


# Professions and Public Health Subcommittee

**Wednesday, February 2, 2022**
**11:30 AM – 2:00 PM**
**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:** Wednesday, February 02, 2022 11:30 am

**End Date and Time:** Wednesday, February 02, 2022 02:00 pm

**Location:** Webster Hall (212 Knott)

**Duration:** 2.50 hrs

**Consideration of the following bill(s):**

HB 593 Telecommunicator Cardiopulmonary Resuscitation by Trabulsy, McClure
HB 1073 Newborn Screenings by Aloupis
HB 1101 Anesthesiologist Assistants by Altman
HB 1209 Administration of Vaccines by Tuck
HB 1521 Professional Counselors Licensure Compact by Koster
HB 1523 Pub. Rec. and Meetings/Professional Counselors Licensure Compact by Koster

**Consideration of the following proposed committee substitute(s):**

PCS for HB 937 -- Nonemergent Patient Care

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

**NOTICE FINALIZED on 01/31/2022 4:04PM by Osborne.Erin**

HB 593

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 593 Telecommunicator Cardiopulmonary Resuscitation
**SPONSOR(S):** Trabulsy
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 890

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

## SUMMARY ANALYSIS

A heart attack occurs when the flow of oxygen-rich blood to a section of heart muscle suddenly becomes blocked. If blood flow is not restored quickly, the section of heart muscle begins to die. Heart attack treatment is most effective if provided when symptoms first occur. Emergency assistance to a person having a heart attack is usually provided by emergency medical technicians (EMTs), paramedics, or a bystander who attempts to administer cardiopulmonary resuscitation (CPR).

The Department of Health (DOH) is responsible for certifying 911 public safety telecommunicators (911 PSTs). To become certified as a 911 PST an applicant is required to receive 232 hours of training, which must include successful completion of a CPR certification class. A 911 PST must renew their certification every two years and must receive 20 hours of continuing education prior to renewal. Current law does not require the 20-hours of continuing education to include CPR training. Current law also does not require 911 PSTs to complete biennial telecommunicator CPR training.

The bill requires a 911 PST to complete biennial telecommunicator CPR training in order to have their certification renewed.

The bill also authorizes certain public safety agencies to enter into a reciprocal agreement with another public safety agency to provide telephonic assistance in administering CPR, including a fire department, law enforcement department, or other emergency medical service that receives or dispatches calls for emergency medical conditions.

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**

Heart Attacks

A heart attack occurs when the flow of oxygen-rich blood to a section of heart muscle suddenly becomes blocked.[1] If blood flow is not restored quickly, the section of heart muscle begins to die. Heart attacks most often occur as a result of ischemic heart disease – also known as coronary heart disease or coronary artery disease, which is caused by plaque build-up inside the coronary arteries. Eventually, an area of plaque can rupture inside of an artery causing a blood clot to form on the plaque's surface. If the blood clot becomes large enough, it can mostly or completely block blood flow through a coronary artery. If the blockage isn't treated quickly, the portion of heart muscle fed by the artery begins to die. Heart attack treatment is most effective if provided when symptoms first occur.[2]

911 Public Safety Telecommunicators

Out-of-hospital cardiac arrest describes the sudden, unexpected loss of heart function, breathing, and consciousness.[3] Every year an estimated 350,000 people have cardiac arrest in the United States in an out-of-hospital environment and only one out of 10 victims survive.[4] 911 public safety telecommunicators[5] (911 PSTs) along with the 911-caller are often the first responders and it is the 911 PST's job to transform the caller into a lay rescuer by instructing them how to perform cardiopulmonary resuscitation (CPR).[6] This is known as telephone CPR.[7] Studies have shown the efficacy of telephone CPR in increasing the survival rate of sudden cardiac arrest.[8]

The Department of Health (DOH) is responsible for certifying 911 PSTs.[9] Certification as a 911 PST is required for any person employed as a 911 PST at a public safety answering point—the public safety agency that receives incoming 911 requests for assistance and dispatches appropriate public safety agencies to respond to the requests.[10] A public safety agency[11] may employ a 911 PST for up to 12 months if the trainee works under the direct supervision of a certified 911 public safety telecommunicator and is enrolled in a 911 PST training program.[12]

DOH is responsible for approving 911 PST training programs, which must be equivalent to the public safety telecommunication program curriculum framework developed by the Department of Education

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[1] U.S. Department of Health & Human Services, National Heart, Lung, and Blood Institute, *Heart Attack,* available at https://www.nhlbi.nih.gov/health-topics/heart-attack (last visited Jan 26. 20, 2022).
[2] Id.
[3] Michael Christopher, *Telecommunicator Cardiopulmonary Resuscitation – A Policy Statement from the American Heart Association,* AHA Journals, Mar. 24, 2020, available at https://www.ahajournals.org/doi/10.1161/CIR.0000000000000744 (last visited Jan. 26, 2022).
[4] Id.
[5] A 911 PST is a public safety dispatcher or 911 operator whose duties and responsibilities include the answering, receiving, transferring, and dispatching functions related to 911 calls; dispatching law enforcement officers, fire rescue services, emergency medical services, and other public safety services to the scene of an emergency; providing real-time information from federal, state, and local crime databases; or supervising or serving as the command officer to a person or persons having such duties and responsibilities.
[6] Rea TD, Eisenberg MS, Culley LL, Becker L. *Dispatcher-assisted cardiopulmonary resuscitation and survival in cardiac arrest*. Circulation. 2001 Nov 20;104(21):2513-6. doi: 10.1161/hc4601.099468. PMID: 11714643.
[7] Id.
[8] Id., *see also* Eisenberg MS, Hallstrom AP, Carter WB, Cummins RO, Bergner L, Pierce J. *Emergency CPR instruction via telephone*. Am J Public Health. 1985 Jan;75(1):47-50. doi: 10.2105/ajph.75.1.47. PMID: 3966598; PMCID: PMC1646147.
[9] Section 401.465(2), F.S.
[10] Section 401.465(2)(a), F.S.
[11] Public safety agency means a functional division of a public agency which provides firefighting, law enforcement, medical, or other emergency services.
[12] Section 401.465(2)(b), F.S.

(DOE) and consist of at least 232 hours.[13] The curriculum framework developed by DOE requires students to successfully complete a CPR certification class.[14]

A 911 PST must renew their certification every two years and must receive 20 hours of continuing education prior to renewal, which does not currently include CPR training.[15] Current law also does not require 911 PSTs to complete biennial telecommunicator CPR training.

**Effect of the Bill**

The bill requires a 911 PST to complete biennial telecommunicator CPR training in order to have their certification renewed.

The bill also authorizes certain public safety agencies to enter into a reciprocal agreement with another public safety agency to provide telephonic assistance in administering CPR, including a fire department, law enforcement department, or other emergency medical service that receives or dispatches calls for emergency medical conditions.

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

B. SECTION DIRECTORY:

**Section 1:** Amends s. 401.465, F.S., relating to 911 public safety telecommunicator certification.
**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

[13] Section 401.465(1)(c), F.S.
[14] Florida Department of Education Curriculum Framework, p. 13 (Jun. 8, 2010), incorporated by reference in rule 64J-3.002, F.A.C., available at https://www.flrules.org/Gateway/reference.asp?No=Ref-01490 (last visited Jan. 26, 2022).
[15] Rule 64J-3.003, F.A.C.

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:

DOH has sufficient rule-making 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 telecommunicator cardiopulmonary resuscitation; amending s. 401.465, F.S.; providing definitions; requiring certain 911 public safety telecommunicators to complete biennial telecommunicator cardiopulmonary resuscitation training; authorizing certain agencies to enter into reciprocal agreements with certain entities to provide telephonic assistance in administering cardiopulmonary resuscitation under certain circumstances; requiring certain employees of such agencies to directly provide telephonic assistance in administering cardiopulmonary resuscitation, when appropriate, or transfer telephone calls for emergency medical conditions to certain entities; providing an effective date.

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

Section 1. Paragraph (c) of subsection (1) of section 401.465, Florida Statutes, is redesignated as paragraph (d), subsections (3) and (4) are renumbered as subsections (4) and (5), respectively, paragraphs (b), (d), (i), and (j) of subsection (2) of that section are amended, new paragraphs (c) and (e) are added to subsection (1) of that section, and a new subsection (3) is added to that section, to read:

401.465 911 public safety telecommunicator certification.—

(1) DEFINITIONS.—As used in this section, the term:

(c) "Public safety agency" has the same meaning as in s. 365.171(3)(d).

