treatment center:

a. May dispense any active, valid order for low-THC cannabis, medical cannabis and cannabis delivery devices issued pursuant to former s. 381.986, Florida Statutes 2016, which was entered into the medical marijuana use registry before July 1, 2017.

b. May not dispense more than a 70-day supply of marijuana within any 70-day period to a qualified patient or caregiver. May not dispense more than one 35-day supply of marijuana in a form for smoking within any 35-day period to a qualified patient or caregiver. A 35-day supply of marijuana in a form for smoking may not exceed 2.5 ounces unless an exception to this amount is approved by the department pursuant to paragraph (4)(f).

c. Must have the medical marijuana treatment center's employee who dispenses the marijuana or a marijuana delivery device enter into the medical marijuana use registry his or her name or unique employee identifier.

d. Must verify that the qualified patient and the caregiver, if applicable, each have an active registration in the medical marijuana use registry and an active and valid medical marijuana use registry identification card, the amount and type of marijuana dispensed matches the physician certification in the medical marijuana use registry for that

qualified patient, and the physician certification has not already been filled.

e. May not dispense marijuana to a qualified patient who is younger than 18 years of age. If the qualified patient is younger than 18 years of age, marijuana may only be dispensed to the qualified patient's caregiver.

f. May not dispense or sell any other type of cannabis, alcohol, or illicit drug-related product, including pipes or wrapping papers made with tobacco or hemp, other than a marijuana delivery device required for the medical use of marijuana and which is specified in a physician certification.

g. Must, upon dispensing the marijuana or marijuana delivery device, record in the registry the date, time, quantity, and form of marijuana dispensed; the type of marijuana delivery device dispensed; and the name and medical marijuana use registry identification number of the qualified patient or caregiver to whom the marijuana delivery device was dispensed.

h. Must ensure that patient records are not visible to anyone other than the qualified patient, his or her caregiver, and authorized medical marijuana treatment center employees.

(14) EXCEPTIONS TO OTHER LAWS.—

(e) Notwithstanding s. 893.13, s. 893.135, s. 893.147, or any other law, but subject to the requirements of this section, the department, including an employee of the department acting within the scope of his or her employment, may acquire, possess,

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test, transport, and lawfully dispose of marijuana and marijuana delivery devices as provided in this section, in s. 381.988, and by department rule.

Section 4. Subsection (1) of section 456.039, Florida Statutes, is amended to read:

456.039 Designated health care professionals; information required for licensure.—

(1) Each person who applies for initial licensure as a physician under chapter 458, chapter 459, chapter 460, or chapter 461, except a person applying for registration pursuant to ss. 458.345 and 459.021, must, at the time of application, and each physician who applies for license renewal under chapter 458, chapter 459, chapter 460, or chapter 461, except a person registered pursuant to ss. 458.345 and 459.021, must, in conjunction with the renewal of such license and under procedures adopted by the Department of Health, and in addition to any other information that may be required from the applicant, furnish the following information to the Department of Health:

(a)1. The name of each medical school that the applicant has attended, with the dates of attendance and the date of graduation, and a description of all graduate medical education completed by the applicant, excluding any coursework taken to satisfy medical licensure continuing education requirements.

2. The name of each hospital at which the applicant has

privileges.

3. The address at which the applicant will primarily conduct his or her practice.

4. Any certification that the applicant has received from a specialty board that is recognized by the board to which the applicant is applying.

5. The year that the applicant began practicing medicine.

6. Any appointment to the faculty of a medical school which the applicant currently holds and an indication as to whether the applicant has had the responsibility for graduate medical education within the most recent 10 years.

7. A description of any criminal offense of which the applicant has been found guilty, regardless of whether adjudication of guilt was withheld, or to which the applicant has pled guilty or nolo contendere. A criminal offense committed in another jurisdiction which would have been a felony or misdemeanor if committed in this state must be reported. If the applicant indicates that a criminal offense is under appeal and submits a copy of the notice for appeal of that criminal offense, the department must state that the criminal offense is under appeal if the criminal offense is reported in the applicant's profile. If the applicant indicates to the department that a criminal offense is under appeal, the applicant must, upon disposition of the appeal, submit to the department a copy of the final written order of disposition.

8. A description of any final disciplinary action taken within the previous 10 years against the applicant by the agency regulating the profession that the applicant is or has been licensed to practice, whether in this state or in any other jurisdiction, by a specialty board that is recognized by the American Board of Medical Specialties, the American Osteopathic Association, or a similar national organization, or by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home. Disciplinary action includes resignation from or nonrenewal of medical staff membership or the restriction of privileges at a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home taken in lieu of or in settlement of a pending disciplinary case related to competence or character. If the applicant indicates that the disciplinary action is under appeal and submits a copy of the document initiating an appeal of the disciplinary action, the department must state that the disciplinary action is under appeal if the disciplinary action is reported in the applicant's profile.

9. Relevant professional qualifications as defined by the applicable board.

(b) In addition to the information required under paragraph (a), each applicant who seeks licensure under chapter 458, chapter 459, or chapter 461, and who has practiced

previously in this state or in another jurisdiction or a foreign country must provide the information required of licensees under those chapters pursuant to s. 456.049. An applicant for licensure under chapter 460 who has practiced previously in this state or in another jurisdiction or a foreign country must provide the same information as is required of licensees under chapter 458, pursuant to s. 456.049.

(c) Each applicant who seeks licensure under chapter 458 or chapter 459 must provide proof of payment of the assessment required under s. 766.314, if applicable.

Section 5. Subsection (1) of section 460.406, Florida Statutes, is amended to read:

460.406 Licensure by examination.—

(1) Any person desiring to be licensed as a chiropractic physician must apply to the department to take the licensure examination. There shall be an application fee set by the board not to exceed $100 which shall be nonrefundable. There shall also be an examination fee not to exceed $500 plus the actual per applicant cost to the department for purchase of portions of the examination from the National Board of Chiropractic Examiners or a similar national organization, which may be refundable if the applicant is found ineligible to take the examination. The department shall examine each applicant whom ~~who~~ the board certifies has met all of the following criteria:

(a) Completed the application form and remitted the

appropriate fee.

(b) Submitted proof satisfactory to the department that he or she is not less than 18 years of age.

(c) Submitted proof satisfactory to the department that he or she is a graduate of a chiropractic college which is accredited by or has status with the Council on Chiropractic Education or its predecessor agency. However, any applicant who is a graduate of a chiropractic college that was initially accredited by the Council on Chiropractic Education in 1995, who graduated from such college within the 4 years immediately preceding such accreditation, and who is otherwise qualified is ~~shall be~~ eligible to take the examination. An ~~No~~ application for a license to practice chiropractic medicine may not ~~shall~~ be denied solely because the applicant is a graduate of a chiropractic college that subscribes to one philosophy of chiropractic medicine as distinguished from another.

(d)1. For an applicant who has matriculated in a chiropractic college before ~~prior to~~ July 2, 1990, completed at least 2 years of residence college work, consisting of a minimum of one-half the work acceptable for a bachelor's degree granted on the basis of a 4-year period of study, in a college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education. However, before ~~prior to~~ being certified by the board to sit for the examination, each applicant who has matriculated

in a chiropractic college after July 1, 1990, must ~~shall~~ have been granted a bachelor's degree, based upon 4 academic years of study, by a college or university accredited by an institutional ~~a regional~~ accrediting agency that ~~which~~ is a member of the Commission on Recognition of Postsecondary Accreditation.

2. Effective July 1, 2000, completed, before ~~prior to~~ matriculation in a chiropractic college, at least 3 years of residence college work, consisting of a minimum of 90 semester hours leading to a bachelor's degree in a liberal arts college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education. However, before ~~prior to~~ being certified by the board to sit for the examination, each applicant who has matriculated in a chiropractic college after July 1, 2000, must ~~shall~~ have been granted a bachelor's degree from an institution holding accreditation for that degree from an institutional ~~a regional~~ accrediting agency that ~~which~~ is recognized by the United States Department of Education. The applicant's chiropractic degree must consist of credits earned in the chiropractic program and may not include academic credit for courses from the bachelor's degree.

(e) Successfully completed the National Board of Chiropractic Examiners certification examination in parts I, II, III, and IV, and the physiotherapy examination of the National Board of Chiropractic Examiners, with a score approved by the

board.

(f) Submitted to the department a set of fingerprints on a form and under procedures specified by the department, along with payment in an amount equal to the costs incurred by the Department of Health for the criminal background check of the applicant.

The board may require an applicant who graduated from an institution accredited by the Council on Chiropractic Education more than 10 years before the date of application to the board to take the National Board of Chiropractic Examiners Special Purposes Examination for Chiropractic, or its equivalent, as determined by the board. The board shall establish by rule a passing score.

Section 6. Subsection (4) of section 464.008, Florida Statutes, is amended to read:

464.008 Licensure by examination.—

~~(4) If an applicant who graduates from an approved program does not take the licensure examination within 6 months after graduation, he or she must enroll in and successfully complete a board-approved licensure examination preparatory course. The applicant is responsible for all costs associated with the course and may not use state or federal financial aid for such costs. The board shall by rule establish guidelines for licensure examination preparatory courses.~~

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Section 7. Paragraph (e) of subsection (1) of section 464.018, Florida Statutes, is amended to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(e) Having been found guilty of~~, regardless of adjudication,~~ or entered a plea of nolo contendere or guilty to, regardless of adjudication, any offense prohibited under s. 435.04 or similar statute of another jurisdiction; or having committed an act which constitutes domestic violence as defined in s. 741.28.

Section 8. Present subsections (13) and (14) of section 467.003, Florida Statutes, are redesignated as subsections (14) and (15), respectively, a new subsection (13) is added to that section, and subsections (1) and (12) of that section are amended, to read:

467.003 Definitions.—As used in this chapter, unless the context otherwise requires:

(1) "Approved midwifery program" means ~~a midwifery school or~~ a midwifery training program ~~which is~~ approved by the department pursuant to s. 467.205.

(12) "Preceptor" means a physician licensed under chapter 458 or chapter 459, a ~~licensed~~ midwife licensed under this chapter, or a certified nurse midwife licensed under chapter

464~~,~~ who has a minimum of 3 years' professional experience~~,~~ and who directs, teaches, supervises, and evaluates the learning experiences of a ~~the~~ student midwife as part of an approved midwifery program.

(13) "Prelicensure course" means a course of study, offered by an accredited midwifery program and approved by the department, which an applicant for licensure must complete before a license may be issued and which provides instruction in the laws and rules of this state and demonstrates the student's competency to practice midwifery under this chapter.

Section 9. Section 467.009, Florida Statutes, is amended to read:

467.009 Accredited and approved midwifery programs; education and training requirements.—

(1) The department shall adopt standards for accredited and approved midwifery programs which must include, but need not be limited to, standards for all of the following:

(a) ~~. The standards shall encompass~~ Clinical and classroom instruction in all aspects of prenatal, intrapartal, and postpartal care, including all of the following:

1. Obstetrics.~~;~~

2. Neonatal pediatrics.~~;~~

3. Basic sciences.~~;~~

4. Female reproductive anatomy and physiology.~~;~~

5. Behavioral sciences.~~;~~

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6. Childbirth education.~~;~~

7. Community care.~~;~~

8. Epidemiology.~~;~~

9. Genetics.~~;~~

10. Embryology.~~;~~

11. Neonatology.~~;~~

12. Applied pharmacology.~~;~~

13. The medical and legal aspects of midwifery.~~;~~

14. Gynecology and women's health.~~;~~

15. Family planning.~~;~~

16. Nutrition during pregnancy and lactation.~~;~~

17. Breastfeeding.~~; and~~

18. Basic nursing skills~~; and any other instruction determined by the department and council to be necessary~~.

(b) ~~The standards shall incorporate the~~ Core competencies, incorporating those established by the American College of Nurse Midwives and the Midwives Alliance of North America, including knowledge, skills, and professional behavior in all of the following areas:

1. Primary management, collaborative management, referral, and medical consultation.~~;~~

2. Antepartal, intrapartal, postpartal, and neonatal care.~~;~~

3. Family planning and gynecological care.~~;~~

4. Common complications.~~; and~~

5. Professional responsibilities.

(c) Noncurricular ~~The standards shall include noncurriculum~~ matters under this section, including, but not limited to, staffing and teacher qualifications.

(2) An accredited and approved midwifery program must offer ~~shall include~~ a course of study ~~and clinical training~~ for a minimum of 3 years which incorporates all of the standards, curriculum guidelines, and educational objectives provided in this section and the rules adopted hereunder.

(3) An accredited and approved midwifery program may reduce ~~If the applicant is a registered nurse or a licensed practical nurse or has previous nursing or midwifery education,~~ the required period of training ~~may be reduced~~ to the extent of the student's ~~applicant's~~ qualifications as a registered nurse or licensed practical nurse or based on prior completion of equivalent nursing or midwifery education, as determined ~~under rules adopted~~ by ~~the~~ department rule~~. In no case shall the training be reduced to a period of less than 2 years~~.

(4)~~(3)~~ An accredited and approved midwifery program may accept students who ~~To be accepted into an approved midwifery program, an applicant shall~~ have both:

(a) A high school diploma or its equivalent.

(b) Taken three college-level credits each of math and English or demonstrated competencies in communication and computation.

(5) ~~(4)~~ As part of its course of study, an accredited and approved midwifery program must require clinical training that includes all of the following:

(a) ~~A student midwife, during training, shall undertake, under the supervision of a preceptor,~~ The care of 50 women in each of the prenatal, intrapartal, and postpartal periods under the supervision of a preceptor.~~, but~~ The same women need not be seen through all three periods.

(b) ~~(5)~~ Observation of ~~The student midwife shall observe~~ an additional 25 women in the intrapartal period ~~before qualifying for a license~~.

(6) Clinical ~~The~~ training required under this section must include all of the following:

(a) ~~shall include~~ Training in ~~either~~ hospitals or alternative birth settings, or both.

(b) A requirement that students demonstrate competency in the assessment of and differentiation~~, with particular emphasis on learning the ability to differentiate~~ between low-risk pregnancies and high-risk pregnancies.

(7) A hospital or birthing center receiving public funds shall be required to provide student midwives access to observe labor, delivery, and postpartal procedures, provided the woman in labor has given informed consent. The Department of Health shall assist in facilitating access to hospital training for accredited and approved midwifery programs.

(8)~~(7)~~ The Department of Education shall adopt curricular frameworks for midwifery programs offered by ~~conducted within~~ public educational institutions under ~~pursuant to~~ this section.

~~(8) Nonpublic educational institutions that conduct approved midwifery programs shall be accredited by a member of the Commission on Recognition of Postsecondary Accreditation and shall be licensed by the Commission for Independent Education.~~

Section 10. Section 467.011, Florida Statutes, is amended to read:

467.011 Licensed midwives; qualifications; examination ~~Licensure by examination~~.—

~~(1) The department shall administer an examination to test the proficiency of applicants in the core competencies required to practice midwifery as specified in s. 467.009.~~

~~(2) The department shall develop, publish, and make available to interested parties at a reasonable cost a bibliography and guide for the examination.~~

~~(3)~~ The department shall issue a license to practice midwifery to an applicant who meets all of the following criteria:

(1) Demonstrates that he or she has graduated from one of the following:

(a) An accredited and approved midwifery program.

(b) A medical or midwifery program offered in another state, jurisdiction, territory, or country whose graduation

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requirements were equivalent to or exceeded those required by s. 467.009 and the rules adopted thereunder at the time of graduation.

(2) Demonstrates that he or she has ~~and~~ successfully completed a prelicensure course offered by an accredited and approved midwifery program. Students graduating from an accredited and approved midwifery program may meet this requirement by showing that the content requirements for the prelicensure course were covered as part of their course of study.

(3) Submits an application for licensure on a form approved by the department and pays the appropriate fee.

(4) Demonstrates that he or she has received a passing score on an ~~the~~ examination specified by the department~~, upon payment of the required licensure fee~~.

Section 11. Section 467.0125, Florida Statutes, is amended to read:

467.0125 Licensed midwives; qualifications; ~~Licensure by~~ endorsement; temporary certificates.—

(1) The department shall issue a license by endorsement to practice midwifery to an applicant who, upon applying to the department, demonstrates to the department that she or he meets all of the following criteria:

(a)~~1. Holds a valid certificate or diploma from a foreign institution of medicine or midwifery or from a midwifery program~~

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~~offered in another state, bearing the seal of the institution or otherwise authenticated, which renders the individual eligible to practice midwifery in the country or state in which it was issued, provided the requirements therefor are deemed by the department to be substantially equivalent to, or to exceed, those established under this chapter and rules adopted under this chapter, and submits therewith a certified translation of the foreign certificate or diploma; or~~

~~2.~~ Holds an active, unencumbered ~~a valid certificate or~~ license to practice midwifery in another state, jurisdiction, or territory ~~issued by that state~~, provided the licensing requirements of that state, jurisdiction, or territory at the time the license was issued were ~~therefor are deemed by the department to be~~ substantially equivalent to~~,~~ or exceeded ~~to exceed,~~ those established under this chapter and the rules adopted hereunder ~~under this chapter~~.

(b) Has successfully completed a ~~4-month~~ prelicensure course conducted by an accredited and approved midwifery program ~~and has submitted documentation to the department of successful completion~~.

(c) Submits an application for licensure on a form approved by the department and pays the appropriate fee ~~Has successfully passed the licensed midwifery examination~~.

(2) The department may issue a temporary certificate to practice in areas of critical need to an applicant ~~any midwife~~

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who is qualifying for a midwifery license ~~licensure by endorsement~~ under subsection (1) and who meets all of the following criteria~~, with the following restrictions~~:

(a) Submits an application for a temporary certificate on a form approved by the department and pays the appropriate fee, which may not exceed $50 and is in addition to the fee required for licensure by endorsement under subsection (1).

(b) Specifies on the application that he or she will ~~The Department of Health shall determine the areas of critical need, and the midwife so certified shall~~ practice only in one or more of the following locations:

1. A county health department.

2. A correctional facility.

3. A United States Department of Veterans Affairs clinic.

4. A community health center funded by s. 329, s. 330, or s. 340 of the Public Health Service Act.

5. Any other agency or institution that is approved by the State Surgeon General and provides health care to meet the needs of an underserved population in this state.

(c) Will practice only ~~those specific areas,~~ under the supervision ~~auspices~~ of a physician licensed under ~~pursuant to~~ chapter 458 or chapter 459, a certified nurse midwife licensed under ~~pursuant to~~ part I of chapter 464, or a midwife licensed under this chapter~~,~~ who has a minimum of 3 years' professional experience.

(3) The department may issue a temporary certificate under this section with the following restrictions:

(a) A requirement that a temporary certificateholder practice only in areas of critical need. The State Surgeon General shall determine the areas of critical need, which ~~Such areas shall~~ include, but are not ~~be~~ limited to, health professional shortage areas designated by the United States Department of Health and Human Services.

(b) A requirement that if a temporary certificateholder's practice area ceases to be an area of critical need, within 30 days after such change the certificateholder must either:

1. Report a new practice area of critical need to the department; or

2. Voluntarily relinquish the temporary certificate.

(4) The department shall review a temporary certificateholder's practice at least annually to determine whether the certificateholder is meeting the requirements of subsections (2) and (3) and the rules adopted thereunder. If the department determines that a certificateholder is not meeting these requirements, the department must revoke the temporary certificate.

(5) A temporary certificate issued under this section is ~~shall be~~ valid ~~only as long as an area~~ for ~~which it is issued remains an area of critical need, but no longer than~~ 2 years~~,~~ and is ~~shall~~ not ~~be~~ renewable.

~~(c) The department may administer an abbreviated oral examination to determine the midwife's competency, but no written regular examination shall be necessary.~~

~~(d) The department shall not issue a temporary certificate to any midwife who is under investigation in another state for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of this section shall apply.~~

~~(e) The department shall review the practice under a temporary certificate at least annually to ascertain that the minimum requirements of the midwifery rules promulgated under this chapter are being met. If it is determined that the minimum requirements are not being met, the department shall immediately revoke the temporary certificate.~~

~~(f) The fee for a temporary certificate shall not exceed $50 and shall be in addition to the fee required for licensure.~~

Section 12. Section 467.205, Florida Statutes, is amended to read:

467.205 Approval of midwifery programs.—

(1) The department must approve an accredited or state-licensed public or private institution seeking to provide midwifery education and training as an approved midwifery program in this state if the institution meets all of the following criteria:

(a) Submits an application for approval on a form approved

by the department.

(b) Demonstrates to the department's satisfaction that the proposed midwifery program complies with s. 467.009 and the rules adopted thereunder.

(c) For a private institution, demonstrates its accreditation by a member of the Council for Higher Education Accreditation or and accrediting agency approved by the United States Department of Education as an institutional accrediting agency for direct-entry midwifery education programs or an accrediting agency approved by the United States Department of Education and its licensing or provisional licensing by the Commission for Independent Education ~~An organization desiring to conduct an approved program for the education of midwives shall apply to the department and submit such evidence as may be required to show that it complies with s. 467.009 and with the rules of the department. Any accredited or state-licensed institution of higher learning, public or private, may provide midwifery education and training.~~

~~(2) The department shall adopt rules regarding educational objectives, faculty qualifications, curriculum guidelines, administrative procedures, and other training requirements as are necessary to ensure that approved programs graduate midwives competent to practice under this chapter.~~

~~(3) The department shall survey each organization applying for approval. If the department is satisfied that the program~~

~~meets the requirements of s. 467.009 and rules adopted pursuant to that section, it shall approve the program~~.

(2)~~(4)~~ The department shall, at least once every 3 years, certify whether each approved midwifery program is currently compliant, and has maintained compliance, ~~complies~~ with the requirements of ~~standards developed under~~ s. 467.009 and the rules adopted thereunder.

(3)~~(5)~~ If the department finds that an approved midwifery program is not in compliance with the requirements of s. 467.009 or the rules adopted thereunder, or has lost its accreditation status, the department must provide its finding to the program in writing and ~~no longer meets the required standards, it~~ may place the program on probationary status for a specified period of time, which may not exceed 3 years ~~until such time as the standards are restored~~.

(4) If a program on probationary status does not come into compliance with the requirements of s. 467.009 or the rules adopted thereunder, or regain its accreditation status, as applicable, within the period specified by the department ~~fails to correct these conditions within a specified period of time~~, the department may rescind the program's approval.

(5) A ~~Any~~ program that has ~~having~~ its approval rescinded has ~~shall have~~ the right to reapply for approval.

(6) The department may grant provisional approval of a new program seeking accreditation status, for a period not to exceed

5 years, provided that all other requirements of this section are met.

(7) The department may rescind provisional approval of a program that fails to meet the requirements of s. 467.009, this section, or the rules adopted thereunder, in accordance with procedures provided in subsections (3) and (4) ~~may be granted pending the licensure results of the first graduating class~~.

Section 13. Subsections (2), (3), and (4) and paragraphs (a) and (b) of subsection (5) of section 468.803, Florida Statutes, are amended to read:

468.803 License, registration, and examination requirements.—

(2) An applicant for registration, examination, or licensure must apply to the department on a form prescribed by the board for consideration of board approval. Each initial applicant shall submit ~~a set of~~ fingerprints to the department in accordance with ~~on a form and under~~ procedures specified by the department~~, along with payment in an amount equal to the costs incurred by the department~~ for state and national criminal history checks of the applicant. ~~The department shall submit the fingerprints provided by an applicant to the Department of Law Enforcement for a statewide criminal history check, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history check of the applicant.~~ The board shall screen the

results to determine if an applicant meets licensure requirements. The board shall consider for examination, registration, or licensure each applicant whom ~~who~~ the board verifies:

(a) Has submitted the completed application and completed the fingerprinting requirements ~~fingerprint forms~~ and has paid the applicable application fee, not to exceed $500~~, and the cost of the state and national criminal history checks~~. The application fee is ~~and cost of the criminal history checks shall be~~ nonrefundable;

(b) Is of good moral character;

(c) Is 18 years of age or older; and

(d) Has completed the appropriate educational preparation.