(e) "Telecommunicator cardiopulmonary resuscitation training" means specific training, including continuous education, that is evidence based and contains nationally accepted guidelines for high-quality telecommunicator cardiopulmonary resuscitation with the recognition of out-of-hospital cardiac arrest over the telephone and the delivery of telephonic instructions for treating cardiac arrest and performing compression-only cardiopulmonary resuscitation.

(2) PERSONNEL; STANDARDS AND CERTIFICATION.—

(b) A public safety agency~~, as defined in s. 365.171(3)(d),~~ may employ a 911 public safety telecommunicator trainee for a period not to exceed 12 months if the trainee works under the direct supervision of a certified 911 public safety telecommunicator, as determined by rule of the department, and is enrolled in a public safety telecommunication training program.

(d) The department shall determine whether the applicant meets the requirements specified in this section and in rules of the department and shall issue a certificate to any person who meets such requirements. Such requirements must include all of the following:

1. Completion of an appropriate 911 public safety telecommunication training program.~~;~~

2. Certification under oath that the applicant is not addicted to alcohol or any controlled substance.~~;~~

3. Certification under oath that the applicant is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties.~~;~~

4. Submission of the application fee prescribed in subsection (4). ~~(3);~~

5. Submission of a completed application to the department which indicates compliance with subparagraphs 1., 2., and 3.~~;~~ ~~and~~

6. Effective October 1, 2012, passage of an examination approved by the department which measures the applicant's competency and proficiency in the subject material of the public safety telecommunication training program.

(i) If a person was employed as a 911 public safety telecommunicator or a state-certified firefighter before April 1, 2012, he or she must pass the examination approved by the department which measures the competency and proficiency in the subject material of the public safety telecommunication program~~,~~ ~~as defined in paragraph (1)(c)~~. Upon passage of the examination, the completion of the public safety telecommunication training program is waived.

(j)1. The requirement for certification as a 911 public

safety telecommunicator is waived for a person employed as a sworn state-certified law enforcement officer, if ~~provided~~ the officer:

a. Is selected by his or her chief executive to perform as a 911 public safety telecommunicator;

b. Performs as a 911 public safety telecommunicator on an occasional or limited basis; and

c. Passes the department-approved examination that measures the competency and proficiency of an applicant in the subject material comprising the public safety telecommunication program.

2. A sworn state-certified law enforcement officer who fails an examination taken under subparagraph 1. must take a department-approved public safety telecommunication training program before ~~prior to~~ retaking the examination.

3. The testing required under this paragraph is exempt from the examination fee required under subsection (4) ~~(3)~~.

(3) TELECOMMUNICATOR CARDIOPULMONARY RESUSCITATION.—

(a) In addition to the certification and recertification requirements in this section, 911 public safety telecommunicators who answer telephone calls and provide dispatch functions for emergency medical conditions must complete telecommunicator cardiopulmonary resuscitation training every 2 years.

(b)1. A public safety agency or any agency that receives

or dispatches telephone calls for emergency medical conditions may enter into a reciprocal agreement with another public safety agency or agency that receives or dispatches such telephone calls, a dedicated phone line, or a call center to provide telephonic assistance in administering cardiopulmonary resuscitation, if the applicable agency, dedicated phone line, or call center that will be accepting the telephone calls employs 911 public safety telecommunicators who have completed telecommunicator cardiopulmonary resuscitation training pursuant to paragraph (a).

2. Any employee of a public safety agency or agency receiving or dispatching telephone calls for emergency medical conditions who answers such telephone calls must directly provide telephonic assistance in administering cardiopulmonary resuscitation, when appropriate, or transfer such calls to the applicable agency, dedicated phone line, or call center with which the transferring agency has a reciprocal agreement as provided in subparagraph 1.

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

PCS for HB 937

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCS for HB 937 Nonemergent Patient Care
**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

In November 2020, as a response to the COVID-19 pandemic, the federal Centers for Medicare and Medicaid Services began issuing waivers to eligible hospitals authorizing the practice of acute hospital care at home. The Acute Hospital Care at Home program (Program) allows eligible hospitals to treat eligible patients in their homes for more than 60 acute conditions, such as asthma, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease. The Program treats patients who require acute inpatient admission to a hospital and at least daily checks by a physician and a medical team monitoring the patient's care needs on an ongoing basis. Patient participation in the Program is voluntary.

Participating hospitals must have screening protocols which assess both medical and non-medical factors, including working utilities, assessment of physical barriers, and screenings for domestic violence concerns. Eligible patients are admitted only from emergency departments and inpatient hospital beds. An in-person evaluation is required prior to starting care at home. Registered nurses must evaluate each patient once per day, either in person or remotely, and two in-person visits must occur daily by either a registered nurse or a paramedic.

Paramedics are regulated by the Department of Health (DOH) and are certified to provide basic life support (BLS) and advanced life support services (ALS). Paramedics are not authorized under current law to provide non-emergent BLS and ALS in a home care setting.

PCS for HB 937 authorizes paramedics to provide BLS and ALS services to acute hospital care at home patients as specified by a physician. A physician who supervises or provides medical direction to a paramedic for acute hospital care at home is liable for any act or omission of the paramedic when performing ALS or BLS services in such setting.

An institutional pharmacy is a pharmacy located within a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility locations where medicinal drugs are compounded, dispensed, stored, or sold. Class III institutional pharmacies are institutional pharmacies affiliated with a hospital which employ a registered pharmacist who consults with and dispenses medicinal drugs to patients on the premises of the hospital, for use on hospital premises. Class III institutional pharmacies also dispense, distribute, compound, and fill prescriptions for medicinal drugs for inpatient treatment only. It is unclear whether such a pharmacy is authorized to dispense to a patient receiving care under an acute care at home program.

The bill authorizes Class III institutional pharmacies to dispense, distribute, compound, and fill prescriptions for medicinal drugs for inpatient treatment and for acute hospital care at home program patients.

The bill has a significant, 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**

Emergency Medical Services

The Department of Health (DOH) regulates paramedics under part III of ch. 401, F.S. A paramedic is a person who is certified by DOH to perform basic life support (BLS) and advanced life support (ALS) services.[1]

BLS service refers to any emergency medical service that uses only basic life support techniques.[2] BLS includes basic non-invasive interventions to reduce morbidity and mortality associated with out-of-hospital medical and traumatic emergencies.[3] The services provided may include stabilization and maintenance of airway and breathing, pharmacological interventions, trauma care, and transportation to an appropriate medical facility.[4]

ALS service refers to any emergency medical or non-transport service that uses advanced life support techniques.[5] ALS includes the assessment or treatment of a person by a qualified individual, such as a paramedic, who is trained in the use of techniques such as the administration of drugs or intravenous fluid, endotracheal intubation, telemetry, cardiac monitoring, and cardiac defibrillation.[6]

Paramedics are not authorized under current law to provide non-emergent BLS and ALS in a home care setting.

Acute Hospital Care at Home

Hospitals are licensed and regulated pursuant to ch. 395, F.S., by the Agency for Health Care Administration (AHCA) in this state.

In November, 2020, as a response to the COVID-19 pandemic, the federal Centers for Medicare and Medicaid Services (CMS) began issuing waivers to eligible hospitals authorizing the practice of acute hospital care at home.[7] The Acute Hospital Care at Home program (Program) allows eligible hospitals to treat eligible patients in their homes. A patient's home is his or her permanent residence, which includes assisted living, but does not include nursing homes.[8]

Treatment for more than 60 acute conditions, such as asthma, congestive heart failure, pneumonia, and chronic obstructive pulmonary disease, may be provided through the Program.[9] The Program treats patients who require acute inpatient admission to a hospital and at least daily rounding by a physician and a medical team monitoring the patient's care needs on an ongoing basis.[10] Patient participation in the program is voluntary.[11]

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[1] S. 401.23(17), F.S.
[2] S. 401.23(8), F.S.
[3] S. 401.23(7), F.S., and U.S. Department of Transportation, National Highway Safety Administration, *National EMS Scope of Practice Model* 23-24, *available at* www.nhtsa.gov/people/injury/ems/pub/emtbnsc.pdf (last visited Jan. 29, 2022).
[4] Id.
[5] S. 401.23(2), F.S.
[6] S. 401.23(1), F.S.
[7] Centers for Medicare and Medicaid Services, Press Release – CMS Announces Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge, https://www.cms.gov/newsroom/press-releases/cms-announces-comprehensive-strategy-enhance-hospital-capacity-amid-covid-19-surge (last visited Jan. 29, 2022).
[8] Centers for Medicare and Medicaid Services, *Acute Hospital Care at Home Frequently Asked Questions,* https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab2 (last visited Jan. 29, 2022).
[9] *Supra*, note 7.
[10] Id.
[11] *Supra*, note 8.

Participating hospitals are required to have screening protocols which assess both medical and non-medical factors, including working utilities, assessment of physical barriers, and screenings for domestic violence concerns. Eligible patients are admitted only from emergency departments and inpatient hospital beds. An in-person evaluation is required prior to starting care at home. Registered nurses must evaluate each patient once per day, either in person or remotely, and two in-person visits must occur daily by either a registered nurse or a paramedic.[12] Programs must obtain a waiver from AHCA rule requiring only registered nurses to conduct evaluations in order for paramedics to conduct such in-person visits.[13]

As of January, 2022, 90 hospital systems and 197 hospitals across 37 states are approved to participate in the Program.[14] Participants in Florida include Mayo Clinic, Cleveland Clinic, Health First hospitals,[15] Keralty Hospital,[16] and Tampa General Hospital.[17]

Pharmacy Regulation

A person must obtain a DOH-issued permit to operate one of five types of pharmacies:

- **Community pharmacy** – Where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis.[18]
- **Institutional pharmacy** – Hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility locations where medicinal drugs are compounded, dispensed, stored, or sold.[19]
- **Nuclear pharmacy** – Where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold, other than hospitals.[20]
- **Special pharmacy** - Locations where medicinal drugs are compounded, dispensed, stored, or sold if these locations do not otherwise meet an applicable pharmacy definition in s. 465.003, F.S.[21]
- **Internet pharmacy** – Locations not otherwise licensed or issued a pharmacy permit within or outside this state, which use the Internet to communicate with or obtain information from consumers in this state to fill or refill prescriptions or to dispense, distribute, or otherwise practice pharmacy in this state.[22]

All permitted pharmacies must pass an on-site inspection before DOH will issue an initial permit and any time a pharmacy changes its ownership or address.[23]

*Institutional Pharmacies*

An institutional pharmacy is a pharmacy within a healthcare institution, such as a hospital, nursing home, or clinic (as opposed to a community pharmacy, which dispenses drugs to the general public on an outpatient basis).[24] There are four types of institutional pharmacies:[25]

- Class I Institutional permits are issued to institutional pharmacies in which all medicinal drugs are administered from individual prescription containers to individual patients and in which

[12] *Supra*, note 8
[13] Programs must obtain an AHCA waiver for Rule 59A-3.243(4)(c) and (6), F.A.C., relating to nursing services.
[14] Centers for Medicare and Medicaid Services, *Approved Facilities/Systems for Acute Hospital Care at Home,* https://qualitynet.cms.gov/acute-hospital-care-at-home/resources#tab1 (last visited Jan. 29, 2022).
[15] Palm Bay Hospital, Holmes Regional Medical Center, Viera Hospital, and Cape Canaveral Hospital.
[16] Formerly Westchester Hospital.
[17] Id.
[18] Ss. 465.003(11)(a)1. and 465.018, F.S.
[19] Ss. 465.003(11)(a)2. and 465.019, F.S.
[20] Ss. 465.003(11)(a)3. and 465.0193, F.S.
[21] Ss. 465.003(11)(a)4. and 465.0196, F.S.
[22] Ss. 465.003(11)(a)5. and 465.0197, F.S.
[23] Rule 64B16-28(1)(d), F.A.C.
[24] S. 465.003(11), F.S.
[25] S. 465.019, F.S.

medicinal drugs are not dispensed on the premises, except that licensed nursing homes[26] may purchase medical oxygen for administration to residents.

- Class II Institutional permits are issued to institutional pharmacies that employ a registered pharmacist who consults with and dispenses medicinal drugs to patients on the premises of the institution, for use on the premises of the institution.
- Modified Class II Institutional permits are issued to institutional pharmacies in a short-term, primary care treatment center that meet all the requirements for a Class II permit, except space and equipment requirements.
- Class III Institutional permits are issued to institutional pharmacies, including central distribution facilities, affiliated with a hospital that provide the same services that are authorized by a Class II institutional pharmacy permit. Additionally, an Class III Institutional pharmacy may:
    - Dispense, distribute, compound, and fill prescriptions for medicinal drugs;
    - Prepare prepackaged drug products;
    - Conduct other pharmaceutical services for the affiliated hospital and for entities under common control that are appropriately permitted;
    - Provide the above-listed services to an entity under common control which holds an active health care clinic establishment permit.[27]

Class III Institutional pharmacies must also maintain policies and procedures which address:[28]

- Safe practices for the preparation, dispensing, prepackaging, distribution, and transportation of medicinal drugs and prepackaged drug products;
- Recordkeeping to monitor the movement, distribution, and transportation of medicinal drugs and prepackaged drug products;
- Recordkeeping of pharmacy staff responsible for each step in the preparation, dispensing, prepackaging, transportation, and distribution of medicinal drugs and prepackaged drug products; and
- Medicinal drugs and prepackaged drug products that may not be safely distributed among Class III institutional pharmacies.

All institutional pharmacies must designate a consultant pharmacist of record.[29] The consultant pharmacist's responsibilities include:[30]

- Maintaining all drug records required by law;
- Ordering and evaluating laboratory or clinical testing when necessary for the proper performance of the consultant pharmacist's responsibilities;[31]
- Conducting drug regimen reviews as required by state or federal law; and
- Inspecting the facility and preparing a written report to be filed at the permitted facility monthly.

*Dispensing by Institutional Pharmacies*

An institutional pharmacy must hold a community pharmacy permit to dispense medicinal drugs to outpatients.[32] However, hospitals that operate Class II or Class III institutional pharmacies may dispense a limited supply of medicinal drugs to emergency department patients and inpatients upon discharge when the prescriber determines the medicinal drug is warranted and community pharmacy services are unavailable. An authorized prescriber may prescribe and a hospital pharmacy may

[26] Nursing homes are licensed under part II, ch. 400, F.S.
[27] A health care clinic establishment permit is required for the purchase of a prescription drug by a place of business at one general physical location that provides health care or veterinary services, which is owned or operated by a business entity. See s. 499.01(2)(r), F.S.
[28] S. 465.019(1)(d), F.S.
[29] S. 465.019(5), F.S., and r. 64B16-28.501, F.A.C.
[30] S. 465.0125, F.S., and r. 64B16-28.501, F.A.C.
[31] A consultant pharmacist may only order these tests for patients under the care of a licensed home health agency and when authorized by a licensed allopathic physician, osteopathic physician, podiatric physician, or dentist. The consultant pharmacist must complete additional training and meet additional qualifications in the practice of institutional pharmacy, as required by the board. See s. 465.0125.
[32] S. 465.019(4), F.S.

dispense the greater of a 48-hour supply of a medicinal drug or a supply sufficient to last until the end of the next business day.[33] An authorized prescriber may prescribe a medicinal drug beyond the initial prescription period if the prescriber determines the medicinal drug is warranted.[34] Additionally, a hospital pharmacy may dispense a supply of a medicinal drug that will last up to 72 hours if the patient is located in an area of the state in which a state of emergency is declared.[35] Such dispensing must be in accordance with the hospital's procedures.

It is unclear whether a Class III institutional pharmacy is authorized to dispense to a patient receiving care under an acute care at home program.

**Effect of the Bill**

Acute Hospital Care at Home

HB 937 authorizes paramedics to provide BLS and ALS to acute hospital care at home patients as specified in a paramedic's supervisory relationship with a physician or a physician's standing orders. A physician who supervises or provides medical direction to a paramedic for acute hospital care at home is liable for any act or omission of the paramedic when performing ALS or BLS services in such setting.

Acute hospital care at home is acute and post-acute health care services provided in a qualified patient's permanent residence through a program approved by CMS and AHCA.

Institutional Pharmacies

The bill authorizes Class III institutional pharmacies to dispense, distribute, compound, and fill prescriptions for medicinal drugs for inpatient treatment and acute care at home patients.

The bill makes technical and conforming changes.

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

B. SECTION DIRECTORY:

**Section 1:** Amends s. 401.23, F.S., relating to definitions.
**Section 2:** Amends s. 401.272, F.S., relating to emergency medical services community health care.
**Section 3:** Amends s. 465.003, F.S., relating to definitions.
**Section 4:** Amends s. 465.019, F.S., relating to institutional pharmacies.
**Section 5:** Amends s. 14.33, F.S., relating to Medal of Heroism.
**Section 6:** Amends s. 252.515, F.S., relating to Post Disaster Relief Assistance Act; immunity from civil liability.
**Section 7:** Amends s. 395.1027, F.S., relating to regional poison control centers.
**Section 8:** Amends s. 401.245, F.S., relating to Emergency Medical Services Advisory Council.
**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:

[33] Id.
[34] Id.
[35] Id.