(3) A person seeking to attain the orthotics or prosthetics experience required for licensure in this state must be approved by the board and registered as a resident by the department. Although a registration may be held in both disciplines, for independent registrations the board may not approve a second registration until at least 1 year after the issuance of the first registration. Notwithstanding subsection (2), a person who has been approved by the board and registered by the department in one discipline may apply for registration in the second discipline without an additional state or national criminal history check during the period in which the first registration is valid. Each independent registration or dual

registration is valid for 2 years after the date of issuance unless otherwise revoked by the department upon recommendation of the board. The board shall set a registration fee not to exceed $500 to be paid by the applicant. A registration may be renewed once by the department upon recommendation of the board for a period no longer than 1 year, as such renewal is defined by ~~the~~ board ~~by~~ rule. The renewal fee may not exceed one-half the current registration fee. To be considered by the board for approval of registration as a resident, the applicant must have one of the following:

(a) A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an ~~a regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs.

(b) A minimum of a bachelor's degree from an institutionally ~~a regionally~~ accredited college or university and a certificate in orthotics or prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board.

(c) A minimum of a bachelor's degree from an institutionally ~~a regionally~~ accredited college or university and a dual certificate in both orthotics and prosthetics from programs recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by

the board.

(4) The department may develop and administer a state examination for an orthotist or a prosthetist license, or the board may approve the existing examination of a national standards organization. The examination must be predicated on a minimum of a baccalaureate-level education and formalized specialized training in the appropriate field. Each examination must demonstrate a minimum level of competence in basic scientific knowledge, written problem solving, and practical clinical patient management. The board shall require an examination fee not to exceed the actual cost to the board in developing, administering, and approving the examination, which fee must be paid by the applicant. To be considered by the board for examination, the applicant must have:

(a) For an examination in orthotics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally ~~a regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from an institutionally ~~a regionally~~ accredited college or university and a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved orthotics internship of 1 year of qualified

experience, as determined by the board, or an orthotic residency or dual residency program recognized by the board.

(b) For an examination in prosthetics:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally ~~a regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs or, at a minimum, a bachelor's degree from an institutionally ~~a regionally~~ accredited college or university and a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board; and

2. An approved prosthetics internship of 1 year of qualified experience, as determined by the board, or a prosthetic residency or dual residency program recognized by the board.

(5) In addition to the requirements in subsection (2), to be licensed as:

(a) An orthotist, the applicant must pay a license fee not to exceed $500 and must have:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally ~~a regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs, or a bachelor's degree from an institutionally accredited

college or university and ~~with~~ a certificate in orthotics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board;

2. An approved ~~appropriate~~ internship of 1 year of qualified experience, as determined by the board, or a residency program recognized by the board;

3. Completed the mandatory courses; and

4. Passed the state orthotics examination or the board-approved orthotics examination.

(b) A prosthetist, the applicant must pay a license fee not to exceed $500 and must have:

1. A Bachelor of Science or higher-level postgraduate degree in orthotics and prosthetics from an institutionally ~~a regionally~~ accredited college or university recognized by the Commission on Accreditation of Allied Health Education Programs, or a bachelor's degree from an institutionally accredited college or university and ~~with~~ a certificate in prosthetics from a program recognized by the Commission on Accreditation of Allied Health Education Programs, or its equivalent, as determined by the board;

2. An internship of 1 year of qualified experience, as determined by the board, or a residency program recognized by the board;

3. Completed the mandatory courses; and

4. Passed the state prosthetics examination or the board-approved prosthetics examination.

Section 14. Section 483.824, Florida Statutes, is amended to read:

483.824 Qualifications of clinical laboratory director.—A clinical laboratory director must have 4 years of clinical laboratory experience with 2 years of experience in the specialty to be directed or be nationally board certified in the specialty to be directed, and must meet one of the following requirements:

(1) Be a physician licensed under chapter 458 or chapter 459;

(2) Hold an earned doctoral degree in a chemical, physical, or biological science from an ~~a regionally~~ accredited institution and maintain national certification requirements equal to those required by the federal Health Care Financing Administration; or

(3) For the subspecialty of oral pathology, be a physician licensed under chapter 458 or chapter 459 or a dentist licensed under chapter 466.

Section 15. Subsection (3) of section 490.003, Florida Statutes, is amended to read:

490.003 Definitions.—As used in this chapter:

(3)(a) "Doctoral degree from an American Psychological Association accredited program" means ~~Effective July 1, 1999,~~

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~~"doctoral-level psychological education" and "doctoral degree in psychology" mean~~ a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at an educational institution that, at the time the applicant was enrolled and graduated:

1.~~(a)~~ Had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada; and

2.~~(b)~~ Had programmatic accreditation from the American Psychological Association.

(b) "Doctoral degree in psychology" means a Psy.D., an Ed.D. in psychology, or a Ph.D. in psychology from a psychology program at an educational institution that, at the time the applicant was enrolled and graduated, had institutional accreditation from an agency recognized and approved by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada.

Section 16. Subsection (1) of section 490.005, Florida Statutes, is amended to read:

490.005 Licensure by examination.—

(1) Any person desiring to be licensed as a psychologist shall apply to the department to take the licensure examination. The department shall license each applicant whom ~~who~~ the board

certifies has met all of the following requirements:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $500 and an examination fee set by the board sufficient to cover the actual per applicant cost to the department for development, purchase, and administration of the examination, but not to exceed $500.

(b) Submitted proof satisfactory to the board that the applicant has received:

1. A doctoral degree from an American Psychological Association accredited program ~~Doctoral-level psychological education~~; or

2. The equivalent of a doctoral degree from an American Psychological Association accredited program ~~doctoral-level psychological education, as defined in s. 490.003(3),~~ from ~~a program at~~ a school or university located outside the United States of America which was officially recognized by the government of the country in which it is located as an institution or program to train students to practice professional psychology. The applicant has the burden of establishing that this requirement has been met.

(c) Had at least 2 years or 4,000 hours of experience in the field of psychology in association with or under the supervision of a licensed psychologist meeting the academic and experience requirements of this chapter or the equivalent as determined by the board. The experience requirement may be met

by work performed on or off the premises of the supervising psychologist if the off-premises work is not the independent, private practice rendering of psychological services that does not have a psychologist as a member of the group actually rendering psychological services on the premises.

(d) Passed the examination. However, an applicant who has obtained a passing score, as established by the board by rule, on the psychology licensure examination designated by the board as the national licensure examination need only pass the Florida law and rules portion of the examination.

Section 17. Subsection (1) of section 490.0051, Florida Statutes, is amended to read:

490.0051 Provisional licensure; requirements.—

(1) The department shall issue a provisional psychology license to each applicant who the board certifies has:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $250, as set by board rule.

(b) Earned a doctoral degree <u>from an American Psychological Association accredited program</u> ~~in psychology as defined in s. 490.003(3)~~.

(c) Met any additional requirements established by board rule.

Section 18. Subsections (1), (3), and (4) of section 491.005, Florida Statutes, are amended to read:

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491.005 Licensure by examination.—

(1) CLINICAL SOCIAL WORK.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, ~~plus the actual per applicant cost to the department for purchase of the examination from the American Association of State Social Worker's Boards or a similar national organization,~~ the department shall issue a license as a clinical social worker to an applicant whom ~~who~~ the board certifies has met all of the following criteria:

(a) ~~Has~~ Submitted an application and paid the appropriate fee.

(b)1. ~~Has~~ Received a doctoral degree in social work from a graduate school of social work which at the time the applicant graduated was accredited by an accrediting agency recognized by the United States Department of Education or ~~has~~ received a master's degree in social work from a graduate school of social work which at the time the applicant graduated:

a. Was accredited by the Council on Social Work Education;

b. Was accredited by the Canadian Association of Schools of Social Work; or

c. Has been determined to have been a program equivalent to programs approved by the Council on Social Work Education by the Foreign Equivalency Determination Service of the Council on Social Work Education. An applicant who graduated from a program at a university or college outside of the United States or

Canada must present documentation of the equivalency determination from the council in order to qualify.

2. The applicant's graduate program must have emphasized direct clinical patient or client health care services, including, but not limited to, coursework in clinical social work, psychiatric social work, medical social work, social casework, psychotherapy, or group therapy. The applicant's graduate program must have included all of the following coursework:

a. A supervised field placement which was part of the applicant's advanced concentration in direct practice, during which the applicant provided clinical services directly to clients.

b. Completion of 24 semester hours or 32 quarter hours in theory of human behavior and practice methods as courses in clinically oriented services, including a minimum of one course in psychopathology, and no more than one course in research, taken in a school of social work accredited or approved pursuant to subparagraph 1.

3. If the course title which appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant shall be required to provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course.

(c) ~~Has~~ Had at least 2 years of clinical social work

experience, which took place subsequent to completion of a graduate degree in social work at an institution meeting the accreditation requirements of this section, under the supervision of a licensed clinical social worker or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If the applicant's graduate program was not a program which emphasized direct clinical patient or client health care services as described in subparagraph (b)2., the supervised experience requirement must take place after the applicant has completed a minimum of 15 semester hours or 22 quarter hours of the coursework required. A doctoral internship may be applied toward the clinical social work experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) ~~Has~~ Passed a theory and practice examination designated by board rule ~~provided by the department for this purpose~~.

(e) ~~Has~~ Demonstrated, in a manner designated by board rule ~~of the board~~, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

(3) MARRIAGE AND FAMILY THERAPY.—Upon verification of

documentation and payment of a fee not to exceed $200, as set by board rule, ~~plus the actual cost of the purchase of the examination from the Association of Marital and Family Therapy Regulatory Board, or similar national organization,~~ the department shall issue a license as a marriage and family therapist to an applicant who the board certifies has met all of the following criteria:

(a) ~~Has~~ Submitted an application and paid the appropriate fee.

(b) 1. Attained one of the following:

a. A minimum of a master's degree in marriage and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education;

b. A minimum of a master's degree with a major emphasis in marriage and family therapy or a closely related field from a university program accredited by the Council on Accreditation of Counseling and Related Educational Programs and graduate courses approved by the board; or

c. ~~Has~~ A minimum of a master's degree with an ~~major~~ emphasis in marriage and family therapy or a closely related field, with a degree conferred before September 1, 2027, from an institutionally accredited college or university ~~from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education or from a Florida university program accredited by the Council for Accreditation of Counseling and~~

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~~Related Educational Programs~~ and graduate courses approved by the board ~~of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling~~.

2. If the course title that appears on the applicant's transcript does not clearly identify the content of the coursework, the applicant must ~~shall~~ provide additional documentation, including, but not limited to, a syllabus or catalog description published for the course. The required master's degree must have been received in an institution of higher education that, at the time the applicant graduated, was fully accredited by an institutional ~~a regional~~ accrediting body recognized by the Council for Higher Education Accreditation or its successor organization ~~Commission on Recognition of Postsecondary Accreditation~~ or publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada, or an institution of higher education located outside the United States and Canada which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by an institutional ~~a regional~~ accrediting body recognized by the Council for Higher Education Accreditation or its successor organization ~~Commission on Recognition of Postsecondary Accreditation~~. Such foreign education and training must have been received in an institution

or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as professional marriage and family therapists or psychotherapists. The applicant has the burden of establishing that the requirements of this provision have been met, and the board shall require documentation, such as an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. An applicant with a master's degree from a program that did not emphasize marriage and family therapy may complete the coursework requirement in a training institution fully accredited by the Commission on Accreditation for Marriage and Family Therapy Education recognized by the United States Department of Education.

(c) Completed ~~Has had~~ at least 2 years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services, which must have been ~~be~~ at the post-master's level under the supervision of a licensed marriage and family therapist with at least 5 years of experience, or the equivalent, who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before

commencing practice. If a graduate has a master's degree with a major emphasis in marriage and family therapy or a closely related field which did not include all of the coursework required by paragraph (b), credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of 10 of the courses required by paragraph (b), as determined by the board, and at least 6 semester hours or 9 quarter hours of the course credits must have been completed in the area of marriage and family systems, theories, or techniques. Within the 2 years of required experience, the applicant must ~~shall~~ provide direct individual, group, or family therapy and counseling to cases including those involving unmarried dyads, married couples, separating and divorcing couples, and family groups that include children. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) ~~Has~~ Passed a theory and practice examination designated ~~provided~~ by board rule ~~the department~~.

(e) ~~Has~~ Demonstrated, in a manner designated by board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

For the purposes of dual licensure, the department shall license as a marriage and family therapist any person who meets the requirements of s. 491.0057. Fees for dual licensure may not exceed those stated in this subsection.

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, ~~plus the actual per applicant cost of purchase of the examination from the National Board for Certified Counselors or its successor organization,~~ the department shall issue a license as a mental health counselor to an applicant who the board certifies has met all of the following criteria:

(a) ~~Has~~ Submitted an application and paid the appropriate fee.

(b)1. Attained ~~Has~~ a minimum of an earned master's degree from a mental health counseling program accredited by the Council for the Accreditation of Counseling and Related Educational Programs which consists of at least 60 semester hours or 80 quarter hours of clinical and didactic instruction, including a course in human sexuality and a course in substance abuse. If the master's degree is earned from a program related to the practice of mental health counseling which is not accredited by the Council for the Accreditation of Counseling and Related Educational Programs, then the coursework and practicum, internship, or fieldwork must consist of at least 60 semester hours or 80 quarter hours and meet all of the following

requirements:

a. Thirty-three semester hours or 44 quarter hours of graduate coursework, which must include a minimum of 3 semester hours or 4 quarter hours of graduate-level coursework in each of the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

b. A minimum of 3 semester hours or 4 quarter hours of graduate-level coursework addressing diagnostic processes, including differential diagnosis and the use of the current diagnostic tools, such as the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. The graduate program must have emphasized the common core curricular experience.

c. The equivalent, as determined by the board, of at least 700 hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct client services, as required in the accrediting

standards of the Council for Accreditation of Counseling and Related Educational Programs for mental health counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement.

2. ~~Has~~ Provided additional documentation if a course title that appears on the applicant's transcript does not clearly identify the content of the coursework. The documentation must include, but is not limited to, a syllabus or catalog description published for the course.

Education and training in mental health counseling must have been received in an institution of higher education that, at the time the applicant graduated, was fully accredited by an institutional ~~a regional~~ accrediting body recognized by the Council for Higher Education Accreditation or its successor organization or publicly recognized as a member in good standing with the Association of Universities and Colleges of Canada, or an institution of higher education located outside the United States and Canada which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by an institutional ~~a regional~~ accrediting body recognized by the Council for Higher Education Accreditation or its successor organization. Such foreign education and training

must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as mental health counselors. The applicant has the burden of establishing that the requirements of this provision have been met, and the board shall require documentation, such as an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs, the Masters in Psychology and Counseling Accreditation Council, or an equivalent accrediting body which consists of at least 60 semester hours or 80 quarter hours to apply for licensure under this paragraph.

(c) Completed ~~Has had~~ at least 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling which

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did not include all the coursework required under sub-subparagraphs (b)1.a. and b., credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.

(d) ~~Has~~ Passed a theory and practice examination designated ~~provided~~ by board rule ~~the department for this purpose~~.

(e) ~~Has~~ Demonstrated, in a manner designated by board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

Section 19. Subsection (6) and paragraph (c) of subsection (9) of section 766.314, Florida Statutes, are amended to read:

766.314 Assessments; plan of operation.—

(6)(a) The association shall make all assessments required by this section, except initial assessments of physicians licensed ~~on or after October 1, 1988, which assessments will be made~~ by the Department of Health ~~Business and Professional Regulation~~, and except assessments of casualty insurers pursuant

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to subparagraph (5)(c)1., which assessments will be made by the Office of Insurance Regulation. ~~Beginning October 1, 1989, for any physician licensed between October 1 and December 31 of any year, the Department of Business and Professional Regulation shall make the initial assessment plus the assessment for the following calendar year.~~ The Department of Health ~~Business and Professional Regulation~~ shall provide the association, in an electronic format, with a monthly report ~~such frequency as determined to be necessary, a listing, in a computer-readable form,~~ of the names and license numbers ~~addresses~~ of all physicians licensed under chapter 458 or chapter 459.

(b)~~1.~~ The association may enforce collection of assessments required to be paid pursuant to ss. 766.301-766.316 by suit filed in county court. The association shall be entitled to an award of attorney's fees, costs, and interest upon the entry of a judgment against a physician for failure to pay such assessment, with such interest accruing until paid. Notwithstanding the provisions of chapters 47 and 48, the association may file such suit in either Leon County or the county of the residence of the defendant. The association shall notify the Department of Health and the applicable board of any unpaid final judgement against a physician within 7 days of the final judgement.

~~2. The Department of Business and Professional Regulation, upon notification by the association that an assessment has not~~

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~~been paid and that there is an unsatisfied judgment against a physician, shall not renew any license to practice for such physician issued pursuant to chapter 458 or chapter 459 until such time as the judgment is satisfied in full.~~

(c) The Agency for Health Care Administration shall, upon notification by the association that an assessment has not been timely paid, enforce collection of such assessments required to be paid by hospitals pursuant to ss. 766.301-766.316. Failure of a hospital to pay such assessment is grounds for disciplinary action pursuant to s. 395.1065 notwithstanding any ~~provision of~~ law to the contrary.

(9)

(c) If ~~In the event~~ the total of all current estimates equals 80 percent of the funds on hand and the funds that will become available to the association within the next 12 months from all sources described in subsections (4) and (5) and paragraph (7)(a), the association may ~~shall~~ not accept any new claims without express authority from the Legislature. Nothing in this section precludes ~~herein shall preclude~~ the association from accepting any claim if the injury occurred 18 months or more before ~~prior to~~ the effective date of this suspension. Within 30 days after ~~of~~ the effective date of this suspension, the association shall notify the Governor, the Speaker of the House of Representatives, the President of the Senate, the Office of Insurance Regulation, the Agency for Health Care

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Administration, and the Department of Health~~, and the Department of Business and Professional Regulation~~ of this suspension.

Section 20. This act shall take effect July 1, 2022.

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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 747 Protections of Medical Conscience
SPONSOR(S): Snyder
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Poche	McElroy
2) Judiciary Committee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A network of federal and state statutes creates legal protections for health care providers' rights of conscience. These laws originated after the U.S. Supreme Court's 1973 decision in *Roe v. Wade*, to ensure that physicians who opposed abortion on grounds of religion or conscience would not be compelled to participate in those procedures.

Over time, the scope of these conscience protections expanded significantly – today, the laws protect physicians, pharmacists, other types of health care providers and medical staff, medical students, researchers, and health care institutions like hospitals and skilled nursing facilities. The laws address various medical procedures beyond abortion, including sterilization, contraception, emergency contraception, end of life care, aid-in-dying, and stem cell research. Some laws are broad enough to protect health care providers who object to any medical treatment on grounds of conscience. Many laws protect not only those who object to performing a specific medical service, but also those who object to informing patients about, referring patients for, or participating in any way in that service. The precise scope and content of these protections varies widely across federal and state law.

HB 747 creates s. 381.00321, F.S., establishing a health care provider's or health care payer's right to decline to participate in any health care service that violates the provider's or payer's conscience, defined as the moral, ethical, or religious beliefs or principles held by the provider or payer. The bill also gives a health care provider that is a business entity and a health care payer that holds itself out as religious, has a religious purpose or mission evidenced by its operating documents, and has internal procedures to implement the purpose or mission the right to make employment, staffing, contracting, and credentialing decisions consistent with their religious beliefs.

The bill also prohibits threatened and actual adverse action against a health care provider or health care payer for declining to participate in a health care service that violates their conscience; reporting to the appropriate governmental agency certain violations by the provider or payer's employer or gross mismanagement, gross waste of funds, abuse of authority, or any action that is a substantial and specific danger to public health or safety.

Lastly, the bill creates a civil cause of action for treble damages, an injunction, or any other appropriate relief for any violation of s. 381.00321, F.S. A prevailing plaintiff is also entitled to attorney fees and court costs. The bill provides immunity from civil, criminal, or administrative liability on the part of a health care provider or health care payer for exercising their right to conscience.

The bill has no fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Conscience

Most definitions in the U.S. legal context broadly define conscience to include moral, ethical, or religious principles. Some scholars believe that the definition between religion and conscience is a distinction without a difference. Others have suggested that "the framers viewed 'free exercise of religion' and 'freedom of conscience' as virtually interchangeable concepts".[1] James Madison is credited with first identifying the right to conscience as fundamental and inalienable, "changing the Virginia Declaration of Rights from a mere statement of the principle of tolerance to the first official legislative pronouncement that freedom of conscience and religion are inherent rights of the individual."[2] Freedom of conscience is a concept that has been highly valued since the founding of the United States.[3]

The Health Care Right of Conscience Act[4] in Illinois was the first state law of its kind and is model legislation in the conscience arena. That Act defines 'conscience' as "a sincerely held set of moral convictions arising from belief in and relation to God, or which, though not so derived, arises from a place in the life of the possessor parallel to that filled by God among adherents to religious faiths."[5] Conscience cannot to be construed as merely one's ideas or opinions.[6]

Conscience Objections and Health Care Professional Ethics

Health care providers with moral objections to specific health care services have an obligation to alert their colleagues and supervisors to these objections, in the interests of minimizing disruption in the delivery of care and minimizing burdens on other providers. Conscientious objection policies may specify that a professional who has invoked the right to refuse to provide a service must not interfere with the patient's ability to obtain it elsewhere. This specification recognizes that it is professionally inappropriate for health care providers who step away from services to then step between a patient and another health care provider, whether by refusing to cooperate with the transfer of a patient's care, refusing to make a referral, or making a patient feel uncomfortable or ashamed about seeking health care.

The American Medical Association issued an opinion interpreting its' Code of Medical Ethics regarding the physician exercise of conscience in the practice of medicine.[7] Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life.

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[1] Smith, S.D., *What does religion have to do with freedom of conscience?*, University of Colorado Law Review, 76, 911-940, 912.
[2] *Everson v. Board of Education*, 330 U.S. 1, 34 (1947).
[3] McConnell, M., *The Origins and Historical Understanding of Free Exercise of Religion*, 103 Harv. L. Rev. 1409 (1990).
[4] *745 Ill. Comp. Stat. 70/2*
[5] *745 Ill. Comp. Stat. 70/3(e)*
[6] Von Bergen, CW, and Bressler, M, *A matter of conscience: do conflicting beliefs and workplace demands constitute religious discrimination?*, Journal of Behavioral Studies in Business, 3, pgs. 113-126, 114 (April 2011).
[7] American Medical Association, *Code of Medical Ethics Opinion 1.1.7 – Physician Exercise of Conscience*, available at https://www.ama-assn.org/delivery-care/ethics/physician-exercise-conscience.

Preserving opportunity for physicians to act or to refrain from acting in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.

Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient.

In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.

In following conscience, the AMA believes that physicians should:

- Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
- Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
- Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
- Be mindful of the burden their actions may place on fellow professionals.
- Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
- In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
- Continue to provide other ongoing care for the patient or formally terminate the patient-physician relationship in keeping with ethics guidance.

Some scholars argue that invoking personal conscience violates medical professional ethics.[8] And while courts will usually not compel health care providers to participate in procedures that violate their personal faith or conscience, they construe objections of associated "complicity" narrowly and thus may require such providers to give patients reasonable information about access to appropriate treatment.[9]

Conscience clauses are not without controversy. Several scholars question whether offering legal protections for health care providers' exercise of conscience is even justified.[10] Other commentators argue that conscience laws should not protect providers from criminal prosecution,[11] civil liability,[12] or regulatory sanction.[13]

[8] Frader, J., Bosk, C.L., *The personal is political, the professional is not: conscientious objection to obtaining/providing/acting on genetic information*, Am J Med Genet C Semin Med Genet. 2009;151C(1):62-67.
[9] Lynch, H.F., *Conflicts of Conscience in Health Care: An Institutional Compromise*, Cambridge, MA, MIT Press, 2008: 231.
[10] Charo, R.A., *The Celestial Fire of Conscience – Refusing to Deliver Medical Care*, New England Journal of Medicine 352 (2005), pgs. 2471-2473, 2473.
[11] Nelson, L., *Provider Conscientious Refusal of Abortion, Obstetrical Emergencies, and Criminal Homicide Law*, American Journal of Bioethics, July;18(7): pgs. 43-50 (2018).

Health Care Conscience Protection Laws

Conscience protection laws protect individuals and entities from being required to perform services that violate their religious beliefs or moral convictions. These statutes have historically related to abortion, sterilization, and contraception. Conscience protections apply to health care providers who refuse to perform, accommodate, or assist with certain health care services on religious or moral grounds. The inspiration for conscience protection laws may have come from the accommodation requirements in Title VIII civil rights laws; however, most conscience laws do not have the "reasonable" and "undue hardship" qualifiers for accommodating religious practices under that federal law.

Conscience protection laws are generally designed to reconcile "the conflict between religious health care providers who provide care in accordance with their religious beliefs and the patients who want access to medical care that these religious providers find objectionable".[14] Such laws protect conscientious objectors from coercive hiring or employment practices, discrimination and other forms of punishment or pressure. Also, these laws generally include civil liability protection. Federal statutes protect health care provider conscience rights and prohibit recipients of certain federal funds from discriminating against health care providers who refuse to participate in these services based on moral objections or religious beliefs.

Despite the level of interest in tracking legislative developments related to conscience laws in the U.S., there exists no empirical data on how frequently these various types of procedural protections arise.[15]

Federal Health Care Conscience Protections

Several federal health care provider conscience protection laws, detailed below, prohibit recipients of certain federal Department of Health and Human Services (HHS) financial assistance from discriminating against certain health care providers because of their refusal or unwillingness to participate in certain medical procedures, such as sterilization procedures and abortions, that are contrary to or consistent with the provider's religious beliefs or moral convictions. Providers protected under these federal laws include:

- Individual physicians;
- Researchers;
- Nurses;
- Applicants for internships or residencies;
- Other health care professionals;
- Hospitals;
- Health insurance plans;
- Provider-sponsored organizations;
- Health maintenance organizations;
- Health care facilities; and
- Other health care entities.[16]

The following "covered entities" must comply with the federal health care provider conscience laws:

- Federal agencies funded by appropriations to the U.S Departments of Health and Human Services (HHS), Labor, and Education;
- Qualified health plans offered through a health insurance exchange;

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[12] Rich, B.A., *Your Morality, My Mortality: Conscientious Objection and the Standard of Care*, Cambridge Quarterly of Healthcare Ethics, 24: pgs. 214-230, 228 (2015).
[13] Id.
[14] White, K.A., *Crisis of conscience: Reconciling religious health care providers' beliefs and patient rights*, Stanford Law Review, 51, 1703-1749 (1999).
[15] Sawicki, N., *The Conscience Defense to Malpractice*, 108 Calif. L. Rev. 1255, pg. 1260 (2020).
[16] U.S. Department of Health and Human Services, Office for Civil Rights, *OCR Fact Sheet: Your Rights Under the Federal Health Care Provider Conscience Protection Laws*, available at https://www.hhs.gov/sites/default/files/ocr/civilrights/provider_conscience_factsheet.pdf.

- Any entity receiving federal financial assistance under certain HHS-implemented statutes; and
- Any entity which receives an HHS grant or contract for biomedical or behavioral research.[17]

Under the federal health care provider conscience laws, covered entities may not, if it would be contrary to the individual's or health care entity's religious beliefs or moral convictions:

- Require the individual to participate in sterilization or abortion;
- Require the entity to make its facilities available for sterilization or abortion;
- Require the entity to provide personnel to participate in sterilization or abortion;
- Discriminate against any physician or health care personnel in employment or staff privileges because the individual participated in or refused to participate in sterilization or abortion;
- Discriminate against any physician or health care personnel in employment or staff privileges because the individual participated in or refused to participate in any lawful health service or research activity;
- Deny admission to or otherwise discriminate against any training program applicant (including applicants for internships or residencies) because of the applicant's reluctance or willingness to participate in sterilization or abortion; or
- Discriminate against any individual or institutional health care entity that does not train in the performance of abortions or provide, pay for, provide coverage of, or refer for abortion.[18]

Also, covered entities must deem accredited any postgraduate physician training program that would be accredited, but for the reliance on an accrediting standard that (regardless of whether such standard provides exceptions or exemptions) requires an entity to perform abortions; or provide training for abortions.[19]

Office of Civil Rights

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces federal civil rights laws, conscience and religious freedom laws, the Health Insurance Portability and Accountability Act (HIPAA) Privacy, Security, and Breach Notification Rules, and the Patient Safety Act and Rule, which together protect your fundamental rights of nondiscrimination, conscience, religious freedom, and health information privacy. OCR protects rights by:

- Teaching health and social service workers about civil rights laws, conscience and religious freedom laws, health information privacy, and patient safety confidentiality laws.
- Educating communities about civil rights, conscience and religious freedom rights, and health information privacy rights.
- Investigating civil rights, conscience and religious freedom, health information privacy, and patient safety confidentiality complaints to identify discrimination or violation of the law and acting to correct problems.

A complaint under the Federal Health Care Provider Conscience Protection Statutes may be filed with the OCR if an individual believes he or she experienced discrimination because they:

- Objected to, participated in, or refused to participate in specific medical procedures, including abortion and sterilization, and related training and research activities.
- Were coerced into performing procedures that are against your religious or moral beliefs.
- Refused to provide health care items or services for the purpose of causing, or assisting in causing, the death of an individual, such as by assisted suicide or euthanasia.

OCR coordinates the handling of complaints with staff of the HHS programs from which the entity, with respect to whom a complaint has been filed, receives funding. If HHS becomes aware that a state or local government or an entity has conducted activities that may violate federal conscience protection

[17] Id.
[18] Id.
[19] Id.

laws, HHS will work with the offending government or entity to achieve voluntary compliance.[20] If voluntary compliance cannot be reached, HHS considers all legal options, including terminating funding and collecting fines paid out from violating the statutory conscience protections.[21]

OCR receives discrimination complaints under the following statutes:

The "Church Amendments"

The conscience provisions contained in 42 U.S.C. § 300a-7 et seq., collectively known as the "Church Amendments," were enacted in the 1970s to protect the conscience rights of individuals and entities that object to performing or assisting in the performance of abortion or sterilization procedures if doing so would be contrary to the provider's religious beliefs or moral convictions. The Church Amendments were also the first federal conscience provisions to be enacted and are the broadest in scope. This provision also extends protections to personnel decisions and prohibits any entity that receives a grant, contract, loan, or loan guarantee under certain Department-implemented statutes from discriminating against any physician or other health care personnel in employment because the individual either performed, or refused to perform an abortion if doing so would be contrary to the individual's religious beliefs or moral convictions. Specifically, the amendments contain the following major provisions:

- Prohibit courts and other public officials from requiring individuals or institutions receiving grants under certain federal programs to perform or assist in abortions or sterilizations or to provide facilities or personal for the same procedures;[22]
- Forbid discrimination against physicians or other health care providers because of their religious or moral objections to performing abortions or sterilizations;[23]
- Extend protection to individuals, including researchers and laboratory staff participating in HHS-funded behavioral or biomedical research;[24] and
- Bar any program funded by HHS from requiring any individual to perform or assist in "any part" of a "health service program or research activity" if such participation would be contrary to the individual's religious beliefs or moral convictions.[25]

The Coats-Snowe Amendment

In 1996, Congress passed the Omnibus Consolidated Rescissions and Appropriations Act of 1996. The Act addressed many issues, including funding for several federal agencies, prison litigation reform, and funding for the District of Columbia and reform of its schools. The Coats-Snowe Amendment was included in a general provision portion of the Act. The Amendment provides conscience protections for health care entities and individuals in connection with abortion training. The Amendment was enacted to address a new standard from the Accreditation Council for Graduate Medical Education (ACGME), which governs medical residencies, that required access to experience with induced abortion to be part of a resident's education, unless the resident had a moral or religious objection to such abortions.[26] Previously, training for abortions had been voluntary and not required for residency accreditation.

The Coats-Snowe Amendment prevents the federal government and any state or local government that receives any federal financial assistance from subjecting any "health care entity" to "discrimination" for refusing to train or arrange for training for induced abortions.[27] Such government units also may not

[20] U.S. Department of Health and Human Services, Office of the Secretary, Office for Civil Rights, *Enforcement of the Federal Health Care Provider Conscience Protection Laws*, slide 8 (June 9, 2016), available at https://www.hhs.gov/sites/default/files/ocr-provider-conscience-powerpoint-6-9-2016.pdf.
[21] Id.
[22] 42 U.S.C. s. 300a-7(b)
[23] 42 U.S.C. s. 300a-7(c)(1); areas of prohibited discrimination include employment, promotion, termination, and extending staff privileges; the Church Amendments also prohibit discrimination against individuals because of their past involvement in lawful abortions or sterilizations.
[24] 42 U.S.C. s. 300a-7(c)(2); under this provision, no individual can be discriminated against on the basis that the individual performed or assisted in any lawful research activity or the individual refused to perform or assist in any research activity because it would be contrary to his or her religious beliefs or moral convictions.
[25] This provision covers a broad array of activities, including contraception programs and research activities administered by HHS.
[26] Accreditation Council for Graduate Medical Education, *1996-1997 Graduate Medical Education Directory 135* (1996), available at http://acgme.org/Portals/0/PDFs/1996-97.pdf.
[27] 42 U.S.C. s. 238n(a)(1)-(2)

discriminate against persons who attend a post-graduate training program that lacks abortion training.[28] The Amendment defines "health care entity" to "include an individual physician, a postgraduate physician training program, and a participant in a program of training in the health professions."[29] It does not define "discrimination."

The Coats-Snowe Amendment also addresses the accreditation of medical training programs. The federal government and any state or local government that receives federal funds must accredit a "health care entity" that, but for its refusal to provide abortion training, would be accredited.[30] As to this provision only, the Amendment expressly confers rulemaking authority. It provides that "[t]he government involved shall formulate such regulations . . . as are necessary to comply with this subsection."

Public Health Service Act S. 245

Enacted in 1996, section 245 of the Public Health Service Act, contained in 42 U.S.C. § 238n, prohibits the federal government and any state or local government receiving federal financial assistance from discriminating against any health care entity on the basis that the entity:

- Refuses to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions;[31]
- Refuses to arrange for such activities[32]; or
- Attends (or attended) a post-graduate physician training program, or any other program of training in the health professions, that does not (or did not) perform induced abortions or require, provide, or refer for training in the performance of induced abortions, or arrange for the training.

The Weldon Amendment

The Weldon Amendment was originally passed as part of the HHS appropriation and has been readopted or incorporated by reference in each subsequent HHS appropriations act since 2005. It provides that "none of the funds made available in this Act [making appropriations for the Departments of Labor, Health and Human Services, and Education] may be made available to a Federal agency or program, or to a state or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions." The Amendment covers a diverse group of healthcare entities, including physicians and other healthcare providers, hospitals, provider-sponsored organizations, HMOs, insurance plans and any kind of healthcare facility, organization or plan.

Patient Protection and Affordable Care Act (PPACA)

The PPACA (Pub. L. No. 111-148 as amended by Pub. L. No. 111-152) includes health care provider conscience protections within the health insurance exchange program. Section 1303(b)(4) of the Act provides that "No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions." An Executive Order from President Obama affirmed that under the PPACA, longstanding federal health care provider conscience laws remain intact, and new protections prohibit discrimination against health care facilities and health care providers based on their unwillingness to provide, pay for, provide coverage of, or refer for abortions.[33]

[28] Id. at s. 238n(a)(3)
[29] Id. at s. 238n(c)(2)
[30] Id. at s. 238n(b)(1)
[31] 42 U.S.C. s. 238n(a)
[32] Id.
[33] The White House, President Barack Obama, Executive Order 13535, *Ensuring Enforcement and Implementation of Abortion Restrictions in the Patient Protection and Affordable Care Act* (March 24, 2010).

Additionally, section 1553 of the Affordable Care Act incudes conscience protections regarding assisted suicide:[34] "The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing."

Section 1303 provides that a State may choose to prohibit abortion coverage in its qualified health plans[35], and that such a plan is not required to provide abortion coverage as part of its "essential health benefits."[36] However, a qualified health plan that declines to provide abortion coverage must provide notice of this exclusion to potential enrollees.[37] And no qualified health plan may "discriminate" against any health care provider or facility because it refuses to provide, pay for, cover, or "refer for" abortions.[38] Section 1303 does not define "discriminate" or "refer for."

Congress recognized the potential conflict between section 1303 and other federal and state statutes, so the law states that nothing in the PPACA shall be construed to preempt or effect state laws on abortion, federal laws on abortion, specifically, those related to conscience protection, willingness or refusal to provide abortion, and discrimination based on that willingness or refusal,[39] or to relieve health care providers of their obligations to provide emergency services under federal or state laws, including the Emergency Medical Treatment and Labor Act.[40] Section 1303 also states that it does not "alter the rights and obligations of employees and employers" under Title VII.[41]

Section 1411 addresses exemptions to the PPACA's "individual responsibility requirement", known as the individual mandate.[42] Under this section, HHS may grant exemptions based on hardship, which HHS has stated includes an individual's inability to secure affordable coverage that does not provide for abortions,[43] membership in a particular religious organization, or membership in a health care sharing ministry.[44]

Medicaid and Medicare Advantage Conscience Provisions

In 1997, Congress passed the Balanced Budget Act of 1997, which included conscience provisions in various sections regarding Medicaid and Medicare. The statute prohibited Medicaid-managed organizations and Medicare Advantage plans from prohibiting or restricting a physician from informing a patient about his or her health and full range of treatment options.[45] But it also provided that Medicaid managed care organizations and Medicare Advantage plans are not required to provide, reimburse for, or cover a counseling or referral service if the organization or plan objects to the service on moral or religious grounds.[46] The organization or plan must, however, provide sufficient notice of their moral objections to prospective enrollees.[47] Neither the Medicaid nor Medicare Advantage provisions define "referral." The HHS Secretary does, however, have explicit rulemaking authority under the Social Security Act to implement these provisions.[48]

[34] 42 USC s. 18113
[35] 42 U.S.C. s. 18023(a)(1)
[36] Id. at s. 18023(b)(1)(A)(i)
[37] Id. at s. 18023(b)(3)(A)
[38] Id. at s. 18023(b)(4)
[39] Id. at s. 18023(c)(2)(A)
[40] Id. at s. 18023(d)
[41] Id. at s. 18023(c)(3)
[42] 42 U.S.C. s. 18081(b)(5)(A)
[43] 84 Fed. Reg. at 23,172
[44] 42 U.S.C. s. 18081(5)
[45] 42 U.S.C. s. 1395w–22(j)(3)(A)(Medicare Advantage); 42 U.S.C. s. 1396u–2(b)(3)(A)(Medicaid).
[46] 42 U.S.C. s. 1395w–22(j)(3)(B)(Medicare Advantage); 42 U.S.C. s. 1396u–2(b)(3)(B)(Medicaid).
[47] 42 U.S.C. ss. 1395w–22(j)(3)(B)(ii) (Medicare Advantage); 42 U.S.C. s. 1396u–2(b)(3)(B)(ii) (Medicaid).
[48] 42 U.S.C. s. 1395w–26(b)(1) (Medicare Advantage).

OCR Enforcement Activities

Some examples of OCR's enforcement activities include:

- OCR received complaints alleging Vanderbilt University violated the conscience rights of two nurse residency program applicants under the Church Amendments by requiring a written promise that the applicants would assist in pregnancy termination procedures.[49] OCR investigated and worked with Vanderbilt to resolve the complaints. In response, Vanderbilt agreed to:
    - Inform nurse residency candidates that it does not require them to participate in pregnancy termination procedures, if it is inconsistent with their religious beliefs and moral convictions;
    - Remove to original acknowledgement form and replace it with information clarifying its accommodations for religious beliefs and moral convictions; and
    - Send revised information packets to new candidates, including the complainants.[50]
- OCR received complaints alleging Mt. Sinai Hospital forced a nurse to assist in performing an abortion, against her religious objections.[51] The complaint also alleged the hospital discriminated against the nurse by reducing the number of on-call shifts she received and asking her to sign a statement of her willingness to participate in abortions in emergencies, as a condition of getting assigned more on-call shifts, all of which violated the Church Amendments, Section 245 of the Public Health Service Act, and the Weldon Amendment.[52] Following an investigation by OCR, the hospital agreed to:
    - Use its best efforts to ensure that non-objecting health care personnel are available to perform abortions;
    - Issue and post a revised Human Resources Policy stating that: "The Mount Sinai Hospital does not discriminate in the employment, promotion, or termination of employment of any physician or other health care personnel…, because he or she performed or assisted in the performance of a lawful sterilization procedure or abortion, or because he or she refused to perform or assist … [due to his or her] religious beliefs or moral convictions";
    - Comply with provisions of the Church Amendments; and
    - Train operating room managers, nurses and surgical technicians on the hospital's obligations to comply with the Church Amendments and train administrative staff to ensure that the operating room nurses' and surgical technicians'' objecting or non-objecting status is properly recorded.[53]

State Health Care Conscience Protections

The states have been leaders in conscience protection in the workplace.[54] While federal conscience protection laws generally deal with appropriations of federal funding, state laws protect against a broader range of penalties, including civil liability, criminal prosecution, loss of licensure, employment discrimination, discrimination in education, and denial of private or public funding.[55] Of these, civil liability immunity is by far the most common procedural protection.[56] In a majority of states, this immunity is absolute – providing no exceptions in the cases of malpractice, denial of emergency treatment, or patient death.[57]

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[49] Supra, FN 13 at slide 21.
[50] Id. at slide 22.
[51] Id. at slide 23.
[52] Id.
[53] Id. at slide 24.
[54] Sonne, J., *Firing Thoreau: Conscience and At-Will Employment, University of Pennsylvania Journal of Labor and Employment Law*, Vol. 9, pgs. 235-291, 267 (2007).
[55] Durham, R., *Neither Right nor Safe to Go Against It: Defending the Constitutionality of Conscience Laws*, University of Cincinnati Law Review (May 12, 2021), available at https://uclawreview.org/2021/05/12/neither-right-nor-safe-to-go-against-it-defending-the-constitutionality-of-conscience-laws/
[56] Supra, FN 8.
[57] Id.

Three states stand out as examples of broader conscience protections at the state level – Illinois, Mississippi, and Washington.

> *Illinois* – Any person, public or private institution, or public official may not discriminate against any other person in any manner because of that person's conscientious refusal to receive, obtain, accept, perform, assist, counsel, suggest, recommend, refer or participate in any particular health care service that violates his or her conscience.[58]
>
> *Mississippi* – Any person, health care provider, health care institution, public or private institution, or public official may not discriminate against any health care provider in any way because the provider declined to participate in a health care service that violates his or her conscience.
>
> *Washington – A* health care provider, religiously sponsored health carrier, or health care facility may not be required to provide or pay for a health care service if they object to so doing for reason of conscience or religion. The law prohibits employment or professional privileges discrimination because of such objection.[59]

In addressing all health care services, the statutes in the preceding three states went well beyond the procedure-specific laws of other states at the time. It is also interesting to note the expansive meaning of "conscience" in each state – Illinois defines it as a "sincerely held set of moral convictions"; Mississippi includes "religious, moral, or ethical principles"; and Washington offers no definition at all.[60]

Following enactment of the Church Amendments, least 47 states and the District of Columbia passed conscience protection laws regarding the refusal to perform abortions.[61] Of these, at least 40 states offer protection from employment discrimination and/or recrimination.[62] The majority of U.S. jurisdictions (47 states) have conscience laws establishing a right on the part of individual and/or institutional health care providers to refuse to participate in abortion.[63] Fewer jurisdictions have laws relating to conscience-driven refusal to participate in sterilization (17 states), contraception (16 states), or emergency contraception (5 states).[64]

Of the forty-seven jurisdictions with abortion-specific conscience laws (forty-six of which protect rights of refusal),[65] thirty-seven explicitly establish immunity from civil liability for individual and/or institutional health care providers who refuse to participate in abortion. Thirty states protect providers from "disciplinary action." This term is often unspecified and undefined, though it is occasionally tied to specific adverse actors like employers. Twenty-six states protect providers from "discrimination," a similarly vague term. Another twenty-six states provide explicit protection against adverse actions by employers (for example, decisions relating to hiring, dismissal, demotion, transfer, wages, or staff privileges). Protection against adverse action by government actors, educational institutions, criminal prosecutors, state licensing boards, and funding sources was less common. Only four states establish a right to refuse but do not explicitly delineate any specific procedural protections.[66]

Each of the thirty-seven states that expressly established civil immunity for abortion refusal identified specific categories of providers entitled to such immunity. The most commonly protected groups were:

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[58] *745 Ill. Comp. Stat. Ann. 70/5* (2002).
[59] *Wash. Rev. Code Ann. s. 70.47.160(2)(a)* (2002).
[60] Supra, FN 47 at pg. 275.
[61] Id.
[62] Id.
[63] Supra, FN 8 at pg. 1273-74.
[64] Id.
[65] Among the seventeen states with sterilization-specific conscience laws, fifteen provide for civil immunity. Civil liability protections were less common in laws relating to contraception and emergency contraception. Sixteen states have contraception-specific laws, but only five establish immunity from civil liability. Five states have laws relating to emergency contraception, but only one establishes immunity from civil liability.
[66] *Ariz. Rev. Stat. Ann. § 36-2154 (2020)*; *Conn. Agencies Regs. § 19-13-D54 (2005)*; *Tenn. Code Ann. §§ 39-15-204, 39-15-205 (2007)*; *W. Va. Code § 16-2F-7 (2020).*

- "Any person" (twenty-six states),
- Health care facilities (twenty-six states),
- Physicians (seventeen states),
- Registered nurses (sixteen states), and
- Staff working at health care facilities (fourteen states).

Other categories of providers also singled out for civil immunity included:

- Private health care facilities (nine states),
- Health care providers (six states),
- Students (five states),
- Pharmacists (three states),
- Any licensed professionals (two states),
- Mental health professionals (two states),
- Public employees (two states), and
- Religious health care facilities (one state).[67]

Overall, all but two states protected extremely broad categories of individuals-either "persons" generally (not including health care professionals), health care providers, or staff and employees of health care facilities.[68] All but five states provided civil immunity to at least some health care facilities.[69] An additional five states limited institutional protections to private facilities[70], and one state protected facilities only if they were religiously affiliated.[71]

Although most states explicitly identify narrower categories of providers for civil immunity, almost every state protects a very broad range of individuals (thirty-five of thirty-seven states), and all or some health care facilities (thirty-two of thirty-seven states). Thus, in civil immunity states, most individuals and facilities are immune from suit if their unwillingness to participate in abortion falls below the standard of care and causes patient injury.[72]

In other reproductive health contexts, there are similar patterns. Of the seventeen states with conscience laws relating to sterilization, only four limit providers' refusal rights in any way.[73] Of the sixteen states with contraception laws, only six states limit providers' refusal rights or impose conditions to protect patients.[74] Of the five states with emergency contraception laws, three states limit providers' refusal rights.[75]

Among the forty-seven states with abortion refusal laws, only one state, Maryland, explicitly limits a provider's civil immunity where their conduct has violated the standard of care. However, Maryland's law does not provide patients with a remedy for all harms. Rather, it only applies in cases where the provider breaches a duty to give a referral and that breach causes the patient's "death or serious physical injury."[76]

Other states limit providers' conscience protections in situations where conscience-based refusals might seriously endanger patients. Thirteen states limit the right to refuse participation in abortion cases

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[67] Supra, FN 8 at pgs. 1276-77.
[68] The two outlier states did not extend their civil immunity provisions to any individual providers. *Nev. Rev. Stat. §449.191 (2019)*(protecting only private health facilities); *Or. Rev. Stat. § 435.475 (2019)*(protecting only hospitals).
[69] *Ga. Code Ann. § 16-12-142 (2013)*; *Iowa Code § 146.2 (2020)*; *Mass. Gen. Laws ch. 112, § 121 (2003); N.C. Gen. Stat. § 14-45-1 (2019)*.
[70] *Ky. Rev. Stat. Ann. § 311.800 (2020)*; *Nev. Rev. Stat. § 449.191*; *Okla. Stat. tit. 63 § 1-741* (2019); *S.C. Code Ann. § 44-41-40 (2019)*; *Wyo. Stat. Ann. §§ 35-6-105, 35-6-106 (2019)*.
[71] *Cal. Health & Safety Code § 123420(c)(2020)*(protecting "nonprofit hospital[s]" and "other facility[ies] or clinic[s] ... organized or operated by a religious corporation or other religious organization," and also persons, physicians, nurses, and facility staff)
[72] Among the fifteen states with sterilization-specific conscience laws that explicitly establish civil immunity, all protect at least one broad category of individual providers (persons, providers, or facility staff), and all but three protect health care facilities.
[73] *Ala. Code § 22-21B-4(b)(2019*; *745 Ill. Comp. Stat. 70/6 (2019)*; *Id. 70/6.1*; *Md. Code Ann., Health-Gen. § 20-214(d)(2020)*; *16 Pa. Code § 51.31(e)(2019)*; *Id. §§ 51.42(a), .43(a)*.
[74] *Cal. Code Regs. tit. 16, § 1746.1(b)(9)(2020)*; *Ga. Code Ann. § 49-7-6 (2001)*; *745 Ill. Comp. Stat. 70/6*; *Id. 70/6.1*; *N.Y. Comp. Codes R. & Regs. tit. 18 § 463.6(d) (2020)*; *Or. Rev. Stat. § 435.225 (2019)*; *Wis. Stat. Ann. § 253.075(3)(b)(2020)*.
[75] *Ariz. Rev. Stat. Ann. § 36-2154(B)(2020)*; *Cal. Code Regs. tit. 16, § 1746(b)(5)(2020)*; *Idaho Code § 18-611(4), (6) (2019)*.
[76] *Md. Code Ann., Health-Gen. § 20-214(d)*.

where a patient requires emergency treatment.[77] A few states restrict the scope of abortion objections to exclude procedures intended to treat miscarriage (four states)[78] or ectopic pregnancy (three states)[79] conditions that can seriously threaten a pregnant patient's health.