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:

The bill and current law provide 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 acute hospital care at home; amending s. 401.23, F.S.; defining the term "acute hospital care at home"; amending s. 401.272, F.S.; authorizing paramedics to perform basic life support services and advanced life support services to acute hospital care at home patients under certain circumstances; providing that a physician or medical director who supervises or directs the provision of such services by a paramedic is liable for any act or omission during the provision of such services; authorizing the Department of Health to adopt rules; amending s. 465.003, F.S.; defining the term "acute hospital care at home"; amending s. 465.019, F.S.; specifying that Class III institutional pharmacies may dispense, distribute, compound, and fill prescriptions for medicinal drugs for inpatient treatment and acute care at home patients; amending ss. 14.33, 252.515, 395.1027, and 401.245, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (1) through (22) of section 401.23, Florida Statutes, are redesignated as subsections (2)



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

through (23), respectively, a new subsection (1) is added to that section, and present subsection (19) of that section is amended, to read:

401.23 Definitions.—As used in this part, the term:

(1) "Acute hospital care at home" means acute and post-acute health care services provided in a clinically qualified patient's permanent residence, as defined in s. 196.012, through a program approved by the Centers for Medicare and Medicaid Services and the Agency for Health Care Administration.

(20) ~~(19)~~ "Physician" means a practitioner who is licensed under ~~the provisions of~~ chapter 458 or chapter 459. For the purpose of providing "medical direction" as defined in this section ~~subsection (14)~~ for the treatment of patients immediately before ~~prior to~~ or during transportation to a United States Department of Veterans Affairs medical facility, "physician" also means a practitioner employed by the United States Department of Veterans Affairs.

Section 2. Paragraph (c) is added to subsection (2) of section 401.272, Florida Statutes, to read:

401.272 Emergency medical services community health care.—

(2) Notwithstanding any other provision of law to the contrary:

(c) Paramedics may provide basic life support services and advanced life support services to acute hospital care at home patients as specified in the paramedic's supervisory



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relationship with a physician or standing orders as described in s. 401.265, s. 458.348, or s. 459.025. Each physician who supervises or provides medical direction to a paramedic who administers basic life support services or advanced life support services to acute care at home patients pursuant to a formal supervisory relationship or standing orders is liable for any act or omission of the paramedic acting under the physician's supervision or medical direction when performing such services. The department may adopt and enforce rules necessary to enforce this paragraph.

Section 3. Subsections (1) through (22) of section 465.003, Florida Statutes, are renumbered as subsections (2) through (23), respectively, and subsection (1) is added to that section, to read:

465.003 Definitions.—As used in this chapter, the term:

(1) "Acute hospital care at home" means acute and post-acute health care services provided in a clinically qualified patient's permanent residence, as defined in s. 196.012, through a program approved by the Centers for Medicare and Medicaid Services and the Agency for Health Care Administration.

Section 4. Paragraph (d) of subsection (2) and paragraph (a) of subsection (4) of section 465.019, Florida Statutes, are amended to read:

465.019 Institutional pharmacies; permits.—

(2) The following classes of institutional pharmacies are



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established:

(d)1. "Class III institutional pharmacies" are those institutional pharmacies, including central distribution facilities, affiliated with a hospital which ~~that~~ provide the same services that are authorized by a Class II institutional pharmacy permit. Class III institutional pharmacies may also:

a. Dispense, distribute, compound, and fill prescriptions for medicinal drugs for inpatient treatment or for acute hospital care at home program patients.

b. Prepare prepackaged drug products.

c. Conduct other pharmaceutical services for the affiliated hospital and for entities under common control that are each permitted under this chapter to possess medicinal drugs.

d. Provide the services in sub-subparagraphs a.-c. to an entity under common control which holds an active health care clinic establishment permit as required under s. 499.01(2)(r).

2. A Class III institutional pharmacy shall maintain policies and procedures addressing:

a. The consultant pharmacist responsible for pharmaceutical services.

b. Safe practices for the preparation, dispensing, prepackaging, distribution, and transportation of medicinal drugs and prepackaged drug products.

c. Recordkeeping to monitor the movement, distribution,

and transportation of medicinal drugs and prepackaged drug products.

d. Recordkeeping of pharmacy staff responsible for each step in the preparation, dispensing, prepackaging, transportation, and distribution of medicinal drugs and prepackaged drug products.

e. Medicinal drugs and prepackaged drug products that may not be safely distributed among Class III institutional pharmacies.

(4)(a) Medicinal drugs shall be dispensed by ~~in~~ an institutional pharmacy to outpatients only when that institution has secured a community pharmacy permit from the department. However, medicinal drugs may be dispensed by a hospital that operates a Class II or Class III institutional pharmacy to a patient of the hospital's emergency department or a hospital inpatient upon discharge if a prescriber, as defined in s. 465.025(1), treating the patient in such hospital determines that the medicinal drug is warranted and that community pharmacy services are not readily accessible, geographically or otherwise, to the patient. Such prescribing and dispensing must be for a supply of the drug that will last for the greater of the following:

1. Up to 48 hours; or

2. Through the end of the next business day.

Section 5. Subsection (1) of section 14.33, Florida



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Statutes, is amended to read:

14.33 Medal of Heroism.—

(1) The Governor may award a Medal of Heroism of appropriate design, with ribbons and appurtenances, to a law enforcement, correctional, or correctional probation officer~~,~~ as defined in s. 943.10(14); a firefighter, as defined in s. 112.191(1)(b); an emergency medical technician, as defined in s. 401.23 ~~s. 401.23(11)~~; or a paramedic, as defined in s. 401.23 ~~s. 401.23(17)~~. A recipient must have distinguished himself or herself conspicuously by gallantry and intrepidity, must have risked his or her life deliberately above and beyond the call of duty while performing duty in his or her respective position, and must have engaged in hazardous or perilous activities to preserve lives with the knowledge that such activities might result in great personal harm.

Section 6. Paragraph (a) of subsection (3) of section 252.515, Florida Statutes, is amended to read:

252.515 Postdisaster Relief Assistance Act; immunity from civil liability.—

(3) As used in this section, the term:

(a) "Emergency first responder" means:

1. A physician licensed under chapter 458.

2. An osteopathic physician licensed under chapter 459.

3. A chiropractic physician licensed under chapter 460.

4. A podiatric physician licensed under chapter 461.

5. A dentist licensed under chapter 466.

6. An advanced practice registered nurse licensed under s. 464.012.

7. A physician assistant licensed under s. 458.347 or s. 459.022.

8. A worker employed by a public or private hospital in the state.

9. A paramedic as defined in s. 401.23 ~~s. 401.23(17)~~.

10. An emergency medical technician as defined in s. 401.23 ~~s. 401.23(11)~~.

11. A firefighter as defined in s. 633.102.

12. A law enforcement officer as defined in s. 943.10.

13. A member of the Florida National Guard.

14. Any other personnel designated as emergency personnel by the Governor pursuant to a declared emergency.

Section 7. Subsection (5) of section 395.1027, Florida Statutes, is amended to read:

395.1027 Regional poison control centers.—

(5) By October 1, 1999, each regional poison control center shall develop a prehospital emergency dispatch protocol with each licensee as defined in s. 401.23 ~~by s. 401.23(13)~~ in the geographic area covered by the regional poison control center. The prehospital emergency dispatch protocol shall be developed by each licensee's medical director in conjunction with the designated regional poison control center responsible

for the geographic area in which the licensee operates. The protocol shall define toxic substances and describe the procedure by which the designated regional poison control center may be consulted by the licensee. If a call is transferred to the designated regional poison control center in accordance with the protocol established under this section and s. 401.268, the designated regional poison control center shall assume responsibility and liability for the call.

Section 8. Paragraph (b) of subsection (2) of section 401.245, Florida Statutes, is amended to read:

401.245 Emergency Medical Services Advisory Council.—

(2)

(b) Representation on the Emergency Medical Services Advisory Council shall include~~:~~ two licensed physicians who are ~~"~~medical directors~~"~~ as defined in s. 401.23 ~~s. 401.23(15)~~ or whose medical practice is closely related to emergency medical services; two emergency medical service administrators, one of whom is employed by a fire service; two certified paramedics, one of whom is employed by a fire service; two certified emergency medical technicians, one of whom is employed by a fire service; one emergency medical services educator; one emergency nurse; one hospital administrator; one representative of air ambulance services; one representative of a commercial ambulance operator; and two laypersons who are in no way connected with emergency medical services, one of whom is a representative of



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the elderly. Ex officio members of the advisory council from state agencies shall include, but are ~~shall~~ not ~~be~~ limited to, representatives from the Department of Education, the Department of Management Services, the State Fire Marshal, the Department of Highway Safety and Motor Vehicles, the Department of Transportation, and the Division of Emergency Management.