Some states have also established patient-protective conditions on the exercise of providers' refusal rights. Eight states impose a duty to notify the patient of the refusal or of the hospital's general policy opposing abortion.[80] Two states require that providers who refuse to participate directly in abortions nevertheless ensure that the patient can access the service from another provider.[81] Two states require refusing providers to give the patient information regarding access to the requested service.[82] Two states require that a refusing provider return the patient's prescription.[83] Only one state imposes a statutory requirement that refusing providers satisfy the duty to secure a patient's informed consent, including the duty to inform patients of "legal treatment options" and the risks and benefits of these options."[84]

The following chart summarizes health care provider conscience protection laws in the states.[85]

State Policies Allowing Providers to Refuse to Provide Health Care Services Due to Conscientious Refusal

State	Abortion		Contraception			Sterilization	
	Provider	Institution	Provider	Pharmacist	Institution	Provider	Institution
Fed. Policy	X	X				X	X
Alabama	X	X					
Alaska	X	Private					
Arizona	X±	X±	X	X	X		
Arkansas	X	X	X	X	X	X	X
California	X	Religious					
Colorado			X	*	Private		
Connecticut	X						

[77] *Ala. Code § 22-21B-4(b)*; *Cal. Health & Safety Code § 123420(d) (2020)*; *Idaho Code § 18-611(4)*; *Id. § 18-611(6)*; *745 Ill. Comp. Stat. 70/6*; *Iowa Code § 146.1 (2020)*; *Ky. Rev. Stat. Ann. § 311.800(1)(2020)*; *La. Stat. Ann. § 40:1061.23(2020)*; *Id. § 40:1061.5*; *Md. Code Ann., Health-Gen. § 20-214(d)*; *Nev. Rev. Stat. § 632.475(3) (2019)*; *Okla. Stat. tit. 63, § 1-741(B)(2019)*; *Id. § 1-741(C)*; *Id. § 1-728c(1)*; *16 Pa. Code §§ 51.42(a), .43(a)*; *Id. § 51.43(b) (1977)*; *S.C. Code Ann. § 44-41-40 (2019)*; *Tex. Occ. Code Ann. § 103.004(2020)*.

[78] *Cal. Health & Safety Code § 123420(d)*; *La. Stat. Ann. § 40:1061.9(1)(b) (2020)*; *Okla. Stat. tit. 63, § 1-741(C)*; *16 Pa. Code § 51.43(b)*.

[79] *Ariz. Rev. Stat. Ann. § 36-2151(1) (2020)*; *La. Stat. Ann. § 40:1061.9(1)(c)*; *Utah Code Ann. § 76-7-301(1)(b)(ii)(2019)*.

[80] *Cal. Health & Safety Code § 123420(c)*; *745 Ill. Comp. Stat. 70/6.1 (2019)*; *La. Stat. Ann. § 40:1061.20(4) (2020)*; *Neb. Rev. Stat. § 28-337 (1977)*; *N.Y. Comp. Codes R. & Regs. tit. 10, § 405.9(b)(10)(2020)*; *Or. Rev. Stat. § 435.475(1)(2019)*; *16 Pa. Code § 51.31(e) (2019)*; *Wyo. Stat. Ann. § 35-6-105 (2019)*.

[81] *Ga. Code Ann. § 16-12-142(b) (2013)*; *745 Ill. Comp. Stat. 70/6.1*.

[82] *745 Ill. Comp. Stat. 70/6.1; N.Y. Comp. Codes R. & Regs. tit. 10, § 405.9(b)(10)*(establishing refusal rights and civil immunity for hospitals, "provided that the hospital ... shall inform the patient of appropriate resources for services or information").

[83] *Ariz. Rev. Stat. Ann. § 36-2154(B) (2020)*(requiring a refusing pharmacy, hospital, health professional, or employee to "return to the patient the patient's written prescription order"); *Ga. Code Ann. § 16-12-142(b)*(requiring a refusing pharmacist to "immediately return the prescription to the prescription holder").

[84] *45 Ill. Comp. Stat. 70/6 (2019)*("Nothing in this Act shall relieve a physician from any duty, which may exist under any laws concerning current standards of medical practice or care, to inform his or her patient of the patient's condition, prognosis, legal treatment options, and risks and benefits of treatment options, provided, however, that such physician shall be under no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience.")

[85] Guttmacher Institute, *Policies Allowing Providers to Refuse*, available at https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.

State Policies Allowing Providers to Refuse to Provide Health Care Services Due to Conscientious Refusal							
State	Abortion		Contraception			Sterilization	
	Provider	Institution	Provider	Pharmacist	Institution	Provider	Institution
Delaware	X	X					
D.C.							
Florida	X	X	X	*			
Georgia	X	X		X		X	X
Hawaii	X	X					
Idaho	X	X	X	X		X	X
Illinois	X	X	X	*	X	X	X
Indiana	X	Private					
Iowa	X	Private					
Kansas	X	X	*+	*+		X	X
Kentucky	X	X				X	
Louisiana	X	X					
Maine	X	X	X	*	Private	X	X
Maryland	X	X				X	X
Massachusetts	X	Private			Private	X	Private
Michigan	X	X					
Minnesota	X	Private					
Mississippi	X	X	X	X	X	X	X
Missouri	X	X					
Montana	X	Private				X	Private
Nebraska	X	X					
Nevada	X	Private					
New Hampshire							
New Jersey	X	Private				X	Private
New Mexico	X	X					X
New York	X	X					
North Carolina	X	X					
North Dakota	X	X					
Ohio	X	X					
Oklahoma	X	X					

State Policies Allowing Providers to Refuse to Provide Health Care Services Due to Conscientious Refusal							
State	Abortion		Contraception			Sterilization	
	Provider	Institution	Provider	Pharmacist	Institution	Provider	Institution
Oregon	X	Private					
Pennsylvania	X	Private					
Rhode Island	X					X	
South Carolina	X	Private					
South Dakota	X	X		X			
Tennessee	X	X	X	*	Private		
Texas	X	Private					
Utah	X	X					
Vermont							
Virginia	X	X					
Washington	X	X				X	X
West Virginia	X					X	X
Wisconsin	X	X				X	X
Wyoming	X	Private					
STATE TOTALS	47	44	9	6	8	17	16

(± In Arizona, private hospitals and health facilities may restrict the information that providers give to patients about lawful health care services if the institution's objection to providing the information is based on the sincerely held religious or moral beliefs)
(+ The law permits refusal if the provider "reasonably believes" the drug or device "may result" in an abortion)
(* Broadly worded refusal clause may apply. In Illinois, a state court held that a regulation requiring pharmacies to provide emergency contraception cannot be enforced against pharmacies that refuse to dispense the medication)

The next chart provides a snapshot of procedural protections in certain conscience laws,[86]

Procedural Protections for Providers in Certain Conscience Laws	
STATE	PROCEDURAL PROTECTIONS
Alabama	Civil liability, Criminal prosecution, Discrimination, Education, Government action
Alaska	Civil liability
Arizona	None
Arkansas	Civil liability, Disciplinary action, Government action
California	Civil liability, Disciplinary action, Education, Employment action, Education
Colorado	N/A
Connecticut	None
Delaware	Civil liability, Disciplinary action
D.C.*	N/A
Florida	Civil liability, Disciplinary action
Georgia	Civil liability, Disciplinary action
Hawaii	Civil liability
Idaho	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Employment

[86] Supra, FN 8.

Procedural Protections for Providers in Certain Conscience Laws	
STATE	**PROCEDURAL PROTECTIONS**
	action, Government action
Illinois	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Education, Employment action, Funding, Government action, State licensure
Indiana	Disciplinary action, Discrimination, Education, Employment action
Iowa	Civil liability, Disciplinary action, Discrimination, Education, Employment action, Government action, State licensure
Kansas	Civil liability, Discrimination, Employment action
Kentucky	Civil liability, Disciplinary action, Discrimination, Education, Employment action, Funding, Government action, State licensure
Louisiana	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Education, Employment action, Government action
Maine	Civil liability, Disciplinary action, Discrimination, Education, Employment action, Government action
Maryland	Civil liability, Disciplinary action, Government action
Massachusetts	Civil liability, Disciplinary action, Discrimination, Education, Employment action, Funding, Government action
Michigan	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Employment action
Minnesota	Civil liability, Discrimination, Employment action
Mississippi*	N/A
Missouri	Civil liability, Discrimination, Education, Employment action, Funding, Government action
Montana	Civil liability, Disciplinary action, Discrimination, Employment action, Funding, Government action
Nebraska	Civil liability, Disciplinary action, Discrimination, Employment action
Nevada	Civil liability, Disciplinary action, Employment action
New Hamp.*	N/A
New Jersey	Civil liability, Criminal prosecution, Disciplinary action, Discrimination
New Mexico	Disciplinary action
New York	Civil liability, Discrimination
North Carolina	Civil liability, Disciplinary action
North Dakota	Discrimination
Ohio	Civil liability, Disciplinary action
Oklahoma	Civil liability, Disciplinary action, Discrimination, Education, Employment action, State licensure
Oregon	Civil liability
Pennsylvania	Civil liability, Criminal prosecution, Disciplinary action, Discrimination, Education, Employment action, Funding, Government action, State licensure
Rhode Island	Civil liability, Disciplinary action
South Carolina	Civil liability, Disciplinary action, Discrimination, Employment action
South Dakota	Civil liability, Employment action, Government action
Tennessee	None
Texas	Discrimination, Education, Employment action
Utah	Civil liability, Disciplinary action, Discrimination, Employment action
Vermont**	Government action
Virginia	Civil liability, Disciplinary action, Employment action
Washington	Discrimination, Employment action
West Virginia	None
Wisconsin	Civil liability, Disciplinary action, Discrimination, Education, Employment action
Wyoming	Civil liability, Disciplinary action, Discrimination, Employment action

(* The state has no abortion conscience law)
(** The state has no abortion refusal law; protects participating providers only.)

Florida Conscience Protection Laws

Florida maintains three statutory conscience protection laws:

- Section 381.0051(5), F.S., relating to family planning, allows a physician or other person to refuse to furnish any contraceptive or family planning service, supplies, or information for medical or religious reasons.
- Section 390.0111(8), F.S., relating to termination of pregnancies, permits any hospital or person to refuse to participate in an abortion, and protects an objector from any disciplinary or other recriminatory action as a result of the refusal.
- Section 483.918, F.S., relating to genetic counselors, permits a counselor to refuse to participate in counseling that conflicts with his or her deeply held moral or religious beliefs.

Effect of Proposed Changes

HB 747 creates s. 381.00321, F.S., establishing a health care provider's or health care payer's right to decline to participate in any health care service that violates the provider's or payer's conscience as informed the moral, ethical, or religious beliefs or principles held by the provider or payer. The bill defines conscience similarly to other states with conscience protection laws – as religious, moral, or ethical beliefs or principles.

Legislative Findings and Intent

The bill includes two statements of legislative findings and intent related to protecting health care provider and health care payer right of conscience:

- The legislature finds that the right of conscience is a fundamental and inalienable right, and that threats to that right of health care providers and payers have increased in severity and amount recently. Certain factors threaten to make the crisis worse unless conscience is restored to its rightful place. As a patient's right to decline medical treatment must be respected, so should the decision of a provider or payer to decline participating in or paying for specific, nonemergency services that violate their conscience.
- The legislature finds that a health care provider or a health care payer should not be compelled to participate or pay for any health care service that the provider or payer objects to on the basis of conscience.

Rights of Conscience

The bill establishes the right of a health care provider to not take part in any way in an inpatient or outpatient test or treatments or other health care-related research that violates the provider's or conscience. Under the bill this applies to a:

- Provider as defined in s. 408.803.
- Clinical laboratory providing services in this state or services to health care providers in this state, if the clinical laboratory is certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.
- Federally qualified health center as defined in 42 U.S.C. s. 1396d(l)(2)(B), as that definition existed on the effective date of the bill.
- Site providing health care services which was established for the purpose of responding to the COVID-19 pandemic pursuant to any federal or state order, declaration, or waiver.
- Health care practitioner as defined in s. 456.001.
- Health care professional licensed under part IV of chapter 468.
- Home health aide as defined in s. 400.462(15).
- Provider licensed under chapter 394 or chapter 397 and its clinical and nonclinical staff providing inpatient or outpatient services.

- Continuing care facility licensed under chapter 651.
- Pharmacy permitted under chapter 465.
- Student of a health care education program.

This right also applies to payers, which applies to a health insurer that pays for, or arranges for, the payment of a health care service provided to a patient, whether that payment is made in whole or in part. A health insurer includes:

- An authorized insurer offering health insurance, as defined in s. 624.603, F.S., for individual or group coverage;
- A health maintenance organization, as defined in s. 641.19(12), F.S., issuing coverage through an individual or group contract; or
- A self-insurance plan, as defined in s. 624.031, F.S.

The conscience protections provided by the bill are very broad in whom they protect and apply to a broad range of medical treatments or research. The protections are not limited to traditionally controversial procedures, like abortion or sterilization, but rather apply to any medical treatment, procedure, or research that violates the provider's or payer's conscience.

The bill also establishes the right of a health care provider that is a business entity, or a health care payer holding itself out to the public as a religious entity, and meeting certain criteria[87] to make employment, staffing, contracting, and credentialing decisions that are consistent with the provider's or payer's religious beliefs.

Liability

The bill makes health care providers and health care payers immune from civil, criminal, or administrative liability for exercising the provider's or payer's right of conscience. Moreover, a provider or payer that is a business entity is also immune from civil, criminal, or administrative liability for any claims arising from a violation of the right of conscience of a person employed by, under contract with, or credentialed by the provider or payer.

Violations

The bill protects a health care provider or health care payer from any actual or threatened adverse action by a person, as a result of declining to participate in or pay for a particular health care service on the basis of conscience, by authorizing a civil cause of action against that person. It also protects a provider or payer from any actual or threatened adverse action for disclosing any information that the practitioner reasonably believes evinces the following, on the part of an employer's:

- Violation of the act's provisions;
- Any violation of any law, rule, or regulation; or
- Gross mismanagement, gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.

Civil Remedies

The bill authorizes a health care provider or health care payer to bring a civil action for damages, injunctive relief, or any other appropriate relief for any actual or threatened adverse action due to declining to participate in a health care service that violates the provider's or payer's conscience. Upon a finding of a violation, a court must award treble damages, and reasonable costs and attorney's fees. A court considering the civil action also may award injunctive relief, including reinstatement of a medical practitioner to his or her previous position, reinstatement of board certification, and relicensure of a

[87] Such criteria include stating in its governing documents that the provider entity has a religious purpose or mission and maintaining internal operating policies and procedures that implement its purpose or mission.

health care provider or health care payer. Any additional burden or expense incurred by another provider or payer is not a defense to a violation of the bill's provisions.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.00321, F.S., relating to rights of conscience of health care providers and health care payers.
Section 2: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not require rule-making to implement its' provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to protections of medical conscience; creating s. 381.00321, F.S.; providing a short title; providing legislative findings and intent; providing definitions; providing that health care providers and health care payers have the right to not participate in or pay for any health care services that violate their consciences; providing that such providers and payers have a right to make certain decisions consistent with their religious beliefs under certain circumstances; prohibiting a person from taking or threatening to take adverse action against such providers and payers for specified actions; providing for civil remedies and damages; providing immunity from civil, criminal, and administrative liability for such providers and payers under certain circumstances; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.00321, Florida Statutes, is created to read:

381.00321 Rights of conscience of health care providers and health care payers.—

(1) SHORT TITLE.—This section may be cited as the

CODING: Words stricken are deletions; words underlined are additions.

"Healthcare Ethics and Liberty Protection Act."

(2) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that the right of conscience is a fundamental and inalienable right. Threats to the right of conscience of health care providers and health care payers have become increasingly common and severe in recent years. The swift pace of scientific advancement, the expansion of medical capabilities, and with the mistaken notion that health care providers and health care payers are mere public utilities, promise to make the crisis worse unless action is taken to restore conscience to its rightful place. As patient autonomy to decline a health care service must be respected, health care providers and health care payers must have the right to decline participating in or paying for specific, nonemergency services that violate their consciences.

(b) A health care provider or health care payer should not be compelled to participate in or pay for any health care service that the provider or payer objects to on the basis of conscience.

(3) DEFINITIONS.—As used in this section, the term:

(a) "Conscience" means the religious, moral, or ethical beliefs or principles held by a health care provider or health care payer.

(b) "Health care payer" means a health insurer that pays for, or arranges for, the payment of a health care service

provided to a patient, whether such payment is made in whole or in part.

(c) "Health care provider" means a health care provider as defined in s. 768.381(1)(f) or a student of a health care education program.

(d) "Health care service" means inpatient or outpatient tests or treatments of a human disease, condition, or dysfunction or medical or other health care-related research.

(e) "Health insurer" means an authorized insurer offering health insurance as defined in s. 624.603 for individual or group coverage, a health maintenance organization as defined in s. 641.19(12) issuing coverage through an individual or group contract, or a self-insurance plan as defined in 624.031.

(f) "Participate" means to take part in any way in providing a health care service or any part of such service.

(4) RIGHTS OF CONSCIENCE.—

(a) A health care provider or health care payer has the right not to participate in or pay for any specific health care service that violates the provider's or payer's conscience.

(b) A health care provider that is a business entity, or a health care payer that holds itself out to the public as religious, and states in its governing documents that it has a religious purpose or mission and has internal operating policies or procedures that implement such purpose or mission, has the right to make employment, staffing, contracting, and

credentialing decisions consistent with the provider's or payer's religious beliefs.

(5) VIOLATIONS AND CIVIL REMEDIES.—

(a) A person may not take or threaten to take adverse action against a health care provider or health care payer for:

1. Declining to participate in a health care service on the basis of conscience.

2. Disclosing information to an appropriate governmental agency that the health care provider or health care payer reasonably believes is evidence of an employer's:

a. Violation of this section;

b. Violation of any law, rule, or regulation;

c. Violation of any standard of care or other ethical guidelines for the provision of any health care service; or

d. Gross mismanagement, gross waste of funds, abuse of authority, or any action that is a substantial and specific danger to public health or safety.

(b) A health care provider or health care payer that establishes a violation of this section has a civil cause of action for treble damages, an injunction, or any other appropriate relief in law or equity. Injunctive relief includes, but is not limited to, reinstatement of a health care provider or health care payer to a previous position, reinstatement of board certification, and relicensure. Such damages are cumulative and may not be limited by any other remedies that may

be available under any other law. A prevailing plaintiff is entitled to recover reasonable attorney fees and court costs. Any additional burden or expense incurred by another health care provider or health care payer arising from the exercise of the right of conscience is not a defense to a violation of this section.

(6) IMMUNITY FROM LIABILITY.—Health care providers and health care payers are immune from civil, criminal, or administrative liability for exercising the right of conscience with respect to a health care service. A health care provider or health care payer that is a business entity is immune from civil, criminal, or administrative liability for any claims related to or arising out of the exercise of the right of conscience by a person employed, contracted, or credentialed by such provider or payer.

Section 2. This act shall take effect July 1, 2022.

HB 861

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 861 Medical Specialty Designations
SPONSOR(S): Massullo
TIED BILLS: **IDEN./SIM. BILLS:** SB 1192

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Morris	McElroy
2) Health & Human Services Committee			

SUMMARY ANALYSIS

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners. The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions.

An unlicensed individual may be subject to administrative action or criminal penalties if the individual states or otherwise implies that he or she is a licensed medical professional. This may include the use of certain terms or titles that the public generally associates with a specific medical profession. DOH does not license a health care practitioner's specialty or sub-specialty based upon board certification, but does limit who can hold themselves out as board-certified specialists.

HB 861 makes using a term designating a medical specialty grounds for discipline of a practitioner unless the practitioner has completed a residency or fellowship program accredited or recognized by the Accreditation Council for Graduate Medical Education in such specialty. The bill also requires DOH to discipline a practitioner who violates the bill's provisions and grants DOH the same enforcement authority as the applicable board.

The bill has an indeterminate, negative fiscal impact on DOH, which current resources are adequate to absorb.

The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Licensure and Regulation of Health Care Practitioners

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.[1] The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions.[2] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA. MQA is statutorily responsible for the following boards and professions established within the division:[3]

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;
- Nursing assistants, as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;
- Midwifery, as provided under ch. 467, F.S.;
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.;
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.;
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.;
- Respiratory therapy, as provided under part V of ch. 468, F.S.;
- Dietetics and nutrition practice, as provided under part X of ch. 468, F.S.;
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.;
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.;
- Electrolysis, as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part III of ch. 483, F.S.;
- Medical physicists, as provided under part IV of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, created under ch. 490, F.S.;
- School psychologists, as provided under ch. 490, F.S.;
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.; and
- Emergency medical technicians and paramedics, as provided under part III of ch. 401, F.S.

[1] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[2] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2019-2020*, p. 5, http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/2019-2020-annual-report.pdf (last visited April 16, 2021).
[3] Section 456.001(4), F.S; Id.

Board Certification and Florida Licensure

DOH does not license health care practitioners by specialty or subspecialty; however, current law limits which health care practitioners may hold themselves out as board-certified specialists. An allopathic physician may not hold himself or herself out as a board-certified specialist unless he or she has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties (ABMS) or other recognizing agency[4] approved by the allopathic board.[5] Additionally, an allopathic physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the allopathic board.[6] Similarly, an osteopathic physician may not hold himself or herself out as a board-certified specialist unless he or she has successfully completed the requirements for certification by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME) and is certified as a specialist by a certifying agency[7] approved by the board.[8]

A dentist may not hold himself or herself out as a specialist, or advertise membership in or specialty recognition by an accrediting organization, unless the dentist has completed a specialty education program approved by the American Dental Association and the Commission on Dental Accreditation and the dentist is:[9]

- Eligible for examination by a national specialty board recognized by the American Dental Association; or
- Is a diplomate of a national specialty board recognized by the American Dental Association.

If a dentist announces or advertises a specialty practice for which there is not an approved accrediting organization, the dentist must clearly state that the specialty is not recognized or that the accrediting organization has not been approved by the American Dental Association or the Florida Board of Dentistry.[10]

Additionally, advanced practice registered nurses may not advertise or hold themselves out as a specialist for which he or she has not received certification.[11]

Discipline of Health Care Practitioners

Section 456.072, F.S., authorizes a regulatory board or DOH, if there is no board, to discipline a health care practitioner's licensure for a number of offenses, including but not limited to:

- Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession; or
- Failing to identify through writing or orally to a patient the type of license under which the practitioner is practicing.

Using a term designating a medical specialty unless the practitioner has completed a residency or fellowship program accredited or recognized by the Accreditation Council for Graduate Medical Education in such specialty is not ground for discipline under current law.