Section 9. This act shall take effect July 1, 2022.

HB 1073

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1073 Newborn Screenings
**SPONSOR(S):** Aloupis
**TIED BILLS:** **IDEN./SIM. BILLS:**

| 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

Cytomegalovirus (CMV) is a common virus that infects people of all ages. Over half of adults are infected with CMV by age 40. Most people infected with CMV show no signs or symptoms. Pregnant women infected with CMV may pass the virus on to their baby. Approximately one of every 200 babies is born with congenital CMV. About one in five babies with congenital CMV have long-term health problems, including hearing loss. Current law requires that a newborn hearing screening must be conducted on all newborns in hospitals in this state on birth admission. Screening for congenital CMV is not required under current law.

HB 1073 requires a hospital or other state-licensed birthing facility to administer a test approved by the U.S. Food and Drug Administration (FDA) on a newborn to screen for congenital CMV should the newborn fail his or her screening for hearing loss. The congenital CMV test must be administered before the newborn becomes 21 days of age or before discharge, whichever occurs earlier.

The bill also requires primary care providers to ensure that newborns in their care are screened for hearing loss within 21 days after birth. If a newborn fails the hearing screening the bill requires primary care providers to administer a FDA-approved test to screen for congenital CMV before the newborn becomes 21 days old.

Current law requires birth centers to refer newborns to a licensed audiologist, physician, or hospital for screening for detection of hearing loss before the newborn is discharged. If the birth is a home birth, the health care provider in attendance must provide a referral to a licensed audiologist, hospital, or other newborn hearing screening provider. The bill adds physicians to the list of facilities and practitioners to whom a parent may be referred to obtain the required newborn hearing screening after a home birth.

Currently, all newborns delivered in a hospital or other state-licensed birthing facility must have a hearing screen performed prior to being discharged. However, if the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening must be completed within 30 days after birth. The bill requires screenings in these cases to be completed within 21 days after birth.

Current law requires that health care providers in attendance of a home birth to coordinate and refer newborns to a licensed audiologist, a hospital, or another newborn hearing screening provider within 30 days after birth. The bill reduces the amount of days such referral is required from 30 days after birth to 7 days after birth, and adds physicians to the list of practitioners to whom a parent may be referred to for obtaining the required newborn hearing screening after a home birth.

The bill requires the results of a newborn hearing screening and congenital CMV and any related diagnostic testing to be reported to DOH within 7 days after receipt of such results.

The bill has a significant, negative fiscal impact on the Department of Health and no fiscal impact on local governments.

The bill provides an effective date of January 1, 2023.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Florida Newborn Screening Program

The Legislature created the Florida Newborn Screening Program (NSP) within the Department of Health (DOH), to promote the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.[1] The NSP also promotes the identification and screening of all newborns in this state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services.[2]

The NSP involves coordination among several entities, including the Bureau of Public Health Laboratories Newborn Screening Laboratory in Jacksonville (state laboratory), DOH Children's Medical Services (CMS) Newborn Screening Follow-up Program in Tallahassee, and referral centers, birthing centers, and physicians throughout the state.[3] Health care providers in hospitals, birthing centers, perinatal centers, county health departments, and school health programs provide screening as part of the multilevel NSP screening process.[4] This includes a risk assessment for prenatal women, and risk factor analysis and screening for postnatal women and newborns as well as laboratory screening for selected disorders in newborns.[5] The NSP attempts to screen all newborns for hearing impairment and to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.[6] While the NSP attempts to screen all prenatal women and newborns, parents and guardians may decline the screening.[7]

Health care providers perform non-laboratory NSP screening, such as hearing and risk factor analysis, and report the results to the Office of Vital Statistics. If necessary, health care providers refer patients to the appropriate health, education, and social services.[8] Health care providers in hospitals and birthing centers perform specimen collection for laboratory NSP screening by collecting a few drops of blood from the newborn's heel on a standardized specimen collection card. [9] The specimen card is then sent to the state laboratory for testing.[10] The results of the laboratory test are released to the newborn's health care provider. In the event that a newborn screen has an abnormal result, the baby's health care provider, or a nurse or specialist from NSP's Follow-up Program provides follow-up services and referrals for the child and his or her family.[11]

To administer the NSP, DOH is authorized to charge and collect a fee not to exceed $15 per live birth occurring in a hospital or birth center.[12] DOH must calculate the annual assessment for each hospital and birth center, and then quarterly generate and mail each hospital and birth center a statement of the

[1] S. 383.14(1), F.S.
[2] Id.
[3] S. 383.14, F.S.
[4] *Supra*, note 1.
[5] Id.
[6] Florida Department of Health, Florida Newborn Screening Guidelines, 2012, http://floridanewbornscreening.com/wp-content/uploads/guidelines-final-05-24-2012small-1.pdf (last visited Jan. 29, 2022).
[7] S. 383.14(4), F.S.; Rule 64C-7.008, F.A.C.; The health care provider must attempt to get a written statement of objection to be placed in the medical record.
[8] Id.
[9] Florida Newborn Screening, What is Newborn Screening?, https://floridanewbornscreening.com/parents/what-is-newborn-screening/ (last visited Jan. 29, 2022). *See also* Specimen Collection Card, http://floridanewbornscreening.com/wp-content/uploads/Order-Form.png (last visited Jan. 29, 2022).
[10] Id.
[11] Id.
[12] S. 383.14(3)(g)1., F.S.

amount due.[13] DOH bills hospitals and birth centers quarterly using vital statistics data to determine the amount to be billed.[14] DOH is authorized to bill third-party payers for the NSP tests and bills insurers directly for the cost of the screening.[15] DOH does not bill families that do not have insurance coverage.[16]

The Legislature established the Florida Genetics and Newborn Screening Advisory Council to advise DOH about which disorders to include in the NSP panel of screened disorders and the procedures for collecting and transmitting specimens.[17] Florida's NSP currently screens for 57 conditions, 53 of which are disorders recommended by the RUSP, including 35 core conditions and 22 secondary conditions.[18] Florida does not currently screen for congenital cytomegalovirus (CMV).

Newborn and Infant Hearing Screening

Section 383.145, F.S., requires that a newborn hearing screening must be conducted on all newborns in hospitals in this state on birth admission. When a newborn is delivered in a facility other than a hospital, the parents must be instructed on the importance of having the hearing screening performed and must be given information to assist them in having the screening performed within three months after the child's birth.[19]

Before a newborn is discharged from a hospital or other state-licensed birthing facility that provides maternity and newborn care services, and unless objected to by the parent or legal guardian,[20] the newborn must be screened for the detection of hearing loss to prevent the consequences of unidentified disorders.[21] However, if the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening must be completed within 30 days after the birth.[22] Before a newborn is discharged from a licensed birth center, such facility must refer the newborn to a licensed audiologist, physician, or hospital for screening for detection of hearing loss and referral for appointment must be made within 30 days after discharge.[23] If the birth is a home birth, the health care provider in attendance must provide a referral to a licensed audiologist, hospital, or other newborn hearing screening provider and the referral for appointment must be made within 30 days after the birth.[24]

All screenings must be conducted by a licensed audiologist, a licensed physician, or appropriately supervised individual who has completed documented training specifically for newborn hearing screening.[25] When ordered by the treating physician, screening of a newborn's hearing must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration (FDA).[26]

A child who is diagnosed as having a permanent hearing impairment must be referred by the licensee or individual who conducted the screening to the primary care physician for medical management, treatment, and follow-up services. Furthermore, any child from birth to 36 months of age who is diagnosed as having a hearing impairment that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program by the licensee or individual who conducted the screening serving the geographical area in which the child resides.[27] Any person who is