If the board or DOH finds that a licensee committed a violation, the board or DOH may:[12]

[4] The allopathic board has approved the specialty boards of the ABMS as recognizing agencies. Rule 64B8-11.001(1)(f), F.A.C.
[5] Section 458.3312, F.S.
[6] Id.
[7] The osteopathic board has approved the specialty boards of the ABMS and AOA as recognizing agencies. Rule 64B15-14.001(h), F.A.C.
[8] Section 459.0152, F.S.
[9] Section 466.0282, F.S. A dentist may also hold himself or herself out as a specialist if the dentist has continuously held himself or herself out as a specialist since December 31, 1964, in a specialty recognized by the American Dental Association.
[10] Section 466.0282(3), F.S.
[11] Section 464.018(1)(s), F.S.
[12] Section 456.073(1), F.S.

- Refuse to certify, or to certify with restrictions, an application for a license;
- Suspend or permanently revoke a license;
- Place a restriction on the licensee's practice or license;
- Impose an administrative fine not to exceed $10,000 for each count or separate offense; if the violation is for fraud or making a false representation, a fine of $10,000 must be imposed for each count or separate offense;
- Issue a reprimand or letter of concern;
- Place the licensee on probation;
- Require a corrective action plan;
- Refund fees billed and collected from the patient or third party on behalf of the patient; or
- Require the licensee to undergo remedial education.

Effect of the Bill

Discipline of Health Care Practitioners

The bill makes using a term designating a medical specialty accredited or recognized by the ACGME by a practitioner grounds for discipline unless the practitioner has completed a residency or fellowship program accredited or recognized by the ACGME in such specialty.

The bill requires DOH to discipline a practitioner who violates the bill's provisions and grants DOH the same enforcement authority as the applicable board.

The provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 2: Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH may experience a recurring increase in workload associated with rulemaking, which can be absorbed within current resources.[13]

   DOH may also experience a recurring increase in workload associated with additional complaints, investigations, and prosecutions resulting from the bill. The extent to which such complaints, investigations, and prosecutions may materialize is unknown; therefore, the fiscal impact is indeterminate.[14]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

[13] Department of Health, Agency Analysis of 2022 House Bill 861 (Jan. 11, 2022).
[14] Id.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care practitioners in violation of the restrictions in this bill may be subject to disciplinary actions and fines.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to DOH to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires DOH to enforce the bill's provisions. This appears to conflict with several sections of the statutes which specifically vest disciplinary authority in the appropriate boards. Disciplinary authority is vested in the department only in the absence of a duly appointed board.[15]

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

[15] Id. *See* sections 456.072 and 456.073, F.S.

A bill to be entitled

An act relating to medical specialty designations; amending s. 456.072, F.S.; providing that using a term designating a certain medical specialty is grounds for disciplinary action; providing enforcement authority; authorizing the Department of Health to adopt rules; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (tt) is added to subsection (1) of section 456.072, Florida Statutes, and subsection (2) of that section is republished, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(tt) Using a term designating a medical specialty for which the Accreditation Council for Graduate Medical Education accredits or recognizes as a residency or fellowship program unless the licensee has completed such residency or fellowship program or unless otherwise expressly authorized by law. The department shall enforce this paragraph and has the same enforcement authority as an applicable board. The department may adopt rules to implement this paragraph.

CODING: Words stricken are deletions; words underlined are additions.

(2) When the board, or the department when there is no board, finds any person guilty of the grounds set forth in subsection (1) or of any grounds set forth in the applicable practice act, including conduct constituting a substantial violation of subsection (1) or a violation of the applicable practice act which occurred prior to obtaining a license, it may enter an order imposing one or more of the following penalties:

(a) Refusal to certify, or to certify with restrictions, an application for a license.

(b) Suspension or permanent revocation of a license.

(c) Restriction of practice or license, including, but not limited to, restricting the licensee from practicing in certain settings, restricting the licensee to work only under designated conditions or in certain settings, restricting the licensee from performing or providing designated clinical and administrative services, restricting the licensee from practicing more than a designated number of hours, or any other restriction found to be necessary for the protection of the public health, safety, and welfare.

(d) Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of $10,000 per count or offense.

(e) Issuance of a reprimand or letter of concern.

(f) Placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department when there is no board, may specify. Those conditions may include, but are not limited to, requiring the licensee to undergo treatment, attend continuing education courses, submit to be reexamined, work under the supervision of another licensee, or satisfy any terms which are reasonably tailored to the violations found.

(g) Corrective action.

(h) Imposition of an administrative fine in accordance with s. 381.0261 for violations regarding patient rights.

(i) Refund of fees billed and collected from the patient or a third party on behalf of the patient.

(j) Requirement that the practitioner undergo remedial education.

In determining what action is appropriate, the board, or department when there is no board, must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the practitioner. All costs associated with compliance with orders issued under this subsection are the obligation of the practitioner.

Section 2. This act shall take effect July 1, 2022.

Amendment No.1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	_____	

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee

Representative Massullo offered the following:

Amendment

Remove line 20 and insert:

or the American Osteopathic Association accredits or recognizes as a residency or fellowship program

HB 931

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 931 Alternate-site Testing
SPONSOR(S): McClure
TIED BILLS: **IDEN./SIM. BILLS:** SB 1374

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Morris	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A clinical laboratory is the physical location in which services are performed to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition. The Board of Clinical Laboratory Personnel within the Department of Health (DOH) oversees the licensure and regulation of clinical laboratory personnel, including supervisors, technologists, technicians, directors, and public health laboratory personnel. Licensure requirements for clinical laboratory personnel include passage of an exam designated by the Board, completion of a medical technology training program, and completion of applicable education requirements. With limited exceptions, including certain laboratories and health care practitioners, only licensed clinical laboratory personnel may perform clinical laboratory testing.

Generally, a hospital's main or central laboratory, or satellite laboratories that are certified by federal law established on the same or adjoining grounds of a licensed hospital, may perform clinical laboratory testing. Current law allows for alternate-site testing, which is any laboratory testing done under the administrative control of a hospital and the supervision of the laboratory director, but performed out of the physical or administrative confines of the hospital's central laboratory. This allows tests to be performed bedside, at a nurse station, in an operating room or the emergency room, or anywhere else under the administrative control of a hospital. Current Agency for Health Care Administration rule authorizes advanced practice registered nurses, registered nurses, licensed practical nurses, and licensed clinical laboratory personnel to perform testing at alternate-sites.

A freestanding emergency department (FED) is a facility that receives individuals for emergency care and is structurally separate from a hospital. Only licensed clinical laboratory personnel may perform clinical laboratory testing in a FED.

HB 931 exempts individuals who perform alternate-site testing outside of a central laboratory of a hospital or at a hospital-based, off campus emergency department from clinical laboratory personnel licensure requirements. This allows all individuals, not just licensed clinical laboratory personnel, to perform alternate-site testing within a hospital or in a FED.

The bill has an insignificant, indeterminate fiscal impact on DOH and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Clinical Laboratories

A clinical laboratory is the physical location in which services are performed to provide information or materials for use in the diagnosis, prevention, or treatment of a disease or the identification or assessment of a medical or physical condition.[1] Services performed in clinical labs include:[2]

- The examination of fluids or other materials taken from the human body;
- The examination of tissue taken from the human body; and
- The examination of cells from individual tissues or fluid taken from the human body.

Clinical laboratories that provide testing services in this state must be certified by the Clinical Laboratory Improvement Amendments of 1988 (CLIA) program under federal law.[3]

Clinical Laboratory Personnel

The Board of Clinical Laboratory Personnel (Board) oversees the licensure and regulation of clinical laboratory personnel, including supervisors, technologists, technicians, directors, and public health laboratory personnel. Generally, licensure requirements for clinical laboratory personnel include passage of an exam designated by the Board, completion of a medical technology training program, and completion of applicable education requirements.[4]

Current law provides exemptions from the application of part I of ch. 483, F.S., which regulates clinical laboratory personnel. Exemptions include:[5]

- Clinical laboratories operated by the United States Government;
- Laboratories operated and maintained exclusively for research and teaching purposes, involving no patient or public health service whatsoever;
- Persons engaged in testing performed by laboratories that are wholly owned and operated by one or more licensed allopathic physicians, osteopathic physicians, chiropractic physicians, podiatric physicians, naturopaths, optometrists, or dentists, who practice in the same group practice, and in which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of that group practice;
- Respiratory therapists and respiratory care practitioners certified or registered under part V of chapter 468;
- Advanced practice registered nurses licensed under part I of chapter 464 who perform provider-performed microscopy procedures in a laboratory setting; and
- Persons performing laboratory testing within a physician office practice for patients referred by a health care provider who is a member of the same physician office practice, if the laboratory or entity operating the laboratory within a physician office practice is under common ownership, directly or indirectly, with an entity licensed pursuant to chapter 395.

[1] S. 483.803, F.S.
[2] Ss. 483.803(2)(a)-(c), F.S.
[3] S. 395.009(1), F.S.
[4] Section 483.809, F.S. and ch. 64B3-5, F.A.C.
[5] S. 483.801, F.S.

Currently, nurses licensed under ch. 464, F.S., and laboratory technicians licensed under part I of ch. 483, F.S., are not exempt from clinical laboratory personnel regulation.

Alternate-Site Laboratory Testing

Generally, a hospital's main or central laboratory or satellite laboratories that are certified by CLIA established on the same or adjoining grounds of a hospital licensed under ch. 395, F.S., may perform clinical laboratory testing.[6] Testing at satellite labs must be done by licensed clinical laboratory personnel. Section 395.0091, F.S., allows for alternate-site testing, which is any laboratory testing done under the administrative control of a hospital and the supervision of the laboratory director, but performed outside of the physical or administrative confines of the hospital's central laboratory. This allows tests to be performed bedside, at a nurse station, in an operating room or the emergency room, or anywhere else under the administrative control of a hospital.

Current Agency for Health Care Administration rule authorizes advanced practice registered nurses, registered nurses, licensed practical nurses, and licensed clinical laboratory personnel to perform testing at alternate-sites.[7] However, current law does not authorize registered nurses or laboratory technicians to perform alternate-site testing within a freestanding emergency department.

Freestanding Emergency Departments

A freestanding emergency department (FED) is a facility that receives individuals for emergency care and is structurally separate from a hospital.[8] The federal Centers for Medicare and Medicaid Services (CMS) refers to these facilities as Provider-based Off-campus Emergency Departments and requires them to operate under the license of the main provider, for purposes of Medicare reimbursement.[9]

In Florida, any licensed hospital which has a dedicated emergency department may provide emergency services in a location separate from the hospital's main premises.[10] There are no additional rules or standards specific for FEDs; in fact, the term FED is not currently defined in statute or rule. The Agency for Health Care Administration (AHCA) interprets existing law to allow a licensed hospital to establish and operate a FED as part of facility operations, similar to other hospital outpatient departments, without a separate license. However, a hospital that wishes to establish a FED is required to get approval from AHCA's Office of Plans and Construction.[11]

Since 2016, the number of FEDs in Florida increased 45 percent, while the number of visits to FEDs increased by 83 percent.[12] Currently, 96 FEDs operate under the licenses of 61 hospitals.[13]

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[6] Rule 59A-3.242, F.A.C.
[7] Rule 59A-3.242(1)(g)(6), F.A.C.
[8] There is no single definition of FED, and there are different requirements as well as different names for FEDs depending on which state they are located in.
[9] 42 C.F.R. § 413.65(a)(2) and (d)(1) (2017). *See also* CMS, *Requirements for Provider-based Off-campus Emergency Departments* (Jan. 11, 2008), available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions-Items/CMS1207239 (last visited Jan. 21, 2022).
[10] S. 395.002(22), F.S. Premises means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital or ambulatory surgical care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee.
[11] Rule 59A-3.066(2)(e), F.A.C.
[12] Florida Agency for Health Care Administration, FloridaHealthFinder.gov, Data Summaries and Reports, *Emergency Department Visits and Admissions by Facility 2016-219,* available at https://www.floridahealthfinder.gov/researchers/QuickStat/quickstat.aspx (last visited Jan. 21, 2022).
[13] Florida Agency for Health Care Administration, Hospital and Outpatient Services Unit, *List of Florida Licensed Hospitals with Off-site Emergency Departments as of Jan. 3, 2022,* available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Reports.shtml (last visited Jan. 21, 2022).

Effect of the Bill

Clinical Laboratory Personnel

The bill exempts individuals who perform alternate-site testing outside of a central laboratory of a hospital or at a hospital-based, off campus emergency department from clinical laboratory personnel regulation under part I of ch. 483, F.S. This allows all individuals, not just licensed clinical laboratory personnel, to perform alternate-site testing within a hospital or in a FED.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amends s. 483.801, F.S., relating to exemptions.
Section 2: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law provides sufficient rulemaking authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to alternate-site testing; amending s. 483.801, F.S.; providing an exemption from regulation for persons performing alternate-site testing at certain locations; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (7) is added to section 483.801, Florida Statutes, to read:

483.801 Exemptions.—This part applies to all clinical laboratories and clinical laboratory personnel within this state, except:

(7) Persons performing alternate-site testing out of the physical or administrative confines of the central laboratory or at a hospital-based, off-campus emergency department licensed under chapter 395.

Section 2. This act shall take effect July 1, 2022.

CODING: Words stricken are deletions; words underlined are additions.

Amendment No.1

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__	(Y/N)
ADOPTED AS AMENDED	__	(Y/N)
ADOPTED W/O OBJECTION	__	(Y/N)
FAILED TO ADOPT	__	(Y/N)
WITHDRAWN	__	(Y/N)
OTHER	_____	

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee

Representative McClure offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

(7) A registered nurse licensed under chapter 464 performing alternate-site testing within a hospital or a hospital-based off-campus emergency department licensed under chapter 395.

T I T L E A M E N D M E N T

Remove line 4 and insert:

for registered nurses performing alternate-site testing at

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 953 Psychology Interjurisdictional Compact
SPONSOR(S): Hunschofsky
TIED BILLS: HB 955 **IDEN./SIM. BILLS:** SB 1370

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Morris	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Current law allows a Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member, or a registered out-of-state-health care provider to provide health care services to Florida patients via telehealth. It does not allow health care practitioners, including Florida licensed psychologists, to use telehealth to provide services to out-of-state patients.

The Psychology Interjurisdictional Compact (PSYPACT or compact) is an interstate compact, which is an agreement between states to enact legislation and enter into a contract for a specific, limited purpose. In 2015, the Association of State and Provincial Psychology Boards (ASPPB) adopted model legislation for the compact which facilitates the practice of psychology using telepsychology and in-person, face-to-face psychological practice to patients in other states. The compact establishes the Psychology Interjurisdictional Compact Commission (commission), made up of each party state's representative of the state licensing board. The commission is responsible for administering the compact. PSYPACT became effective in April, 2019, and currently has 27 member states. The bill enacts PSYPACT and authorizes Florida to enter into the compact.

Psychologists licensed in PSYPACT states may apply for authorization to practice telepsychology (APIT) and temporary authorization to practice (TAP), which are required under the compact to practice telepsychology and temporary in-person, face-to-face practice in other PSYPACT states. To practice telepsychology in PSYPACT states, psychologists licensed in compact states may apply to the Commission for authorization and obtain an E.Passport from the ASPPB. To conduct temporary in-person, face-to-face practice, a psychologist licensed in a compact state may apply to the Commission for temporary authority and obtain an interjurisdictional practice certificate from the ASPPB. Thus, under the compact a Florida licensed psychologist is eligible to provide services to out-of-state patients through either telehealth or a temporary authorization to practice.

The compact requires all participating states to report certain licensure information to a coordinated licensure information system (CLIS), including identifying information, licensure data, and adverse actions taken against a psychologist's license or practice privileges in a compact state. Such information is public under the compact unless a compact state designates the information it contributes to the CLIS as confidential, prohibiting disclosure to the public without express permission of the reporting state.

The bill has an insignificant, negative fiscal impact on DOH and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Professional Shortage

There is currently a health care provider shortage in the U.S.[1] This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[2] and the passage of the Patient Protection and Affordable Care Act.[3] Aging populations create a disproportionately higher health care demand.[4] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

According to the U.S. Health Resources and Services Administration (HRSA), the U.S. will experience a 7% increase in demand for psychologists by 2030, producing a shortage of approximately 14,300 psychologists nationwide.[5] In Florida, HRSA estimates a shortage of 1,420 clinical, counseling, and school psychologists by 2030.[6] Exacerbated by the COVID-19 pandemic, the American Academy of Pediatrics declared a national state of emergency in children's mental health, creating a need for more mental health professionals and increased access to such.[7]

Psychologist Licensure in Florida

The Board of Psychology oversees the licensure and regulation of psychologists in this state.[8] To receive a license to practice psychology, an individual must:[9]

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[1] For example, as of December 31, 2021, the U.S. Department of Health and Human Services has designated 7,613 Primary Care Health Professional Shortage Area (HPSA) (requiring 15,184 additional primary care physicians to eliminate the shortage), 6,803 Dental HPSAs (requiring 11,181 additional dentists to eliminate the shortage), and 6,078 Mental Health HPSAs (requiring 6,851 additional mental health providers to eliminate the shortage). U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics* (Jan. 1, 2022), https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport (last visited Jan. 22, 2022).

[2] According to the U.S. Census Bureau, the U.S population is expected to increase by almost 100 million between 2014 and 2060, and by 2030, one in five Americans is projected to be 65 and over. Sandra L. Colby & Jennifer M. Ortman, U.S. Census Bureau, *Projections of the Size and Composition of the U.S.Population: 2014 to 2060* (March 2015), https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf (last visited Jan. 22, 2022).

[3] U.S. Dep't of Health and Human Services, *Department of Health and Human Services Strategic Plan: Goal 1: Strengthen Health Care*, *available at* http://www.hhs.gov/secretary/about/goal5.html (last visited on Jan. 22, 2022).

[4] One analysis measured current primary care utilization (office visits) and projected the impact of population increases, aging, and insured status changes. The study found that the total number of office visits to primary care physicians will increase from 462 million in 2008 to 565 million in 2025, and (because of aging) the average number of visits will increase from 1.60 to 1.66. The study concluded that the U.S. will require 51,880 additional primary care physicians by 2025. (Petterson, Stephen M., et al., "Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025," Annals of Family Medicine, vol. 10, No. 6 (November/December 2012), *available at* http://www.annfammed.org/content/10/6/503.full.pdf+html (last visited on Jan. 22, 2022).

[5] Health Resources Services Administration, *Behavioral Health Workforce Projections, 2016-2030: Clinical, Counseling and School Psychologists,* https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/psychologists-2018.pdf (last visited Jan. 22, 2022).

[6] Health Resources Services Administration, *State-Level Projections of Supply and Demand for Behavioral Health Occupations: 2016-2030* (September 2018), https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-level-estimates-report-2018.pdf (last visited Jan. 22, 2022).

[7] American Academy of Pediatrics, AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health, https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/ (last visited Jan. 22, 2022).

[8] Section 490.004, F.S.

[9] Section 490.005(1), F.S.

- Meet one of the following educational requirements:
    - Received a doctoral-level psychological education from an institution that had institutional accreditation from an agency recognized by the United States Department of Education or was recognized as a member in good standing with the Association of Universities and Colleges of Canada, and had programmatic accreditation from the American Psychological Association;[10] or
    - Received the equivalent of a doctoral-level education from a program at a school or university located outside of the United States, which is officially recognized by the government of the country in which it is located as a program or institution to train students to practice professional psychology.
- Complete 2 years or 4,000 hours of supervised experience;
- Pass the Examination for Professional Practice in Psychology;[11] and
- Pass an examination on Florida laws and rules.

The American Psychological Association (APA) is recognized by the U.S. Department of Education and the Council for Higher Education Accreditation as the national accrediting authority for professional education and training in psychology.[12]

Applicants for licensure by endorsement must:[13]

- Be a diplomate in good standing with the American Board of Professional Psychology;
- Hold a doctoral degree in psychology with at least 10 years of experience as a licensed psychologist in any jurisdiction or territory of the U.S. within the 25 years preceding the date of application.

Telehealth

A Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[14] or a registered out-of-state-health care provider to provide health care services to Florida patients via telehealth.[15] Current law sets the standard of care for telehealth providers at the same level as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services. A patient receiving telehealth services may be in any location at the time services are rendered and a telehealth provider may be in any location when providing telehealth services to a patient.[16]

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

Sovereign Immunity

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly

[10] Section 490.003(3), F.S., defines doctoral-level education as a Psy.D, an Ed.D., or a Ph.D in psychology.
[11] Rule 64B19-11.001, F.A.C.
[12] American Psychological Association, *Understanding APA Accreditation*, http://www.apa.org/ed/accreditation/about/index.aspx (last visited Jan. 20, 2022).
[13] Section 490.006, F.S.
[14] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[15] S. 456.47(4), F.S.
[16] S. 456.47(2), F.S.

waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through an enactment of general law. [17]

In 1973, the Legislature enacted s. 768.28, F.S., a partial waiver of sovereign immunity, allowing individuals to sue state government and its subdivisions.[18] According to subsection (1), individuals may sue the government under circumstances where a private person "would be liable to the claimant, in accordance with the general laws of [the] state . . . . " Section 768.28(5), F.S., imposes a $200,000 limit on the government's liability to a single person, and a $300,000 total limit on liability for claims arising out of a single incident.

Impaired Practitioner Program

The impaired practitioner treatment program was created to provide resources to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or both, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety.[19] For a profession that does not have a program established within its individual practice act, the DOH is required to designate an approved program by rule.[20] By rule, DOH designates the approved program by contract with a consultant to initiate intervention, recommend evaluation, refer impaired practitioners to treatment providers, and monitor the progress of impaired practitioners. The impaired practitioner program may not provide medical services.[21]

Interstate Compacts

An interstate compact is an agreement between two or more states to address common problems or issues, create an independent, multistate governmental authority, or establish uniform guidelines, standards or procedures for the compact's member states.[22] Article 1, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other, without the consent of Congress. However, the case law has provided that not all interstate agreements are subject to congressional approval, but only those that may encroach on the federal government's power.[23] Florida is a party to multiple interstate compacts, including the Nurse Licensure Compact,[24] Driver's License Compact,[25] Compact on Adoption and Medical Assistance,[26] and the Interstate Compact on Educational Opportunity for Military Children.[27]

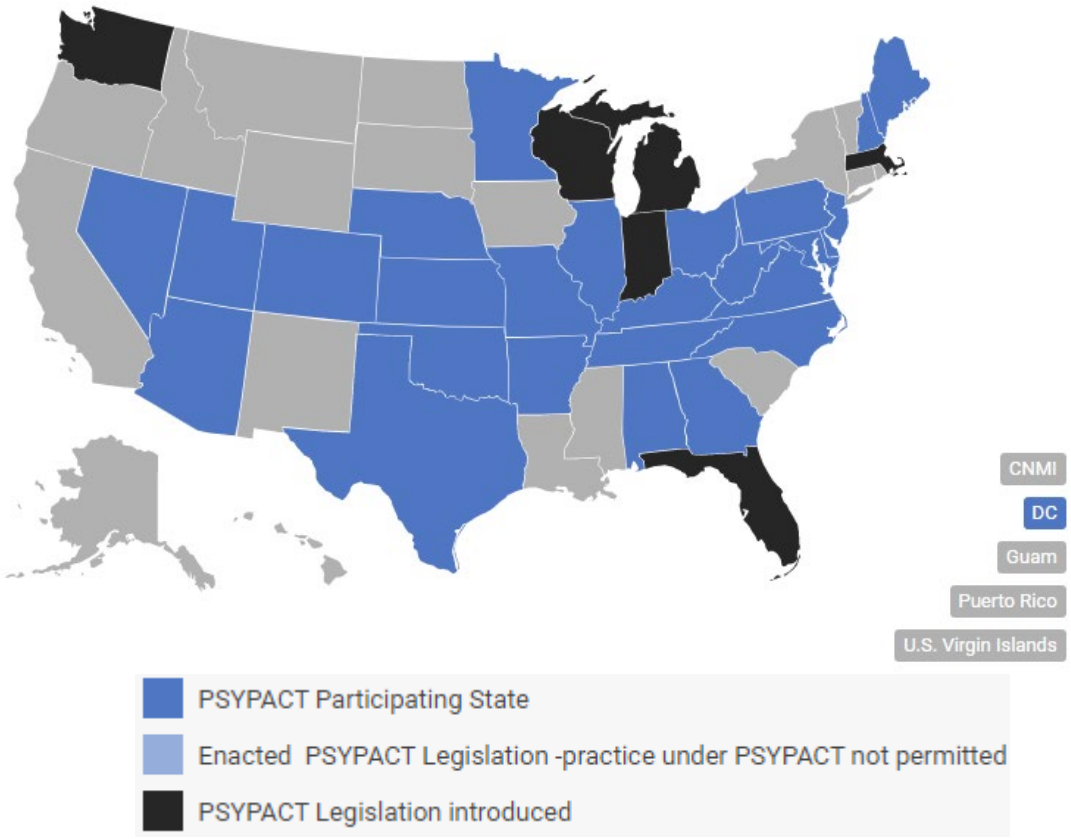
Psychology Interjurisdictional Compact

The Psychology Interjurisdictional Compact (PSYPACT or compact) was created by the Association of State and Provincial Psychology Boards (ASPPB) and is an interstate compact that facilitates the practice of telepsychology and temporary in-person, face-to-face practice of psychology across state boundaries.[28] The compact establishes the Psychology Interjurisdictional Compact Commission (Commission) which is responsible for creating and finalizing bylaws, rules, and regulation. The Commission also grants psychologists authority to practice telepsychology and temporary in-person,

[17] Fla. Const. art. X, s. 13.
[18] Chapter 73-313, L.O.F., codified at s. 768.28, F.S.
[19] Section 456.076, F.S. The provisions of s. 456.076, also apply to veterinarians under s. 474.221, F.S. and radiological personnel under s. 486.315, F.S.
[20] Section 456.076(1), F.S.
[21] Rule 64B31-10.001(1)(a), F.A.C.
[22] National Center for Interstate Compacts, *What Are Interstate Compacts?,* https://compacts.csg.org/compacts/ (last visited Jan. 20, 2022).
[23] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[24] Section 464.0095, F.S.
[25] Section 322.44, F.S.
[26] Section 409.406, F.S.
[27] Section 1000.36, F.S.
[28] PSYPACT, About Us, https://psypact.site-ym.com/page/About (last visited Jan. 22, 2022).

face-to-face psychology across state lines.[29] Nothing in the compact is to be construed as a waiver of sovereign immunity.

Psychologists licensed in PSYPACT states may apply to the Commission for authority to practice telepsychology in PSYPACT states. Authorized psychologists must obtain an E.Passport[30] Certificate from ASPPB to practice telepsychology. To conduct temporary in-person practice in PSYPACT states, psychologists licensed in PSYPACT states can apply to the Commission for an interjurisdictional practice certificate for temporary authority to practice in a distant state.[31] PSYPACT currently has 27 member states.



The compact is arranged in 14 articles and addresses the following issues:[32]

Purpose (Article I)

The primary purposes of PSYPACT are:

- Allowing for telepsychological communications from providers to patients in separate states;
- Allowing for up to 30 days of in-person, face-to-face practice;
- Recognizing that states have vested interest protecting public health and safety and the best available protection is afforded through the compact and legislation;
- Only applying to individuals not holding licenses in both home and receiving jurisdictions; and

[29] Id.
[30] Under the compact, an E.Passport is a certificate issued by the Association for State and Provincial Psychology Boards that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.
[31] *Supra*, note 28. A distant state is a compact state where a psychologist is physically present to provide temporary in-person, face-to-face psychological services.
[32] Psychology Interjurisdictional Compact (PSYPACT), https://cdn.ymaws.com/psypact.site-ym.com/resource/resmgr/psychology_interjurisdiction.pdf (last visited Jan. 22, 2022).

- Not applying to permanent in-person, face-to-face practice.

Definitions (Article II)

The compact provides definitions for terms used in the model legislation.

Home State Licensure (Article III)

Under the compact, a psychologist must be licensed by his or her home state, which must be a compact state, to provide services permitted by the compact. PSYPACT authorizes psychologists with a home state license to practice telepsychology in receiving states only if the receiving state requires:

- The psychologist to hold an active E.Passport;
- A mechanism for receiving and investigating complaints about licensees;
- Notification to the Commission of any adverse action of significant investigatory information regarding a licensee;
- An identity history summary (background screening) of all applicants at initial licensure; and
- Compliance with the bylaws and rules of the Commission.

PSYPACT authorizes the practice of temporary, face-to-face practice in a distant state only if the compact state:

- Currently holds an active interjurisdictional practice certificate;
- Has a mechanism for receiving and investigating complaints about licensees;
- Notifies the Commission of any adverse action of significant investigatory information regarding a licensee;
- Requires an identity history summary (background screening) of all applicants at initial licensure; and
- Complies with the bylaws and rules of the Commission.

Compact Privilege to Practice Telepsychology (Article IV)

PSYPACT authorizes the practice of telepsychology in a receiving state in which a psychologist is not licensed, only if the psychologist:

- Holds a graduate degree in psychology from an institute of higher education which, at the time the degree was awarded was:
    - Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees or authorize by provincial statute or royal charter to grant doctoral degrees; or
    - A foreign college or university deemed to be equivalent by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services or by a recognizes foreign credential evaluation.
- Holds a graduate degree in psychology that meets designated criteria;
- Possess current, full and unrestricted license to practice psychology in a home state which is a compact state;
- Has no history of adverse action which violate the rules of the Commission;
- Has no criminal record history which violates the rules of the Commission;
- Possess a current and active E. Passport;
- Provides attestations regarding areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background and knowledge and adherence to legal requirements in the home and receiving states, and provides a release of information to allow for primary source verification in a manner specified by the Commission; and

- Meets other criteria as defined by the rules of the Commission.

PSYPACT also requires psychologists practicing under the compact to practice within his or her areas of competency and within the scope of practice of the receiving state. Receiving states are authorized to limit or revoke a psychologist's authority to practice interjurisdictional telepsychology and to take any necessary actions under applicable law to protect the health and safety of the receiving state's citizens. States taking such action must immediately notify the psychologist's home state and the Commission. E. Passports must be revoked if a psychologist's home state license or other state license is restricted, suspended, or otherwise limited.

Compact Temporary Authorization to Practice (Article V)

The compact requires compact states to recognize the right of a psychologist licensed in a compact state to temporarily practice in other compact states where the psychologist is not licensed. To practice temporarily in another compact state, a licensed psychologist must:

- Hold a graduate degree in psychology from an institute of higher education which, at the time the degree was awarded was:
    - Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees or authorize by provincial statute or royal charter to grant doctoral degrees; or
    - A foreign college or university deemed to be equivalent by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services or by a recognizes foreign credential evaluation.
- Hold a graduate degree in psychology from an educational program that:
    - Is identified and labeled as a psychology program and specify in institutional catalogues and brochures its intent to educate and train professional psychologists;
    - Stands as a recognizable, coherent, organizational entity within the institution;
    - Has clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;
    - Consists of an integrated, organized sequence of study;
    - Has an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
    - Has a director who must be a psychologist and a member of the core faculty;
    - Has an identifiable student body who are matriculated in that program for a degree;
    - The program must include supervised practicum, internship, or filed training appropriate to the practice of psychology;
    - Has a curriculum must encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for a master's degree; and
    - Includes an acceptable residency as defined by Commission rules.
- Possess a current, full and unrestricted license to practice psychology in a home state which is a compact state;
- Have no history of adverse action or criminal record history that violate Commission rules;
- Possess a current, active interjurisdictional practice certificate;
- Provide attestations regarding areas of intended practice and work experience and allow for primary source verification in a manner specified by the Commission; and
- Meet other criteria as defined by the Commission rules.

A psychologist practicing in a distant state under a temporary authorization to practice must practice within the scope of practice within such state and is subject to its authority and laws. A distant state may limit or revoke a psychologist's temporary authorization in accordance with state law and take any necessary action under the state's law to protect the health and safety of its citizens. Any action taken by a distant state must be reported to the home state and the Commission and the psychologist's interjurisdictional practice certificate must be revoked.

Compact of Telepsychological Practice in a Receiving State (Article VI)

A psychologist must practice interjurisdictional telepsychology in accordance with the scope of practice of the receiving jurisdiction and within the rules of the commission, as well as:

- The psychologist initiates a client/patient contact in home state via telecommunications technologies with a client/patient in a receiving state; or
- Other condition regarding telepsychology as determined by rule promulgated by the commission.

Adverse Actions (Article VII)

This section covers how the compact, home and receiving states will conduct and report adverse actions. As well as the consequences for a psychologist who receives adverse actions.

The home state may take adverse actions against a psychologist license. A receiving state may take adverse action on a psychologist authority to practice interjurisdictional telepsychology and temporary authorization to practice within that receiving state.

If a home state takes adverse action against a psychologist's license, a psychologist's authority to practice interjurisdictional telepsychology is terminated and the E.Passport is revoked. In addition, that psychologist's temporary practice is terminated, and the IPC is revoked. All adverse actions taken should be reported to the Commission.

A home state's psychology regulatory authority is required to investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a receiving state as it would if such conduct had occurred by a licensee within the home state. In such cases, the home state's law shall control in determining any adverse action against a psychologist's license.

Nothing in the compact will override a compact state's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain non-public if required by the compact state's law. The psychologist must cease providing services while in an alternative program.

Additional Authorities Invested in a Compact State's Psychology Regulatory Authority (Article VIII)

PSYPACT authorizes compact states to maintain their psychologist regulatory authority, including:

- Issuing subpoenas, for both hearings and investigations; and
- Issuing orders to cease and desist and injunctive relief orders to revoke a psychologist's authority to practice interjurisdictional telepsychology or through temporary authorization.

The compact also prohibits a psychologist from changing their home state status if an investigation is taking place. The compact encourages conclusions of all investigations to be reported to the Commission. All information provided to the Commission or distributed by compact states pursuant to the psychologist shall remain confidential, filed under seal and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated discretionary sharing of information by compact states.

Coordinated Licensure Information System (Article IX)

The compact requires all compact states to share licensee information. Compact states must submit a uniform dataset to a coordinated database on all psychologists to whom the compact is applicable, as required by the rules of the commission. The database allows for expedited sharing of adverse action

against compact psychologists. The coordinated database information must be expunged according to laws of the reporting compact state.

Establishment of the Psychology Interjurisdictional Compact Commission (Article X)

The compact establishes the Psychology Interjurisdictional Compact Commission as the ruling commission. The Commission must consist of one voting representative appointed by each compact state who serves as that state's Commissioner. The applicable state regulatory board must also appoint a delegate to represent the Board of Psychology. Vacancies of Commissioners must be filled in accordance of the laws of the compact state. Each commissioner is granted one vote in regard to creation of rules and bylaws and must have the opportunity to participate in the business and affairs of the Commission.

Rulemaking (Article XI)

PSYPACT provides rule-making authority to the Commission. Rules and amendments to the rules passed by the Commission are binding on the party states as of the effective date specified in each rule or amendment.

Prior to the promulgation and adoption of a rule, and at least 60 days in advance, the Commission must provide notice of the meeting at which the rule is to be considered and voted upon. The notice must be posted on the Commission's website and the website of the licensing board of each member state, or the publication in which each state would otherwise publish proposed rules, and include:

- The time, date, and location of the meeting;
- The text of the proposed rule or amendment,
- The reason for the proposed rule or amendment;
- A request for comment from interested persons; and
- The manner in which interested persons may submit comments.

The public may submit written comments, which must be made publicly available, prior to the adoption of the proposed rule. The Commission must hold a public hearing before it adopts a rule if requested by:

- At least 25 people submit comments independently of each other;
- A governmental entity; or
- A duly appointed person in an association having at least 25 members.

If a hearing is held, the Commission must publish the place, time, and date of he scheduled public hearing. Anyone wishing to speak at the hearing must notify the Executive Director of the Commission, or another designated member, within five business days before the hearing. Hearings must be conducted in a manner that provides fair and reasonable opportunity for the public to comment orally or in writing. Transcripts of hearings are not required unless a written request is made. Recordings may be made in lieu of transcripts. The Commission may make transcripts of hearings if it so chooses. Rules may be grouped together in the same hearing for convenience of the Commission.

Following the hearing, the Commission must consider all comments received from the public. A majority vote of the Commission is required for adoption of rules and the Commission may decide the effective date of the rule.

The commission has the authority to consider and adopt emergency rules, without prior notice, if there is an imminent threat to public health, safety, or welfare; to prevent a loss of funds of the commission or a party state; or to meet a deadline for the promulgation of an administrative rule that is required by federal law. The standard rule-making procedure is to be applied retroactively as soon as possible but no later than 90 days after the effective date of the emergency rule.

Oversight, Dispute Resolution and Enforcement (Article XII)

The executive, legislative, and judicial branches of state government in each compact state is charged with enforcing the compact and must take any necessary action to effectuate its purpose and intent. The Commission is entitled to receive service of process relating to its powers, responsibilities, or actions, and may intervene in any proceeding affecting such.

If a party state defaults in the performance of its duties or responsibilities under the compact, the Commission must notify the defaulting state, as well as other party states, in writing of the nature of the default and proposed cure of the default. The Commission will also provide remedial training and technical assistance related to the default. If the defaulting state fails to cure the default, the Commission may terminate its membership in PSYPACT, upon majority affirmative vote of the majority of the administrators. The Commission must notify the governor and the majority and minority leaders of the defaulting state's legislature, as well as all compact states, of its intent to suspend or terminate the state's membership in the compact. However, termination of membership is to only be imposed after all other means of compliance have been exhausted.

A termination of membership in the compact may be appealed by petitioning the U.S. District Court for the state of Georgia or the federal district in which the compact's principal office is located. The compact's principal office is located in Tyrone, Georgia. The Commission may also bring an action in federal court against a defaulting state to enforce compliance with the provisions of the compact. The Commission may seek injunctive relief, damages, or any other remedies available under state or federal law. A prevailing party in either action is entitled to court costs and reasonable attorneys' fees.

In the event that a dispute arises between party states, the Commission will attempt to resolve such disputes. The compact directs the Commission to promulgate a rule that provides for mediation and binding dispute resolution.

Date of Implementation of Psychology Interjurisdictional Compact Commission and Associated Rules, Withdrawal and Amendment (Article XIII)

The compact became effective on the date of enactment in the seventh compact state, which occurred on April 9, 2019.[33] States that join after the adoption of the rules shall be subject to the rules as they exist on the date which the compact becomes law in that state.

To withdraw from PSYPACT, a state must enact a statute repealing the compact. Such withdrawal does not take effect until six months after the enactment of the repealing legislation. Any adverse actions or investigations that occur prior to the effective date of a withdrawal must be reported as required under the compact.

The compact may be amended by the party states; however, an amendment will not be effective until it is enacted into the laws of all compact states.

Construction and Severability (XIV)

This compact is to be liberally construed to effectuate its purposes. PSYPACT contains a severability clause that provides that if the entire compact is found to be held contrary to the constitution of any state member thereto, the compact shall remain in full force and effect as to the remaining compact states.

[33] PSYPACT, *History*, https://psypact.site-ym.com/page/History (last visited Jan. 22, 2022).

Effect of the Bill

Psychologist Licensure Compact

The bill enacts the Psychology Interjurisdictional Compact (see description of compact provisions in the Background section) and authorizes Florida to enter into the compact with all other jurisdictions that have legally joined the compact. This allows an eligible Florida licensed psychologist to provide services to out-of-state patients through either telehealth or a temporary authorization to practice.

The bill amends current law to allow PSYPACT implementation. It requires DOH to report any significant investigation information relating to a psychologist practicing under the compact to the coordinated database. It requires psychologists practicing under the compact to withdraw from all practice under the compact if the psychologist in an impaired practitioner program. It requires the Board of Psychology (Board) to appoint an individual to serve on the Commission and exempts out-of-state licensed psychologists who practice under the compact from psychologist licensure requirements in this state. The bill authorizes the Board to take adverse action against a psychologist's authority to practice under the compact and impose disciplinary actions for violation of prohibited acts.

The bill makes conforming changes to statute to reference the compact and the requirements under the compact. The bill does not require changes to Florida's licensure and license renewal requirements.

Sovereign Immunity

The bill provides that an individual of the Board, when serving as the state administrator of the compact, and any administrator, officer, executive director, employee, or representative of the commission, when acting within the scope of their employment, duties, or responsibilities in this state, are considered agents of the state. The bill also provides that the Commission will pay any claims or judgments pursuant to s. 768.28, F.S., and may maintain insurance coverage to pay any such claims or judgements.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Creates s. 490.0075, F.S., relating to Psychology Interjurisdictional Compact.
Section 2: Amends s. 456.073, F.S., relating to disciplinary proceedings.
Section 3: Amends s. 456.076, F.S., relating to impaired practitioner program.
Section 4: Amends s. 490.004, F.S., relating to Board of Psychology.
Section 5: Amends s. 490.005, F.S., relating to licensure by examination.
Section 6: Amends s. 490.006, F.S., relating to licensure by endorsement.
Section 7: Amends s. 490.009, F.S., relating to discipline.
Section 8: Amends s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; recovery limits; civil liberty for damages caused during a riot; limitation on attorney fees; statute of limitation; exclusions; indemnification; risk management programs.
Section 9: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

   DOH estimates 1 full-time equivalent (FTE) position will be needed to implement the provisions of the bill at a total cost of $56,892 ($44,314/Salary $12,272/Expense $306/Human Resources).[34]

   DOH may also experience an increase in cost related to annual membership with PSYPACT, additional complaints and investigations, and updating licensure systems and can be absorbed within current resources.[35]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Fees associated with applying for a license in a compact state would be eliminated for a psychologist whose home state is Florida and wants to practice in a compact state, as well as a psychologist whose home state is in a compact state and wishes to practice in Florida.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   As discussed below in the section entitled, "RULE-MAKING AUTHORITY," the bill delegates authority to the commission to adopt rules that facilitate and coordinate the implementation and administration of the Psychology Interjurisdictional Compact.

   If enacted into law, the state will effectively bind itself to rules not yet adopted by the commission. The Florida Supreme Court has held that while it is within the province of the Legislature to adopt federal statutes enacted by Congress and rules promulgated by federal administrative bodies that are in existence at the time the Legislature acts, it is an unconstitutional delegation of legislative power to prospectively adopt federal statutes not yet enacted by Congress and rules not yet promulgated by federal administrative bodies.[36][37] Under this holding, the constitutionality of the bill's

[34] Department of Health Agency Analysis of 2022 House Bill 953 (Jan. 21, 2022).
[35] Id.
[36] *Freimuth v. State*, 272 So.2d 473, 476 (Fla. 1972) (quoting *Fla. Ind. Comm'n v. State ex rel. Orange State Oil Co.*, 155 Fla. 772 (1945).
[37] This prohibition is based on the separation of powers doctrine, set forth in Article II, Section 3 of the Florida Constitution, which has been construed in Florida to require the Legislature, when delegating the administration of legislative programs, to establish the minimum standards and guidelines ascertainable by reference to the enactment creating the program. *See Avatar Development Corp. v. State*, 723 So.2d 199 (Fla. 1998).

adoption of prospective rules might be questioned, and there does not appear to be binding Florida case law that squarely address this issue in the context of interstate compacts.

The most recent opportunity Florida courts have had to address this issue appears to be in *Department of Children and Family Services v. L.G.*, involving the Interstate Compact for the Placement of Children (ICPC).[38] The First District Court of Appeal considered an argument that the regulations adopted by the Association of Administrators of the Interstate Compact were binding and that the lower court's order permitting a mother and child to relocate to another state was in violation of the ICPC. The court denied the appeal and held that the Association's regulations did not apply as they conflicted with the ICPC and the regulations did not apply to the facts of the case.

The court also references language in the ICPC that confers to its compact administrators the "power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact."[39] The court states that "the precise legal effect of the ICPC compact administrators' regulations in Florida is unclear," but noted that it did not need to address the question to decide the case.[40] However, in a footnote, the court provided:

> Any regulations promulgated before Florida adopted the ICPC did not, of course, reflect the vote of a Florida compact administrator, and no such regulations were ever themselves enacted into law in Florida. When the Legislature did adopt the ICPC, it did not (and could not) enact as the law of Florida or adopt prospectively regulations then yet to be promulgated by an entity not even covered by the Florida Administrative Procedure Act. *See Freimuth v. State,* 272 So.2d 473, 476 (Fla.1972); *Fla. Indus. Comm'n v. State ex rel. Orange State Oil Co.,* 155 Fla. 772, 21 So.2d 599, 603 (1945) ("[I]t is within the province of the legislature to approve and adopt the provisions of federal statutes, and all of the administrative rules made by a federal administrative body, that are in existence and in effect at the time the legislature acts, but it would be an unconstitutional delegation of legislative power for the legislature to adopt in advance any federal act or the ruling of any federal administrative body that Congress or such administrative body might see fit to adopt in the future."); *Brazil v. Div. of Admin.,* 347 So.2d 755, 757–58 (Fla. 1st DCA 1977), *disapproved on other grounds by LaPointe Outdoor Adver. v. Fla. Dep't of Transp.,* 398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.[41]

In accordance with the discussion provided by the court in this above-cited footnote, it may be argued that the bill's delegation of rule-making authority to the commission is similar to the delegation to the ICPC compact administrators, and thus, could constitute an unlawful delegation of legislative authority. This case, however, does not appear to be binding as precedent as the court's footnote discussion is dicta.[42]

B. RULE-MAKING AUTHORITY:

The bill authorizes the Commission to adopt rules to facilitate and coordinate the implementation and administration of the compact. The compact specifies that the rules have the force and effect of law and are binding in all compact states. If a compact state fails to meet its obligations under the compact or the promulgated rules, the state may be subject to remedial training, alternative dispute resolution, suspension, termination, or legal action.

[38] 801 So.2d 1047 (Fla. 1st DCA 2001).
[39] Id at 1052.
[40] Id.
[41] Id.
[42] Dicta are statements of a court that are not essential to the determination of the case before it and are not a part of the law of the case. Dicta has no biding legal effect and is without force as judicial precedent. 12A FLA JUR. 2D *Courts and Judges* s. 191 (2015).

The compact details the rule-making process that must be followed including, notice, an opportunity for public participation, and hearings. The compact also provides a procedure for emergency rule-making in cases of imminent danger to public health, safety, or welfare, to prevent financial loss to the state's or commission, or to comply with federal laws or regulations. All rules and amendments are binding on party state as of the effective date specified.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Psychology Interjurisdictional Compact; creating s. 490.0075, F.S.; creating the Psychology Interjurisdictional Compact; providing purposes and objectives; defining terms; providing for recognition of psychologist licenses in compact states; authorizing a compact state to require licensure under certain circumstances; requiring compact states to meet certain criteria to participate in the compact; providing criteria that a psychologist must satisfy to practice under the compact; maintaining that authority over a psychologist's license remains with the home state but authorizing receiving states to define the scope of and act on a psychologist's authority to practice in the compact state under the compact; prohibiting a psychologist from practicing under the compact if his or her authority to do so has been acted on by any compact state; requiring compact states to report adverse actions they take against psychologists to the Psychology Interjurisdictional Compact Commission; requiring compact states to participate in a coordinated licensure information system; providing for the development of the system, reporting procedures, and the exchange of certain information

between compact states; establishing the Psychology Interjurisdictional Compact Commission; providing for the jurisdiction and venue for court proceedings; providing membership, duties, and powers; authorizing the commission to adopt rules; providing rulemaking procedures; providing for state enforcement of the compact; providing for the termination of compact membership; providing procedures for the resolution of certain disputes; providing compact amendment procedures; authorizing nonparty states to participate in commission activities before adoption of the compact; providing construction and severability; amending s. 456.073, F.S.; requiring the Department of Health to report certain investigative information to the coordinated licensure information system; amending s. 456.076, F.S.; requiring monitoring contracts for impaired practitioners participating in treatment programs to contain certain terms; amending s. 490.004, F.S.; requiring the Board of Psychology to appoint an individual to serve as the state's commissioner on the Psychology Interjurisdictional Compact Commission; amending s. 490.005, F.S.; exempting certain persons from licensure requirements; amending s. 490.006, F.S.; exempting certain persons from requirements for licensure by endorsement;

amending s. 490.009, F.S.; authorizing certain disciplinary action under the compact for certain prohibited acts; amending s. 768.28, F.S.; designating the state commissioner and other members or employees of the commission as state agents for the purpose of applying sovereign immunity and waivers of sovereign immunity; requiring the commission to pay certain judgments or claims; authorizing the commission to maintain insurance coverage to pay such judgments or claims; providing an effective date.