[13] Id.
[14] S. 383.14(3)(g), F.S.
[15] S. 383.14(3)(h), F.S.
[16] *Supra*, note 3.
[17] S. 383.14(5), F.S.
[18] Florida Newborn Screening, *What is Screened*, https://floridanewbornscreening.com/conditions/core-secondary-conditions/ (last visited Jan. 22, 2022).
[19] S. 383.145(3)(i), F.S.
[20] S. 383.145(3)(c), F.S.
[21] S. 383.145(3)(a), F.S.
[22] S. 383.145(3)(g), F.S.
[23] S. 383.145(3)(b), F.S.
[24] S. 383.145(3)(d), F.S.
[25] S. 383.145(3)(e), F.S.
[26] S. 383.145(3)(h), F.S.
[27] S. 383.145(3)(k), F.S.

not covered through insurance and cannot afford the costs for testing must be given a list of newborn hearing screening providers who provide the necessary testing free of charge.[28]

Cytomegalovirus

Cytomegalovirus is a common virus for people of all ages; however, a healthy person's immune system usually keeps the virus from causing illness.[29] In the United States, nearly one in three children are already infected with CMV by age five. Over half of adults have been infected with CMV by age 40. Once CMV is in a person's body, it stays there for life and can reactivate. A person can also be re-infected with a different strain of the virus. Most people with CMV infection have no symptoms and aren't aware that they have been infected.[30]

A pregnant woman can pass CMV to her unborn baby. The virus in the woman's blood can cross through the placenta and infect the infant. This can happen when a pregnant woman is infected with CMV for the first time or is infected with CMV again during pregnancy.[31] Some infants with congenital CMV infection have health problems that are apparent at birth or that develop later during infancy or childhood. In the most severe cases, CMV can cause the death of an unborn child (pregnancy loss).

Infants with congenital CMV infection may have signs at birth, which include:[32]

- Rash;
- Jaundice (yellowing of the skin or whites of the eyes);
- Microcephaly (small head);
- Low birth weight;
- Hepatosplenomegaly (enlarged liver and spleen);
- Seizures; and
- Retinitis (damaged eye retina).

Infants with signs of congenital CMV infection at birth may have long-term health problems, such as:[33]

- Hearing loss;
- Developmental and motor delay;
- Vision loss;
- Microcephaly (small head); and
- Seizures.

Some infants without signs of congenital CMV infection at birth may have hearing loss. Hearing loss may be present at birth or may develop later, even in infants who passed the newborn hearing test.[34]

CMV is the most common infectious cause of birth defects in the United States. About one out of 200 children are born with congenital CMV. One out of five infants with congenital CMV will have symptoms or long-term health problems, such as hearing loss. Hearing loss may progress from mild to severe during the first two years of life, which is a critical period for language learning. Over time, hearing loss can affect a child's ability to develop communication, language, and social skills.[35]

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[28] S. 383.145(3)(l), F.S.
[29] About Cytomegalovirus (CMV), Centers for Disease Control and Prevention, https://www.cdc.gov/cmv/overview.html (last visited Jan. 29, 2022).
[30] Id.
[31] Babies Born with Congenital Cytomegalovirus (CMV), Centers for Disease Control and Prevention, https://www.cdc.gov/cmv/congenital-infection.html, (last visited Jan. 29, 2022).
[32] Id.
[33] Id.
[34] Id.
[35] CMV Fact Sheet for Healthcare Providers, Centers for Disease Control and Prevention, https://www.cdc.gov/cmv/fact-sheets/healthcare-providers.html#:~:text=Cytomegalovirus%20(CMV)%20is%20the%20most,Hearing%20loss (last visited Jan. 29, 2022).

Infants may have hearing loss that may or may not be detected by newborn hearing test. Congenital CMV infection is diagnosed by detection of CMV DNA in the urine, saliva (preferred specimens), or blood, within three weeks after birth. Infection cannot be diagnosed using tests that detect antibodies to CMV. Congenital CMV infection cannot be diagnosed using samples collected more than three weeks after birth because testing after this time cannot distinguish between congenital infection and an infection acquired during or after delivery.[36]

Infants who show signs of congenital CMV disease can be treated with medicines called antivirals. Antivirals may decrease the severity of hearing loss. Infants who get treated with antivirals should be closely monitored by their doctor because of possible side effects.[37]

Florida's Newborn Screening Program, hospitals, birthing centers and health care practitioners are not currently required to screen for congenital CMV.

**Effect of the Bill**

HB 1073 requires a hospital or other state-licensed birthing facility to administer a FDA approved test, or other diagnostically equivalent test, on a newborn to screen for congenital cytomegalovirus should the newborn fail his or her screening for hearing loss. The congenital cytomegalovirus test must be administered before the newborn becomes 21 days of age or before discharge, whichever occurs earlier. There will be costs associated with the administration of this test. The bill does not address whether such costs are to be borne by the parents of the newborn, insurers or the hospital or birthing center.

The bill also requires licensed health care providers practicing in the primary care setting to ensure that newborns in their care are screened for hearing loss within 21 days after birth. If a newborn fails the hearing screening the bill requires licensed health care provider to administer a FDA approved test to screen for congenital cytomegalovirus before the newborn becomes 21 days of age. There will be costs associated with the administration of this test. The bill does not address whether such costs are to be borne by the parents of the newborn, insurers or the licensed health care provider. Additionally, health care providers who fail to ensure that a CMV test is timely conducted could be subject to regulatory discipline under their respective practice acts.

Current law requires that all newborns delivered in a hospital or other state-licensed birthing facility must have a hearing screen performed prior to being discharged. However, if the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening must be completed within 30 days after birth. The bill requires screenings in these cases to be completed within 21 days after birth.

Current law requires that health care providers in attendance of a home birth are responsible for coordination and referral to a licensed audiologist, a hospital, or another newborn hearing screening provider within 30 days after birth. The bill requires that the referral for appointment be made within 7 days after birth and adds physicians to the list of facilities and practitioners to whom a parent may be referred to for obtaining the required newborn hearing screening after a home birth.

The bill requires that the results of a newborn hearing screening and congenital cytomegalovirus and any related diagnostic testing to be reported to DOH within 7 days after receipt of such results.

The bill makes technical and conforming changes.

The bill provides an effective date of January 1, 2023.

[36] About Cytomegalovirus (CMV), Centers for Disease Control and Prevention, available at https://www.cdc.gov/cmv/overview.html (last visited Jan. 29, 2022).
[37] Congenital CMV and Hearing Loss, Centers for Disease Control and Prevention, available at https://www.cdc.gov/cmv/hearing-loss.html, (last visited Jan. 29, 2022).

B. SECTION DIRECTORY:

**Section 1:** Amends s. 383.145, F.S., relating to newborn and infant hearing screening.
**Section 2:** Provides an effective date of January 1, 2023.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill has a significant, negative fiscal impact on DOH. DOH estimates a potential general revenue impact of $440,749 to create a CMV follow-up program, which includes:[38]

- $372,153 in recurring expenses for four FTE (salary, benefits, and expenses); and
- $68,596 in non-recurring expenses for data system updates and technology integration.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The number of infants that may be effected by this bill is unknown; however, in 2021, 9,500 infants failed the newborn hearing screening.[39] The bill would require each of these infants to undergo CMV testing. Staff estimates the costs for CMV tests to be between $45-$70 per tests. This equates to $427,500-$665,000 in testing costs.

The bill does not address whether costs associated with the administration of these tests are to be borne by the parents of the newborn, insurers, licensed health care providers, hospitals or birthing centers.

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.

[38] Department of Health Agency Analysis of 2022 House Bill 1073 (Jan. 26, 2022).
[39] *Id.*

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 newborn screenings; amending s. 383.145, F.S.; providing and revising definitions; requiring hospitals and other state-licensed birthing facilities to test for congenital cytomegalovirus in newborns within a specified timeframe under certain circumstances; revising the timeframe within which health care providers attending home births must make certain referrals; requiring certain health care providers practicing in the primary care setting to screen newborns in their care for hearing loss within a specified timeframe; requiring such providers to test such newborns for congenital cytomegalovirus within a specified timeframe under certain circumstances; revising the timeframe within which hospitals must complete newborn hearing screenings that were not completed before discharge due to scheduling or temporary staffing limitations; requiring that certain test results be reported to the Department of Health within a specified timeframe; removing a requirement that the parents of certain newborns be instructed on and provided specified information; removing obsolete language; removing a requirement that certain uninsured persons be provided a list of specified providers; providing an effective

date.

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

Section 1. Section 383.145, Florida Statutes, is amended to read:

383.145 Newborn and infant hearing screening.—

(1) LEGISLATIVE INTENT.—It is the intent of the Legislature ~~this section is~~ to provide a statewide comprehensive and coordinated interdisciplinary program of early hearing loss ~~impairment~~ screening, identification, and follow-up ~~followup~~ care for newborns. The goal is to screen all newborns for hearing loss ~~impairment~~ in order to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. It is further the intent of the Legislature that ~~the provisions of~~ this section ~~act~~ only be implemented to the extent that funds are specifically included in the General Appropriations Act for carrying out the purposes of this section.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Audiologist" means a person licensed under part I of chapter 468 to practice audiology.