WHEREAS, states license psychologists to protect the public through verification of education, training, and experience and to ensure accountability for professional practice, and

WHEREAS, this compact is intended to regulate the day-to-day practice of telepsychology, or the provision of psychological services using telecommunication technologies, by psychologists across state boundaries in the performance of their psychological practice as defined by an appropriate state psychology regulatory authority, and

WHEREAS, this compact is intended to regulate the temporary in-person, face-to-face practice of psychology by psychologists across state boundaries for up to 30 days within a calendar year in the performance of their psychological practice as defined by an appropriate state psychology regulatory authority, and

WHEREAS, this compact is intended to authorize state psychology regulatory authorities to afford legal recognition, in a manner consistent with the terms of the compact, to psychologists licensed in another state, and

WHEREAS, this compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of psychologists and that such state regulation will best protect public health and safety, and

WHEREAS, this compact does not apply when a psychologist is licensed in both the home and receiving states, and

WHEREAS, while this compact does not apply to permanent in-person, face-to-face practice, it does allow for authorization of temporary psychological practice, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 490.0075, Florida Statutes, is created to read:

490.0075 Psychology Interjurisdictional Compact.—The Psychology Interjurisdictional Compact is hereby enacted and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

PSYCHOLOGY INTERJURISDICTIONAL COMPACT

ARTICLE I

PURPOSE

This compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services in a state where the psychologist is not licensed to practice psychology;

(2) Enhance the states' ability to protect the public's health and safety, especially client or patient safety;

(3) Encourage the cooperation of compact states in the areas of psychologist licensure and regulation;

(4) Facilitate the exchange of information between compact states regarding psychologist licensure, adverse actions, and disciplinary history;

(5) Promote compliance with the laws governing the practice of psychology in each compact state; and

(6) Invest all compact states with the authority to hold licensed psychologists accountable through the mutual recognition of compact state licenses.

ARTICLE II

DEFINITIONS

As used in this compact, the term:

(1) "Adverse action" means any disciplinary action that is

a matter of public record which is taken by a state's psychology regulatory authority against an individual's license to practice psychology in that state.

(2) "Association of State and Provincial Psychology Boards" means the membership organization composed of state and provincial psychology regulatory authorities that are responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) "Authority to practice interjurisdictional telepsychology" means a licensed psychologist's authority to practice telepsychology, within the limits authorized under this compact, in a compact state other than the one in which he or she is licensed.

(4) "Bylaws" means those rules established by the Psychology Interjurisdictional Compact Commission pursuant to Article X for its governance, or for directing and controlling its actions and conduct.

(5) "Client or patient" means the recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, or consulting services.

(6) "Commissioner" means the voting representative appointed by each state psychology regulatory authority pursuant to article X.

(7) "Compact state" means a state, the District of

Columbia, or a United States territory that has enacted this compact legislation and that has not withdrawn pursuant to subsection (3) of article XIII or been terminated pursuant to subsection (2) of article XII.

(8) "Confidentiality" means the principle that data or information is not made available or disclosed to unauthorized persons or processes.

(9) "Coordinated licensure information system," also referred to as "coordinated database," means an integrated process that is administered by the Association of State and Provincial Psychology Boards for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws and the Psychology Interjurisdictional Compact.

(10) "Day" means any part of a day in which the psychologist practices psychology.

(11) "Distant state" means the compact state where a psychologist is physically present, not through the use of telecommunication technologies, to provide temporary in-person, face-to-face psychological services.

(12) "E-passport" means a certificate issued by the Association of State and Provincial Psychology Boards which allows a licensed psychologist to provide telepsychological services across state lines.

(13) "Executive board" means a group of directors elected

or appointed to act on behalf of, and within the powers granted to them by, the commission.

(14) "Home state" means a compact state where a psychologist is licensed to practice psychology, as provided in article III.

(15) "Identity history summary" means a summary of information retained by the Federal Bureau of Investigation, or other designee with similar authority, in connection with arrests and, in some instances, federal employment or military service.

(16) "In-person, face-to-face" means interactions in which the psychologist and the client or patient are in the same physical space and does not include interactions that may occur through the use of telecommunication technologies.

(17) "Interjurisdictional Practice Certificate (IPC)" means the certificate issued by the Association of State and Provincial Psychology Boards which grants temporary authority to practice based on notification to the state psychology regulatory authority of one's intention to practice temporarily, and verification of one's qualifications for such practice.

(18) "License" means authorization by a state psychology regulatory authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) "Noncompact state" means a state that is not a compact state.

(20) "Psychologist" means an individual who is licensed by a state psychology regulatory authority to independently practice psychology in that state.

(21) "Psychology Interjurisdictional Compact Commission," also referred to as "commission," means the national administration of which all compact states are members.

(22) "Receiving state" means a compact state where the client or patient is physically located when the telepsychological services are delivered.

(23) "Rule" means a written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to article XI of the compact which is of general applicability; implements, interprets, or prescribes a policy or provision of the compact; or is an organizational, procedural, or practice requirement of the commission; and has the force and effect of statutory law in a compact state, and includes the amendment, repeal, or suspension of an existing rule.

(24) "Significant investigatory information" means:

(a) Investigative information that a state psychology regulatory authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate a violation of state statute or rule that would be considered more substantial than a minor infraction; or

(b) Investigative information that indicates that the

psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified or had an opportunity to respond.

(25) "State" means a state, commonwealth, territory, or possession of the United States, or the District of Columbia.

(26) "State psychology regulatory authority" means the board, office, or other agency with the legislative mandate to license and regulate the practice of psychology in that state.

(27) "Telepsychology" means the provision of psychological services using telecommunication technologies.

(28) "Temporary authorization to practice" means a licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this compact, in another compact state.

(29) "Temporary in-person, face-to-face practice" means when a psychologist is physically present, not through the use of telecommunication technologies, in the distant state to provide psychological services for up to 30 days within a calendar year and based on notification to the distant state.

ARTICLE III

HOME STATE LICENSURE

(1) The home state is a compact state where a psychologist is licensed to practice psychology.

(2) A psychologist may hold one or more compact state

licenses at a time. If the psychologist is licensed in more than one compact state, the home state is the compact state where the psychologist is physically present when the services are delivered as authorized by the authority to practice interjurisdictional telepsychology under the terms of this compact.

(3) A compact state may require a psychologist who is not previously licensed in a compact state to obtain and retain a license to be authorized to practice in the compact state under circumstances that are not authorized by the authority to practice interjurisdictional telepsychology under the terms of this compact.

(4) A compact state may require a psychologist to obtain and retain a license to be authorized to practice in a compact state under circumstances that are not authorized by a temporary authorization to practice under the terms of this compact.

(5) A home state's license authorizes a psychologist to practice in a receiving state under the authority to practice interjurisdictional telepsychology only if the compact state:

(a) Currently requires the psychologist to hold an active e-passport;

(b) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(c) Notifies the commission, in compliance with the terms herein, of any adverse action or significant investigatory

information regarding a licensed individual;

(d) Requires an identity history summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, or other designee with similar authority, no later than 10 years after activation of the compact; and

(e) Complies with the bylaws and rules of the commission.

(6) A home state's license grants a psychologist temporary authorization to practice in a distant state only if the compact state:

(a) Currently requires the psychologist to hold an active IPC;

(b) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(c) Notifies the commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(d) Requires an identity history summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, or other designee with similar authority, no later than 10 years after activation of the compact; and

(e) Complies with the bylaws and rules of the commission.

ARTICLE IV

COMPACT PRIVILEGE TO PRACTICE TELEPSYCHOLOGY

(1) Compact states shall recognize the right of a psychologist, licensed in a compact state in conformance with article III, to practice telepsychology in other compact states, or receiving states, in which the psychologist is not licensed, under the authority to practice interjurisdictional telepsychology as provided in the compact.

(2) To exercise the authority to practice interjurisdictional telepsychology in a receiving state under the terms and provisions of this compact, a psychologist licensed to practice in a compact state must:

(a) Hold a graduate degree in psychology from an institution of higher education that was, at the time the degree was awarded:

1. Regionally accredited by an accrediting body recognized by the United States Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

2. A foreign college or university deemed to be equivalent to subparagraph 1. by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services or by a recognized foreign credential evaluation service;

(b) Hold a graduate degree in psychology which meets the following criteria:

1. The program, wherever it may be administratively housed, is clearly identified and labeled as a psychology program. Such program must specify in pertinent institutional catalogs and brochures its intent to educate and train professional psychologists;

2. The psychology program stands as a recognizable and coherent organizational entity within the institution;

3. There is a clear authority and primary responsibility for the core and specialty areas regardless of whether the program overlaps across administrative lines;

4. The program consists of an integrated, organized sequence of study;

5. There is an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

6. The designated director of the program is a psychologist and a member of the core faculty;

7. The program has an identifiable body of students who are matriculated in that program for a degree;

8. The program includes supervised practicum, internship, or field training appropriate to the practice of psychology;

9. The curriculum encompasses a minimum of 3 academic years of full-time graduate study for doctoral degrees and a minimum of 1 academic year of full-time graduate study for

master's degrees; and

10. The program includes an acceptable residency as defined by the rules of the commission;

(c) Possess a current, full, and unrestricted license to practice psychology in a home state that is a compact state;

(d) Have no history of adverse actions that violate the rules of the commission;

(e) Have no criminal history reported on an identity history summary which violates the rules of the commission;

(f) Possess a current, active e-passport;

(g) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the commission; and

(h) Meet other criteria as defined by the rules of the commission.

(3) The home state maintains authority over the license of any psychologist practicing in a receiving state under the authority to practice interjurisdictional telepsychology.

(4) A psychologist practicing in a receiving state under the authority to practice interjurisdictional telepsychology will be subject to the receiving state's scope of practice. A

receiving state may, in accordance with that state's due process law, limit or revoke a psychologist's authority to practice interjurisdictional telepsychology in the receiving state and may take any other necessary actions under the receiving state's applicable law to protect the health and safety of the receiving state's citizens. If a receiving state takes action, the state shall promptly notify the home state and the commission.

(5) If a psychologist's license in any home state or another compact state or any authority to practice interjurisdictional telepsychology in any receiving state is restricted, suspended, or otherwise limited, the e-passport must be revoked and the psychologist is not eligible to practice telepsychology in a compact state under the authority to practice interjurisdictional telepsychology.

ARTICLE V

COMPACT TEMPORARY AUTHORIZATION TO PRACTICE

(1) Compact states shall recognize the right of a psychologist licensed in a compact state in conformance with article III to practice temporarily in other compact states, or distant states, in which the psychologist is not licensed, as provided in the compact.

(2) To exercise the temporary authorization to practice in distant states under the terms and provisions of this compact, a psychologist licensed to practice in a compact state must:

(a) Hold a graduate degree in psychology from an institution of higher education that was, at the time the degree was awarded:

1. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

2. A foreign college or university deemed to be equivalent to subparagraph 1. above by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services or by a recognized foreign credential evaluation service;

(b) Hold a graduate degree in psychology that meets the following criteria:

1. The program, wherever it may be administratively housed, is clearly identified and labeled as a psychology program. Such program must specify in pertinent institutional catalogs and brochures its intent to educate and train professional psychologists;

2. The psychology program stands as a recognizable and coherent organizational entity within the institution;

3. There is a clear authority and primary responsibility for the core and specialty areas regardless of whether the program overlaps across administrative lines;

4. The program consists of an integrated, organized

sequence of study;

5. There is an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

6. The designated director of the program is a psychologist and a member of the core faculty;

7. The program has an identifiable body of students who are matriculated in that program for a degree;

8. The program includes supervised practicum, internship, or field training appropriate to the practice of psychology;

9. The curriculum encompasses a minimum of 3 academic years of full-time graduate study for doctoral degrees and a minimum of 1 academic year of full-time graduate study for master's degrees; and

10. The program includes an acceptable residency as defined by the rules of the commission;

(c) Possess a current, full, and unrestricted license to practice psychology in a home state that is a compact state;

(d) Have no history of adverse actions that violate the rules of the commission;

(e) Have no criminal history that violates the rules of the commission;

(f) Possess a current, active IPC;

(g) Provide attestations in regard to areas of intended practice and work experience, and provide a release of information to allow for primary source verification in a manner

specified by the commission; and

(h) Meet other criteria as defined by the rules of the commission.

(3) A psychologist practicing in a distant state under a temporary authorization to practice shall practice within the scope of practice authorized by the distant state.

(4) A psychologist practicing in a distant state under a temporary authorization to practice will be subject to the distant state's authority and law. A distant state may, in accordance with that state's due process law, limit or revoke a psychologist's temporary authorization to practice in the distant state and may take any other necessary actions under the distant state's applicable law to protect the health and safety of the distant state's citizens. If a distant state takes action, the state shall promptly notify the home state and the commission.

(5) If a psychologist's license in any home state or another compact state or temporary authorization to practice in any distant state is restricted, suspended, or otherwise limited, the IPC shall be revoked and the psychologist is not eligible to practice in a compact state under the temporary authorization to practice.

ARTICLE VI

CONDITIONS OF TELEPSYCHOLOGY PRACTICE IN A RECEIVING STATE

A psychologist may practice in a receiving state under the authority to practice interjurisdictional telepsychology only in the performance of the scope of practice for psychology as defined by an appropriate state psychology regulatory authority, as defined in the rules of the commission, and under the following circumstances:

(1) The psychologist initiates a client or patient contact in a home state via telecommunication technologies with a client or patient in a receiving state; and

(2) Other conditions regarding telepsychology as determined by rules promulgated by the commission.

ARTICLE VII

ADVERSE ACTIONS

(1) A home state may take adverse action against a psychologist's license issued by the home state. A distant state shall have the power to take adverse action on a psychologist's temporary authorization to practice within that distant state.

(2) A receiving state may take adverse action on a psychologist's authority to practice interjurisdictional telepsychology within that receiving state. A home state may take adverse action against a psychologist based on an adverse action taken by a distant state regarding temporary in-person, face-to-face practice.

(3) If a home state takes adverse action against a

psychologist's license, that psychologist's authority to practice interjurisdictional telepsychology is terminated and the e-passport is revoked. Furthermore, that psychologist's temporary authorization to practice is terminated and the IPC is revoked.

(a) All home state disciplinary orders that take adverse action shall be reported to the commission in accordance with the rules promulgated by the commission. A compact state shall report adverse actions in accordance with the rules of the commission.

(b) In the event that discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the rules of the commission.

(c) Other actions may be imposed as determined by the rules promulgated by the commission.

(4) A home state's psychology regulatory authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a receiving state in the same manner as it would if such conduct had occurred by a licensee within the home state. In such cases, the home state's law shall control in determining any adverse action against a psychologist's license.

(5) A distant state's psychology regulatory authority shall investigate and take appropriate action with respect to

reported inappropriate conduct engaged in by a psychologist practicing under temporary authorization to practice which occurred in that distant state in the same manner as it would if such conduct had occurred by a licensee within the home state. In such cases, the distant state's law shall control in determining any adverse action against a psychologist's temporary authorization to practice.

(6) Nothing in this compact shall override a compact state's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the compact state's law. Compact states must require psychologists who enter any alternative programs to not provide telepsychology services under the authority to practice interjurisdictional telepsychology or temporary psychological services under the temporary authorization to practice in any other compact state during the term of the alternative program.

(7) Other judicial or administrative remedies will not be available to a psychologist in the event a compact state takes adverse action pursuant to subsection (3).

ARTICLE VIII

ADDITIONAL AUTHORITIES INVESTED IN A COMPACT STATE'S PSYCHOLOGY REGULATORY AUTHORITY

(1) In addition to any other powers granted under state

law, a compact state's psychology regulatory authority shall have the authority under this compact to:

(a) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a compact state's psychology regulatory authority for the attendance and testimony of witnesses, or the production of evidence from another compact state, shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing state psychology regulatory authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses or evidence are located; and

(b) Issue cease and desist or injunctive relief orders to revoke a psychologist's authority to practice interjurisdictional telepsychology or temporary authorization to practice.

(2) During the course of any investigation, a psychologist may not change his or her home state licensure. A home state psychology regulatory authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The home state psychology regulatory authority shall promptly report the conclusions of such investigations to the commission. Once an investigation has been

completed, and pending the outcome of such investigation, the psychologist may change his or her home state licensure. The commission shall promptly notify the new home state of any such decisions as provided in the rules of the commission. All information provided to the commission or distributed by compact states related to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The commission may create additional rules for mandated or discretionary sharing of information by compact states.

ARTICLE IX

COORDINATED LICENSURE INFORMATION SYSTEM

(1) The commission shall provide for the development and maintenance of a Coordinated Licensure Information System and a reporting system containing licensure and disciplinary action information on all psychologists to whom this compact is applicable in all compact states as defined by the rules of the commission.

(2) Notwithstanding any other provision of state law to the contrary, a compact state shall submit a uniform data set to the coordinated database on all licensees as required by the rules of the commission, including:

(a) Identifying information;

(b) Licensure data;

(c) Significant investigatory information;

(d) Adverse actions against a psychologist's license;

(e) An indicator that a psychologist's authority to practice interjurisdictional telepsychology or temporary authorization to practice is revoked;

(f) Nonconfidential information related to alternative program participation information;

(g) Any denial of application for licensure, and the reasons for such denial; and

(h) Other information that may facilitate the administration of this compact, as determined by the rules of the commission.

(3) The coordinated database administrator shall promptly notify all compact states of any adverse action taken against, or significant investigatory information on, any licensee in a compact state.

(4) Compact states reporting information to the coordinated database may designate information that may not be shared with the public without the express permission of the compact state reporting the information.

(5) Any information submitted to the coordinated database which is subsequently required to be expunged by the law of the compact state reporting the information shall be removed from the coordinated database.

ARTICLE X

ESTABLISHMENT OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT COMMISSION

(1) COMMISSION CREATED.—The compact states hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(a) The commission is a body politic and an instrumentality of the compact states.

(b) Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the commission is located. The commission may waive venue and jurisdictional defenses to the extent that it adopts or consents to participate in alternative dispute resolution proceedings.

(c) Nothing in this compact shall be construed to be a waiver of sovereign immunity.

(2) MEMBERSHIP, VOTING, AND MEETINGS.—

(a) The commission shall consist of one voting representative appointed by each compact state who shall serve as that state's commissioner. The state psychology regulatory authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the compact state. This delegate shall be limited to:

1. The executive director, the executive secretary, or a similar executive of the compact state's psychology regulatory authority;

2. A current member of the state psychology regulatory authority of a compact state; or

3. A designee empowered with the appropriate delegate authority to act on behalf of the compact state.

(b) A commissioner may be removed or suspended from office as provided by the law of the state from which the commissioner is appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compact state in which the vacancy exists.

(c) Each commissioner shall be entitled to one vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission. A commissioner shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for commissioners' participation in meetings by telephone or other means of communication.

(d) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

(e) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in article XI.

(f) The commission may convene in a closed, nonpublic meeting if the commission must discuss:

1. Noncompliance of a compact state with its obligations

under the compact;

2. Employment, compensation, or discipline of or other personnel matters, practices, or procedures related to specific employees, or other matters related to the commission's internal personnel practices and procedures;

3. Current, threatened, or reasonably anticipated litigation against the commission;

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

5. An accusation of any person of a crime or a formal censure of any person;

6. Information disclosing trade secrets or commercial or financial information which is privileged or confidential;

7. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

8. Investigatory records compiled for law enforcement purposes;

9. Information related to any investigatory reports prepared by or on behalf of or for use of the commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact; or

10. Matters specifically exempted from disclosure by federal or state statute.

(g) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission's legal counsel or

designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(3) BYLAWS.—

(a) The commission shall, by a majority vote of the commissioners, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including, but not limited to:

1. Establishing the fiscal year of the commission;

2. Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the commission;

3. Providing reasonable procedures for calling and conducting meetings of the commission, ensuring reasonable

advance notice of all meetings, and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals involved in such proceedings, and proprietary information, including trade secrets. The commission may meet in closed session only after a majority of the commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the commission must make public a copy of the vote to close the meeting which reveals the vote of each commissioner with no proxy votes allowed;

4. Establishing the titles, duties and authority, and reasonable procedures for the election of the officers of the commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar law of any compact state, the bylaws shall exclusively govern the personnel policies and programs of the commission;

6. Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

7. Providing a mechanism for concluding the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment or reserving of all of its debts and obligations.

(b) The commission shall publish its bylaws in a convenient form and file a copy thereof, and a copy of any amendment thereto, with the appropriate agency or officer in each of the compact states.

(c) The commission shall maintain its financial records in accordance with the bylaws.

(d) The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

(4) POWERS.—The commission has the power to:

(a) Promulgate uniform rules to facilitate and coordinate implementation and administration of this compact. The rules shall have the force and effect of law and shall be binding in all compact states;

(b) Bring and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state psychology regulatory authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law is not affected;

(c) Purchase and maintain insurance and bonds;

(d) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a compact state;

(e) Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the compact, and establish the commission's personnel policies and programs

relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(f) Accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the commission shall strive to avoid any appearance of impropriety or conflict of interest;

(g) Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use, any property, real, personal, or mixed; provided that at all times the commission shall strive to avoid any appearance of impropriety or conflict of interest;

(h) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(i) Establish a budget and make expenditures;

(j) Borrow money;

(k) Appoint committees, including advisory committees consisting of commission members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this compact and the bylaws;

(l) Provide and receive information from, and to cooperate with, law enforcement agencies;

(m) Adopt and use an official seal; and

(n) Perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(5) EXECUTIVE BOARD.—

(a) The executive board shall have the power to act on behalf of the commission according to the terms of this compact, and shall consist of the following six members:

1. Five voting members who are elected from the current membership of the commission by the commission; and

2. One ex-officio, nonvoting member from the Association of State and Provincial Psychology Boards.

(b) The ex-officio member must have served as staff for or a member of a state psychology regulatory authority and shall be selected by its respective organization.

(c) The commission may remove any member of the executive board as provided in its bylaws.

(d) The executive board shall meet at least annually.

(e) The executive board shall have the following duties and responsibilities:

1. Recommend to the entire commission changes to the rules or bylaws, this compact legislation, or fees paid by compact states, such as annual dues, and other applicable fees;

2. Ensure compact administration services are appropriately provided, contractual or otherwise;

3. Prepare and recommend the budget;

4. Maintain financial records on behalf of the commission;

5. Monitor compact compliance of member states and provide compliance reports to the commission;

6. Establish additional committees as necessary; and

7. Other duties as provided in rules or bylaws.

(6) FINANCING.—

(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(c) The commission may levy and collect an annual assessment from each compact state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the commission, which shall promulgate a rule binding upon all compact states.

(d) The commission may not incur obligations of any kind before securing the funds adequate to meet the same; nor shall the commission pledge the credit of any of the compact states,

except by and with the authority of the compact state.

(e) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the commission.

(7) QUALIFIED IMMUNITY, DEFENSE, AND INDEMNIFICATION.—

(a) The members, officers, executive director, employees, and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities; provided that nothing in this paragraph shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(b) The commission shall defend any member, officer, executive director, employee, or representative of the

commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that nothing herein may be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

ARTICLE XI

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment.

(2) If a majority of the legislatures of the compact states reject a rule by enactment of a statute or resolution in the same manner used to adopt the compact, such rule shall have no further force and effect in any compact state.

(3) Rules or amendments to the rules shall be adopted at a regular or special meeting of the commission.

(4) Before promulgation and adoption of a final rule or rules by the commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking:

(a) On the website of the commission; and

(b) On the website of each compact state's psychology regulatory authority or the publication in which each state would otherwise publish proposed rules.

(5) The notice of proposed rulemaking shall include:

(a) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(b) The text of the proposed rule or amendment and the reason for the proposed rule;

(c) A request for comments on the proposed rule from any interested person; and

(d) The manner in which interested persons may submit notice to the commission of their intention to attend the public hearing and any written comments.

(6) Before adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(7) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(a) At least 25 individuals who submit comments independently of each other;

(b) A governmental subdivision or agency; or

(c) A duly appointed person in an association that has at least 25 members.

(8) If a hearing is held on the proposed rule or amendment, the commission shall publish the place, time, and date of the scheduled public hearing.

(a) All individuals wishing to be heard at the hearing shall notify the executive director of the commission or other designated member in writing of their desire to appear and testify at the hearing at least 5 business days before the scheduled date of the hearing.

(b) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(c) A transcript of the hearing is not required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection does not preclude the commission from making a transcript or recording of the hearing if it so chooses.

(d) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this section.