~~(a) "Agency" means the Agency for Health Care Administration.~~

(b) "Department" means the Department of Health.

(c) "Hearing loss ~~impairment~~" means a hearing loss of 30 dB HL or greater in the frequency region important for speech recognition and comprehension in one or both ears, approximately 500 through 4,000 hertz.

(d) "Hospital" means a facility as defined in s. 395.002(13) and licensed under chapter 395 and part II of chapter 408.

(e)~~(d)~~ "Infant" means an age range from 30 days through 12 months.

(f)~~(e)~~ "Licensed health care provider" means a physician or physician assistant licensed under ~~pursuant to~~ chapter 458; an osteopathic physician or physician assistant licensed under ~~or~~ chapter 459; an advanced practice registered nurse, a registered nurse, or a licensed practical nurse licensed under part I of ~~pursuant to~~ chapter 464; a midwife licensed under chapter 467; or a speech-language pathologist~~,~~ or an audiologist licensed under part I of ~~pursuant to~~ chapter 468~~, rendering services within the scope of his or her license~~.

(g)~~(f)~~ "Management" means the habilitation of the ~~hearing-impaired~~ child with hearing loss.

(h)~~(g)~~ "Newborn" means an age range from birth through 29 days.

(i) "Physician" means a person licensed under chapter 458 to practice medicine or chapter 459 to practice osteopathic medicine.

(j)~~(h)~~ "Screening" means a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation.

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.—

(a) Each ~~licensed~~ hospital or other state-licensed birthing facility that provides maternity and newborn care services shall ensure ~~provide~~ that all newborns are, before ~~prior to~~ discharge, screened for the detection of hearing loss~~,~~ to prevent the consequences of unidentified disorders. If a newborn fails the screening for the detection of hearing loss, the hospital or other state-licensed birthing facility must administer a test approved by the United States Food and Drug Administration or another diagnostically equivalent test on the newborn to screen for congenital cytomegalovirus before the newborn becomes 21 days of age or before discharge, whichever occurs earlier.

(b) Each licensed birth center that provides maternity and newborn care services shall ensure ~~provide~~ that all newborns are, before ~~prior to~~ discharge, referred to an ~~a licensed~~ audiologist, a physician ~~licensed under chapter 458 or chapter 459~~, ~~or~~ a hospital, or another ~~other~~ newborn hearing screening provider~~,~~ for screening for the detection of hearing loss~~,~~ to prevent the consequences of unidentified disorders. ~~The referral for appointment shall be made within 30 days after discharge.~~

Written documentation of the referral must be placed in the newborn's medical chart.

(c) If the parent or legal guardian of the newborn objects to the screening, the screening must not be completed. In such case, the physician, midwife, or other person who is attending the newborn shall maintain a record that the screening has not been performed and attach a written objection that must be signed by the parent or guardian.

(d) For home births, the health care provider in attendance is responsible for coordination and referral to an ~~a licensed~~ audiologist, a physician, a hospital, or another ~~other~~ newborn hearing screening provider. The referral for appointment must ~~shall~~ be made within 7 ~~30~~ days after the birth. ~~In cases in which the home birth is not attended by a primary health care provider, a referral to a licensed audiologist, physician licensed pursuant to chapter 458 or chapter 459, hospital, or other newborn hearing screening provider must be made by the health care provider within the first 3 months after the child's birth.~~

(e) Licensed health care providers practicing in the primary care setting must ensure that newborns in their care are screened for hearing loss within 21 days after the birth. If a newborn fails the screening for the detection of hearing loss, the licensed health care provider must administer a test approved by the United States Food and Drug Administration or

another diagnostically equivalent test on the newborn to screen for congenital cytomegalovirus before the newborn becomes 21 days of age.

(f) ~~(e)~~ All newborn and infant hearing screenings must ~~shall~~ be conducted by an ~~a licensed~~ audiologist, a physician ~~licensed under chapter 458 or chapter 459~~, or an appropriately supervised individual who has completed documented training specifically for newborn hearing screening. Every ~~licensed~~ hospital that provides maternity or newborn care services shall obtain the services of an ~~a licensed~~ audiologist, a physician ~~licensed pursuant to chapter 458 or chapter 459~~, or another ~~other~~ newborn hearing screening provider, through employment or contract or written memorandum of understanding, for the purposes of appropriate staff training, screening program supervision, monitoring the scoring and interpretation of test results, rendering of appropriate recommendations, and coordination of appropriate follow-up ~~followup~~ services. Appropriate documentation of the screening completion, results, interpretation, and recommendations must be placed in the medical record within 24 hours after completion of the screening procedure.

(g) ~~(f)~~ The screening of a newborn's hearing must ~~should~~ be completed before the newborn is discharged from the hospital. However, if the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening

must be completed within 21 ~~30~~ days after the birth ~~discharge~~. Screenings completed after discharge or performed because of initial screening failure must be completed by an audiologist ~~licensed in the state~~, a physician ~~licensed under chapter 458 or chapter 459~~, ~~or~~ a hospital, or another ~~other~~ newborn hearing screening provider.

(h) ~~(g)~~ Each hospital shall formally designate a lead physician responsible for programmatic oversight for newborn hearing screening. Each birth center shall designate a licensed health care provider to provide such programmatic oversight and to ensure that the appropriate referrals are being completed.

(i) ~~(h)~~ When ordered by the treating physician, screening of a newborn's hearing must include auditory brainstem responses, or evoked otoacoustic ~~otacoustic~~ emissions, or appropriate technology as approved by the United States Food and Drug Administration.

(j) The results of any test conducted pursuant to this section, including, but not limited to, newborn hearing loss screening, congenital cytomegalovirus testing, and any related diagnostic testing, must be reported to the department within 7 days after receipt of such results.

~~(i) Newborn hearing screening must be conducted on all newborns in hospitals in this state on birth admission. When a newborn is delivered in a facility other than a hospital, the parents must be instructed on the importance of having the~~



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

~~hearing screening performed and must be given information to assist them in having the screening performed within 3 months after the child's birth.~~

(k) ~~(j)~~ The initial procedure for screening the hearing of the newborn or infant and any medically necessary follow-up ~~followup~~ reevaluations leading to diagnosis shall be a covered benefit for~~, reimbursable under Medicaid as an expense compensated supplemental to the per diem rate for Medicaid patients enrolled in MediPass or~~ Medicaid patients covered by a fee-for-service ~~fee for service~~ program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(30), except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental polices, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers are ~~shall be~~ eligible to bill Medicaid for the professional and technical component of each procedure code.

(l) ~~(k)~~ A child who is diagnosed as having ~~a~~ permanent hearing loss must ~~impairment shall~~ be referred to the primary care physician for medical management, treatment, and follow-up



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

~~followup~~ services. Furthermore, in accordance with Part C of the Individuals with Disabilities Education Act, Pub. L. No. 108-446, Infants and Toddlers with Disabilities, any child from birth to 36 months of age who is diagnosed as having ~~a~~ hearing loss ~~impairment~~ that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program serving the geographical area in which the child resides.

~~(l) Any person who is not covered through insurance and cannot afford the costs for testing shall be given a list of newborn hearing screening providers who provide the necessary testing free of charge.~~

Section 2. This act shall take effect January 1, 2023.

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 Aloupis offered the following:

**Amendment (with title amendment)**

Remove lines 96-128 and insert:

audiologist, ~~a physician licensed under chapter 458 or chapter 459, or~~ a hospital, or another ~~other~~ newborn hearing screening provider~~,~~ for screening for the detection of hearing loss~~,~~ to prevent the consequences of unidentified disorders. The referral for appointment must ~~shall~~ be made within 7 ~~30~~ days after discharge. Written documentation of the referral must be placed in the newborn's medical chart.

(c) If the parent or legal guardian of the newborn objects to the screening, the screening must not be completed. In such case, the physician, midwife, or other person who is attending

the newborn shall maintain a record that the screening has not been performed and attach a written objection that must be signed by the parent or guardian.