(9) If a written notice of intent to attend the public hearing by interested parties is not received, the commission may proceed with promulgation of the proposed rule without a public hearing.

(10) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the commission shall consider all written and oral comments received.

(11) The commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule based on the rulemaking record and the full text of the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without

prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, but no later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to:

(a) Meet an imminent threat to public health, safety, or welfare;

(b) Prevent a loss of commission or compact state funds;

(c) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the commission before the end of the notice period. If a challenge is not made, the revision will

take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

ARTICLE XII

OVERSIGHT; DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION; DISPUTE RESOLUTION; AND ENFORCEMENT

(1) OVERSIGHT.—

(a) The executive, legislative, and judicial branches of state government in each compact state shall enforce this compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of this compact and the rules promulgated hereunder shall have standing as statutory law.

(b) All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a compact state pertaining to the subject matter of this compact which may affect the powers, responsibilities, or actions of the commission.

(c) The commission shall be entitled to receive service of process in any such proceeding, and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission shall render a judgment or order void as to the commission, this compact, or promulgated rules.

(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION.—

(a) If the commission determines that a compact state has defaulted in the performance of its obligations or responsibilities under this compact or the promulgated rules, the commission shall:

1. Provide written notice to the defaulting state and other compact states of the nature of the default, the proposed means of remedying the default, and any other action to be taken by the commission; and

2. Provide remedial training and specific technical assistance regarding the default.

(b) If a state in default fails to remedy the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the compact states, and all rights, privileges, and benefits conferred by this compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(c) Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. The commission shall submit a notice of intent to suspend or terminate a defaulting compact state to the state's governor, the majority and minority leaders of the state's legislature, and each of the compact states.

(d) A compact state that has been terminated is

responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(e) The commission may not bear any costs incurred by the state that is found to be in default or has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting state.

(f) The defaulting state may appeal the action of the commission by petitioning the United States District Court for the state of Georgia or the federal district where the compact has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

(3) DISPUTE RESOLUTION.—

(a) Upon request by a compact state, the commission shall attempt to resolve disputes related to the compact which arise among compact states and between compact and noncompact states.

(b) The commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the commission.

(4) ENFORCEMENT.—

(a) The commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the state of Georgia or the federal district where the compact has its principal offices against a compact state in default to enforce compliance with the provisions of the compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) The remedies herein are not the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XIII

DATE OF IMPLEMENTATION OF THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT COMMISSION AND ASSOCIATED RULES; WITHDRAWAL, AND AMENDMENTS

(1) The compact shall become effective on the date on which the compact is enacted into law in the seventh compact state. The provisions that become effective at that time shall be limited to the powers granted to the commission relating to assembly and the promulgation of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the compact.

(2) Any state that joins the compact subsequent to the

commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the commission shall have the full force and effect of law on the day the compact becomes law in that state.

(3) Any compact state may withdraw from this compact by enacting a statute repealing the same.

(a) A compact state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(b) Withdrawal does not affect the continuing requirement of the withdrawing state's psychology regulatory authority to comply with the investigative and adverse action reporting requirements of this act before the effective date of withdrawal.

(4) Nothing contained in this compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a compact state and a noncompact state which does not conflict with the provisions of this compact.

(5) This compact may be amended by the compact states. An amendment to this compact will not become effective and binding upon any compact state until it is enacted into the law of all compact states.

ARTICLE XIV

CONSTRUCTION AND SEVERABILITY

This compact shall be liberally construed so as to effectuate the purposes thereof. If this compact shall be held contrary to the constitution of any state member thereto, the compact shall remain in full force and effect as to the remaining compact states.

Section 2. Subsection (10) of section 456.073, Florida Statutes, is amended to read:

456.073 Disciplinary proceedings.—Disciplinary proceedings for each board shall be within the jurisdiction of the department.

(10) The complaint and all information obtained pursuant to the investigation by the department are confidential and exempt from s. 119.07(1) until 10 days after probable cause has been found to exist by the probable cause panel or by the department, or until the regulated professional or subject of the investigation waives his or her privilege of confidentiality, whichever occurs first. The department shall report any significant investigation information relating to a nurse holding a multistate license to the coordinated licensure information system pursuant to s. 464.0095, and any significant investigatory information relating to a psychologist practicing under the Psychology Interjurisdictional Compact to the coordinated licensure information system pursuant to s. 490.0075. Upon completion of the investigation and a

recommendation by the department to find probable cause, and pursuant to a written request by the subject or the subject's attorney, the department shall provide the subject an opportunity to inspect the investigative file or, at the subject's expense, forward to the subject a copy of the investigative file. Notwithstanding s. 456.057, the subject may inspect or receive a copy of any expert witness report or patient record connected with the investigation if the subject agrees in writing to maintain the confidentiality of any information received under this subsection until 10 days after probable cause is found and to maintain the confidentiality of patient records pursuant to s. 456.057. The subject may file a written response to the information contained in the investigative file. Such response must be filed within 20 days of mailing by the department, unless an extension of time has been granted by the department. This subsection does not prohibit the department from providing such information to any law enforcement agency or to any other regulatory agency.

Section 3. Subsection (5) of section 456.076, Florida Statutes, is amended to read:

456.076 Impaired practitioner programs.—

(5) A consultant shall enter into a participant contract with an impaired practitioner and shall establish the terms of monitoring and shall include the terms in a participant contract. In establishing the terms of monitoring, the

consultant may consider the recommendations of one or more approved evaluators, treatment programs, or treatment providers. A consultant may modify the terms of monitoring if the consultant concludes, through the course of monitoring, that extended, additional, or amended terms of monitoring are required for the protection of the health, safety, and welfare of the public. If the impaired practitioner is a psychologist practicing under the Psychology Interjurisdictional Compact pursuant to s. 490.0075, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact.

Section 4. Subsection (7) is added to section 490.004, Florida Statutes, to read:

490.004 Board of Psychology.—

(7) The board shall appoint an individual to serve as the state's commissioner on the Psychology Interjurisdictional Compact Commission, as required under s. 490.0075.

Section 5. Subsection (4) is added to section 490.005, Florida Statutes, to read:

490.005 Licensure by examination.—

(4) A person licensed as a psychologist in another state who is practicing pursuant to the Psychology Interjurisdictional Compact under s. 490.0075, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 6. Subsection (4) is added to section 490.006, Florida Statutes, to read:

490.006 Licensure by endorsement.—

(4) A person licensed as a psychologist in another state who is practicing pursuant to the Psychology Interjurisdictional Compact under s. 490.0075, and only within the scope provided therein, is exempt from the licensure requirements of this section.

Section 7. Section 490.009, Florida Statutes, is amended to read:

490.009 Discipline.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2) or s. 490.0075:

(a) Attempting to obtain, obtaining, or renewing a license under this chapter by bribery or fraudulent misrepresentation or through an error of the board or department.

(b) Having a license to practice a comparable profession revoked, suspended, or otherwise acted against, including the denial of certification or licensure by another state, territory, or country.

(c) Being convicted or found guilty, regardless of adjudication, of a crime in any jurisdiction which directly relates to the practice of his or her profession or the ability to practice his or her profession. A plea of nolo contendere

creates a rebuttable presumption of guilt of the underlying criminal charges. However, the board shall allow the person who is the subject of the disciplinary proceeding to present any evidence relevant to the underlying charges and circumstances surrounding the plea.

(d) False, deceptive, or misleading advertising or obtaining a fee or other thing of value on the representation that beneficial results from any treatment will be guaranteed.

(e) Advertising, practicing, or attempting to practice under a name other than one's own.

(f) Maintaining a professional association with any person who the applicant or licensee knows, or has reason to believe, is in violation of this chapter or of a rule of the department or, in the case of psychologists, of the department or the board.

(g) Knowingly aiding, assisting, procuring, or advising any nonlicensed person to hold himself or herself out as licensed under this chapter.

(h) Failing to perform any statutory or legal obligation placed upon a person licensed under this chapter.

(i) Willfully making or filing a false report or record; failing to file a report or record required by state or federal law; willfully impeding or obstructing the filing of a report or record; or inducing another person to make or file a false report or record or to impede or obstruct the filing of a report

or record. Such report or record includes only a report or record which requires the signature of a person licensed under this chapter.

(j) Paying a kickback, rebate, bonus, or other remuneration for receiving a patient or client, or receiving a kickback, rebate, bonus, or other remuneration for referring a patient or client to another provider of mental health care services or to a provider of health care services or goods; referring a patient or client to oneself for services on a fee-paid basis when those services are already being paid for by some other public or private entity; or entering into a reciprocal referral agreement.

(k) Committing any act upon a patient or client which would constitute sexual battery or which would constitute sexual misconduct as defined in s. 490.0111.

(l) Making misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed under this chapter.

(m) Soliciting patients or clients personally, or through an agent, through the use of fraud, intimidation, undue influence, or a form of overreaching or vexatious conduct.

(n) Failing to make available to a patient or client, upon written request, copies of test results, reports, or documents in the possession or under the control of the licensee which have been prepared for and paid for by the patient or client.

(o) Failing to respond within 30 days to a written communication from the department concerning any investigation by the department or to make available any relevant records with respect to any investigation about the licensee's conduct or background.

(p) Being unable to practice the profession for which he or she is licensed under this chapter with reasonable skill or competence as a result of any mental or physical condition or by reason of illness; drunkenness; or excessive use of drugs, narcotics, chemicals, or any other substance. In enforcing this paragraph, upon a finding by the State Surgeon General, the State Surgeon General's designee, or the board that probable cause exists to believe that the licensee is unable to practice the profession because of the reasons stated in this paragraph, the department shall have the authority to compel a licensee to submit to a mental or physical examination by psychologists or physicians designated by the department or board. If the licensee refuses to comply with the department's order, the department may file a petition for enforcement in the circuit court of the circuit in which the licensee resides or does business. The licensee may ~~shall~~ not be named or identified by initials in the petition or in any other public court records or documents, and the enforcement proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee affected under this

paragraph shall be afforded an opportunity at reasonable intervals to demonstrate that he or she can resume the competent practice for which he or she is licensed with reasonable skill and safety to patients.

(q) Performing any treatment or prescribing any therapy which, by the prevailing standards of the mental health professions in the community, would constitute experimentation on human subjects, without first obtaining full, informed, and written consent.

(r) Failing to meet the minimum standards of performance in professional activities when measured against generally prevailing peer performance, including the undertaking of activities for which the licensee is not qualified by training or experience.

(s) Delegating professional responsibilities to a person whom the licensee knows or has reason to know is not qualified by training or experience to perform such responsibilities.

(t) Violating a rule relating to the regulation of the profession or a lawful order of the department previously entered in a disciplinary hearing.

(u) Failing to maintain in confidence a communication made by a patient or client in the context of such services, except as provided in s. 490.0147.

(v) Making public statements which are derived from test data, client contacts, or behavioral research and which identify

or damage research subjects or clients.

(w) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2)(a) The department, or in the case of psychologists, the board, may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or licensee who is found guilty of violating any provision of subsection (1) of this section or who is found guilty of violating any provision of s. 456.072(1).

(b) The board may take adverse action against a psychologist's authority to practice interjurisdictional telepsychology or his or her temporary authorization to practice under the Psychology Interjurisdictional Compact pursuant to s. 490.0075, and may impose any of the penalties in s. 456.072(2) if a psychologist commits an act specified in subsection (1) or s. 456.072(1).

Section 8. Paragraph (h) is added to subsection (10) of section 768.28, Florida Statutes, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(10)

(h) For purposes of this section, the individual appointed under s. 490.004(7) as the state's commissioner on the

Psychology Interjurisdictional Compact Commission, when serving in that capacity pursuant to s. 490.0075, and any administrator, officer, executive director, employee, or representative of the Psychology Interjurisdictional Compact Commission, when acting within the scope of his or her employment, duties, or responsibilities in this state, is considered an agent of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

Section 9. This act shall take effect July 1, 2022.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 955 Pub. Rec. and Meetings/Psychology Interjurisdictional Compact
SPONSOR(S): Hunschofsky
TIED BILLS: HB 953 **IDEN./SIM. BILLS:** SB 1372

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Morris	McElroy
2) Government Operations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 953 authorizes Florida to enter into the Psychology Interjurisdictional Compact (PSYPACT or compact) enacting its provisions into the laws of the state. PSYPACT is an interstate compact that facilitates the practice of psychology using telepsychology and in-person, face-to-face psychological practice to patients in other states. The compact requires states to submit psychologist licensure and regulation records, including any actions taken against the ability to practice, to a coordinated licensure information system (coordinated database). The compact also requires a commission to be formed to oversee the implementation and administration of the compact and the coordinated database.

This bill, which is linked to the passage of HB 953, creates public records and public meetings exemptions for certain records and meetings relating to PSYPACT.

The bill also creates a public meeting exemption for commission meetings, if the commission must discuss:

- Noncompliance of a party state with its obligations under the compact;
- The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedure;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations for the purchase or sale of goods, services, or real estate;
- Accusing a person of a crime or formally censuring a person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public;
- Disclosure of active investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation for compliance with the compact;
- Matters specifically exempted from disclosure by federal law or the laws of any party state; and
- Information made exempt pursuant to the rules or the bylaws of the commission, which would protect the public's interest, the privacy of individuals, and proprietary information.

The bill provides that the public record exemption is subject to the Open Government Sunset Review Act and will repeal on October 2, 2027, unless reviewed and saved from repeal by the Legislature. It also provides a statement of public necessity as required by the Florida Constitution.

The bill has an insignificant, negative fiscal impact on the Department of Health and no fiscal impact on local governments.

The bill will become effective on the same date that HB 953 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill creates a public record exemption; thus, it requires a two-thirds vote for final passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Public Records

Article I, s. 24(a) of the Florida Constitution sets forth the state's public policy regarding access to government records. This section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government. The Legislature, however, may provide by general law for the exemption of records from the requirements of art. I, s. 24(a) of the Florida Constitution.[1] The general law must state with specificity the public necessity justifying the exemption[2] and must be no broader than necessary to accomplish its purpose.[3]

Public policy regarding access to government records is addressed further in s. 119.07(1), F.S., which guarantees every person a right to inspect and copy any state, county, or municipal record, unless the record is exempt. Furthermore, the Open Government Sunset Review Act[4] provides that a public record or public meeting exemption may be created or maintained only if it serves an identifiable public purpose. In addition, it may be no broader than necessary to meet one of the following purposes:[5]

- Allow the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption.
- Protect sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety; however, only the identity of an individual may be exempted under this provision.
- Protect trade or business secrets.

The Open Government Sunset Review Act requires the automatic repeal of a newly created public record exemption on October 2nd of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.[6]

Psychology Interjurisdictional Compact

HB 953 authorizes Florida to enter into the Psychological Interjurisdictional Compact (PSYPACT or compact) by enacting its provisions into Florida law. PSYPACT was created by the Association of State and Provincial Psychology Boards (ASPPB) and is an interstate compact that facilitates the practice of telepsychology and temporary in-person, face-to-face practice of psychology across state boundaries.[7] The compact establishes the Psychology Interjurisdictional Compact Commission (Commission) which is responsible for creating and finalizing bylaws, rules, and regulation. The Commission also grants psychologists authority to practice telepsychology and temporary in-person, face-to-face psychology across state lines.[8]

[1] Article I, s. 24(c), Fla. Const.
[2] This portion of a public record exemption is commonly referred to as a "public necessity statement."
[3] Article I, s. 24(c), FLA. CONST.
[4] Section 119.15, F.S.
[5] Section 119.15(6)(b), F.S.
[6] Section 119.15(3), F.S.
[7] PSYPACT, About Us, https://psypact.site-ym.com/page/About (last visited Jan. 22, 2022).
[8] Id.

To practice telepsychology, in PSYPACT states, only psychologists licensed in PSYPACT states may apply to the Commission for authority. Authorized psychologists must obtain an E.Passport[9] Certificate from ASPPB to practice telepsychology. To conduct temporary in-person practice in PSYPACT states, only psychologists licensed in PSYPACT states can apply to the Commission for an interjurisdictional practice certificate for temporary authority to practice in a distant state.[10]

Coordinated Licensure Information System

The compact requires all compact states to share licensee information.[11] Compact states must submit a uniform dataset to a coordinated database on all psychologists to whom the compact is applicable. The database allows for expedited sharing of information, which is not currently exempt from disclosure requirements under s. 119.07(1), F.S. and s. 24(a), Art. 1 of the Florida Constitution, including:[12]

- Identifying information;
- Licensure data;
- Significant investigatory information;
- Adverse actions against a psychologist's license;
- Indicators that a psychologist's authority to practice under the compact is revoked;
- Nonconfidential information related to participation in alternative programs;
- Any licensure application denials and reasons for such denial; and
- Other information, determined by Commission rule, which may facilitate the administration of the compact.

The coordinated database information must be expunged according to laws of the reporting compact state.[13]

Effect of the Bill

The bill creates public record and public meeting exemptions related to PSYPACT.

The bill creates a public records exemption for a psychologist's personal identifying information, other than his or her name, licensure status, or licensure number, obtained from the coordinated database required under PSYPACT and held by DOH or the Board. The bill allows such information to be publicly disclosed if the state which originally reported the information to the coordinated database authorizes such disclosure by law. If disclosure is authorized, information may only be disclosed to the extent authorized by law of the reporting state.

The bill also creates a public meeting exemption for commission meetings, if the commission must discuss:

- Noncompliance of a party state with its obligations under the compact;
- The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedure;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations for the purchase or sale of goods, services, or real estate;
- Accusing a person of a crime or formally censuring a person;

[9] Under the compact, an E.Passport is a certificate issued by the Association for State and Provincial Psychology Boards that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.
[10] *Supra*, note 7. A distant state is a compact state where a psychologist is physically present to provide temporary in-person, face-to-face psychological services.
[11] Psychology Interjurisdictional Compact (PSYPACT), https://cdn.ymaws.com/psypact.site-ym.com/resource/resmgr/psychology_interjurisdiction.pdf (last visited Jan. 22, 2022).
[12] Id.
[13] Id.

- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public;
- Disclosure of active investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation for compliance with the compact; and
- Matters specifically exempted from disclosure by federal law or the laws of any party state.

Recordings, minutes, and records generated during an exempt portion of a Commission meeting are also exempt from public disclosure.

The bill provides a public necessity statement for the public records exemption, as required by the State Constitution, and states that the protection of such information is required under the compact, which the state must adopt in order to become a party state to the compact. Without the public records exemption, the state would be unable to effectively and efficiently implement and administer the compact.

Additionally, the bill provides a statement of public necessity for the public meeting exemption, as required by the State Constitution, and states that PSYPACT requires any meeting in which certain matters are discussed and matters that are exempt from disclosure by federal or state statute are discussed to be closed to the public. Without the public meeting exemption, the state will be prohibited from becoming a party to the compact and would be unable to effectively and efficiently administer the compact. The bill further provides that without the public records exemption for the recordings, minutes, and records generated during an exempt meeting, the release of such information would negate the public meeting exemption.

The bill provides for repeal of the public record exemption on October 2, 2027, unless reviewed and saved from repeal through reenactment by the Legislature.

The effective date of this bill is the same date that HB 953 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof becomes law.

B. SECTION DIRECTORY:

Section 1: Creates s. 490.0076, F.S., relating to Psychology Interjurisdictional Compact; public records and meeting exemptions.
Section 2: Provides a public necessity statement.
Section 3: Provides that the bill is effective on the same date that HB 953 (2022) or similar legislation takes effect.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

Vote Requirement

Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill creates a public record exemption; thus, it requires a two-thirds vote for final passage.

Public Necessity Statement

Article I, s. 24(c) of the Florida Constitution requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill creates a public record exemption; thus, it includes a public necessity statement.

Breadth of Exemption

Article I, s. 24(c) of the State Constitution provides that an exemption must be created by general law and the law must contain only exemptions from public record or public meeting requirements. The exemption does not appear to be in conflict with the constitutional requirement.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rule-making or rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to public records and meetings; creating s. 490.0076, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health or the Board of Psychology pursuant to the Psychology Interjurisdictional Compact; authorizing disclosure of the information under certain circumstances; providing an exemption from public meeting requirements for certain meetings of the Psychology Interjurisdictional Compact Commission; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such meetings; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing a contingent effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 490.0076, Florida Statutes, is created to read:

490.0076 Psychology Interjurisdictional Compact; public records and meetings exemptions.—

(1) A psychologist's personal identifying information,

CODING: Words stricken are deletions; words underlined are additions.

other than the psychologist's name, licensure status, or licensure number, obtained from the coordinated licensure information system, as described in article IX of s. 490.0075, and held by the department or the Board of Psychology is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated information system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Psychology Interjurisdictional Compact Commission, established in article X of s. 490.0075, is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution if the commission must discuss:

1. Noncompliance of a compact state with its obligations under the compact;

2. Employment, compensation, or discipline of, or other personnel matters, practices, or procedures related to, specific employees, or other matters related to the commission's internal personnel practices and procedures;

3. Current, threatened, or reasonably anticipated litigation against the commission;

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

5. An accusation of any person of a crime or a formal censure of any person;

6. Information disclosing trade secrets or commercial or financial information that is privileged or confidential;

7. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

8. Investigatory records compiled for law enforcement purposes;

9. Information related to any investigatory reports prepared by or on behalf of or for the use of the commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the compact; or

10. Matters specifically exempted from disclosure by federal or state statute.

(b) In keeping with the intent of the Psychology Interjurisdictional Compact, recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2027, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that a psychologist's personal identifying

information, other than the psychologist's name, licensure status, or licensure number, obtained from the coordinated licensure information system, as described in article IX of s. 490.0075, Florida Statutes, and held by the Department of Health or the Board of Psychology, be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Psychology Interjurisdictional Compact, which the state must adopt in order to become a member state of the compact. Without the public records exemption, this state will be unable to effectively and efficiently implement and administer the compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting of the Psychology Interjurisdictional Compact Commission held as provided in s. 490.0075, Florida Statutes, in which matters specifically exempted from disclosure by federal or state law are discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution.

(b) The Psychology Interjurisdictional Compact requires the closure of any meeting, or any portion of a meeting, of the Psychology Interjurisdictional Compact Commission if it is discussing certain sensitive and confidential subject matters or if a majority of the commission members vote to close a meeting to the public in whole or in part. In the absence of a public

meeting exemption, this state would be prohibited from becoming a member state of the compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting that is exempt pursuant to s. 490.0076(2), Florida Statutes, be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meeting exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 3. This act shall take effect on the same date that HB 953 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee

Representative Hunschofsky offered the following:

Amendment

Remove everything after the enacting clause and insert:

Section 1. Section 490.0076, Florida Statutes, is created to read:

490.0076 Psychology Interjurisdictional Compact; public records and meeting exemptions.—

(1) A psychologist's personal identifying information, other than the psychologist's name, licensure status, or licensure number, obtained from the coordinated licensure information system, as described in article IX of s. 490.0075, and held by the department or the Board of Psychology is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution

unless the state that originally reported the information to the coordinated information system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by law by the reporting state.

(2)(a) A meeting or a portion of a meeting of the Psychology Interjurisdictional Compact Commission, established in article X of s. 490.0075 at which matters specifically exempted from disclosure by federal or state statute are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2027, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that a psychologist's personal identifying information, other than the psychologist's name, licensure status, or licensure number, obtained from the coordinated licensure information system, as described in article IX of s. 490.0075, Florida Statutes, and held by the Department of Health or the Board of Psychology, be made exempt from s. 119.07(1),

Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Psychology Interjurisdictional Compact, which the state must adopt in order to become a member state of the compact. Without the public records exemption, this state will be unable to effectively and efficiently implement and administer the compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting of the Psychology Interjurisdictional Compact Commission held as provided in s. 490.0075, Florida Statutes, in which matters specifically exempted from disclosure by federal or state law are discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution.

(b) The Psychology Interjurisdictional Compact requires the closure of any meeting, or any portion of a meeting, of the Psychology Interjurisdictional Compact Commission in which the substance of paragraph (a) is discussed to be closed to the public. In the absence of a public meeting exemption, this state would be prohibited from becoming a member state of the compact. Thus, this state will be unable to effectively and efficiently administer the compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting that is exempt pursuant to s. 490.0076(2),

Florida Statutes, be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meeting exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 3. This act shall take effect on the same date that HB 953 or similar legislation takes effect if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.