(d) For home births, the health care provider in attendance is responsible for coordination and referral to an ~~a licensed~~ audiologist, a hospital, or another ~~other~~ newborn hearing screening provider. The health care provider in attendance must make the referral for appointment ~~shall be made~~ within 7 ~~30~~ days after the birth. In cases in which the home birth is not attended by a ~~primary~~ health care provider, the newborn's primary health care provider is responsible for coordinating the ~~a~~ referral ~~to a licensed audiologist, physician licensed pursuant to chapter 458 or chapter 459, hospital, or other newborn hearing screening provider must be made by the health care provider within the first 3 months after the child's birth~~.

(e) For home births and births in a licensed birth center, if a newborn is referred to a newborn hearing screening provider and the newborn fails the screening for the detection of hearing loss, the newborn's primary health care provider must refer the newborn for administration of a test approved by the United States Food and Drug Administration or another diagnostically equivalent test on the newborn to screen for congenital cytomegalovirus.

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

Remove lines 9-15 and insert:

referrals; providing that a newborn's primary health care provider is responsible for coordinating such referrals under certain circumstances; requiring a newborn's primary health care provider to refer the newborn for testing for congenital cytomegalovirus under certain circumstances; revising the timeframe within which

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1101 Anesthesiologist Assistants
**SPONSOR(S):** Altman
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1366

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

## SUMMARY ANALYSIS

An anesthesiologist assistant assists an anesthesiologist with developing and implementing an anesthesia care plan for patients. Anesthesiologist assistants are regulated under chs. 458 and 459, F.S., and by the Boards of Medicine (BOM) and Osteopathic Medicine (BOOM) within the Department of Health (DOH).

Anesthesiologist assistants perform duties under a protocol with an anesthesiologist. Current law limits the duties that an anesthesiologist assistant may perform to those that are expressly listed in statute and established by BOM or BOOM rule. An anesthesiologist or a group of anesthesiologists must file a written protocol with the BOM and BOOM upon establishment of a supervisory relationship with an anesthesiologist assistant, which must be signed by the anesthesiologist assistant and all supervising physicians.

Anesthesiologist assistants work under the direct supervision of an anesthesiologist. An anesthesiologist must be onsite and physically present in the office or surgical suite when a procedure is performed to supervise an anesthesiologist assistant. The supervising anesthesiologist must also be immediately available to provide assistance to the anesthesiologist assistant while services are delivered to a patient.

HB 1101 expands the scope of the practice of an anesthesiologist assistant by allowing an anesthesiologist assistant to perform any duty, in addition to statutory and the BOM and BOOM established duties, contained within their protocol.

The bill requires the protocol to be signed by either a single supervising anesthesiologist or a supervising anesthesiologist designated by a group practice rather than all supervising anesthesiologists. The bill also authorizes anesthesiologist assistants to personally administer prescribed anesthetic under the direct supervision of an anesthesiologist.

The bill revises the direct supervision requirements by requiring supervising anesthesiologists to be reasonably physically available to an anesthesiologist assistant, as needed.

Current law authorizes hospitals to establish criteria for granting privileges to health care practitioners to render patient care. The bill prohibits hospitals from denying clinical privileges to anesthesiologist assistants, except for cause, so long as the supervising anesthesiologist is a staff member in good standing at the hospital.

Anesthesiologist assistants must submit sworn statements of any prior felony convictions and any prior discipline or denial of licensure or certification in any state in an application for licensure in this state. The bill removes the requirement such statements be sworn, allowing applications for licensure to be completed electronically.

The bill has no fiscal impact on DOH and local governments.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

**Anesthesiologist Assistants**

Licensure

An anesthesiologist assistant assists an anesthesiologist[1] with developing and implementing an anesthesia care plan for patients.

To become licensed as an anesthesiologist assistant in this state, an applicant must:

- Complete a training program accredited by the Commission on Accreditation of Allied Health Education Programs;[2]
- Pass an examination established by the National Commission on Certification of Anesthesiologist Assistants;
- Be certified in advanced cardiac life support; and
- Submit an application fee, as set by the BOM or the BOOM and completed an application, which must include:
    - A certificate of completion of an approved graduate level program;
    - A sworn statement of any prior felony convictions;
    - A sworn statement of any prior discipline or denial of licensure or certification in any state; and
    - Two letters of recommendation from anesthesiologists.

Anesthesiologist assistants must hold a current certificate issued by the National Commission on Certification of Anesthesiologist Assistants or complete 40 hours of continuing education every two years.[3]

Practice Protocol

Anesthesiologist assistants may perform duties established by BOM or BOOM rule and included in a protocol with an anesthesiologist. Such duties include:[4]

- Obtaining a comprehensive patient history and present the history to the supervising anesthesiologist;
- Pretesting and calibrating anesthesia delivery systems and monitoring, obtaining, and interpreting information from the systems and monitors;
- Assisting the supervising anesthesiologist with the implementation of medically accepted monitoring techniques;
- Establishing basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support;
- Administering intermittent vasoactive drugs and starting and adjusting vasoactive infusions;
- Administering anesthetic drugs, adjuvant drugs, and accessory drugs;

[1] An anesthesiologist is an allopathic or osteopathic physician regulated under chs. 458 and 459, F.S., respectively, and the Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) within the Department of Health (DOH), who has completed an anesthesiology training program approved by the Accreditation Council for Graduate Medical Education and is certified by the American Board of Anesthesiology.
[2] Rules 64B8-31.004 and 64B15-7.004, F.A.C.
[3] S. 458.3475(5) and 459.023(5), F.S.
[4] S. 458.3475(3) and 459.023(3), F.S.

- Assisting the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures;
- Administering blood, blood products, and supportive fluids;
- Supporting life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances;
- Recognizing and taking appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy;
- Participating in management of the patient while in the post-anesthesia recovery area, including the administration of any supporting fluids or drugs; and
- Placing special peripheral and central venous and arterial lines for blood sampling and monitoring, as appropriate.

An anesthesiologist or a group of anesthesiologists must file a written protocol with the BOM and BOOM upon establishment of a supervisory relationship with an anesthesiologist assistant. Such protocol must be updated biennially, include the signatures of the anesthesiologist assistant, all supervising physicians, and the:[5]

- Name, address, and license number of the anesthesiologist assistant;
- Name, address, license number, and federal Drug Enforcement Administration number of each physician who will be supervising the anesthesiologist assistant;
- Address of the anesthesiologist assistant's primary practice location and the address of any other locations where the anesthesiologist assistant may practice;
- Date the protocol was developed and the dates of all revision;
- Duties and functions of the anesthesiologist assistant;
- Conditions or procedures that require the personal provision of care by an anesthesiologist; and
- Procedures to be followed in the event of an anesthetic emergency.

Duties Under Direct Supervision

An anesthesiology assistant may only provide services under the direct supervision of an anesthesiologist.[6] Direct supervision means onsite, personal supervision by an anesthesiologist who is present in the office or surgical suite when the procedure is being performed and is immediately available to provide assistance to the anesthesiologist assistant while services are being delivered.[7]

Clinical Privileges

Clinical privileges are privileges granted to licensed health care practitioners by a hospital to render patient care, but does not include admitting patients.[8] Each facility licensed under ch. 395, F.S., which includes hospitals, establishes its own rules and procedures for consideration of applications for clinical privileges.[9] Current statute prohibits hospitals from denying clinical privileges to physician assistants, except for cause, so long as the supervising physician is a staff member in good standing at the hospital.[10] Current law is silent on denial of hospital clinical privileges for anesthesiologist assistants.

## Effect of the Bill

Practice Protocol

[5] S 458.3475(2)(b) and 459.023(2)(b), F.S.
[6] S. 458.3475(3)(a) and 459.023(3)(a), F.S. The practice of anesthesiology includes pain relief during and after surgery and childbirth, during chronic disease processes, and during resuscitation and critical care of patients in the operating room and intensive care.
[7] S. 458.3475(1)(g) and 459.023(1)(g), F.S.
[8] S. 395.002, F.S.
[9] S. 395.0191, F.S.
[10] S. 458.347(3) and 459.022(3), F.S.

HB 1101 expands the scope of the practice an anesthesiologist assistant. Current law limits the duties that an anesthesiology assistant may perform duties to those that are expressly listed in statute and established by BOM or BOOM rule. The bill removes this limitation by allowing an anesthesiology assistant to perform any task, including the BOM and BOOM established duties, contained within their protocol.

The bill revises the signatory requirement for supervisory protocols. The bill requires the signature of a single supervising anesthesiologist or a supervising anesthesiologist designated by the practice group instead of the signature of all supervising physicians. This means one anesthesiologist in a practice group is the signatory authority for every other anesthesiologist in a practice group, regardless of whether other anesthesiologists in such practice group have expressly agreed to the protocol in question.

Duties Under Direct Supervision

The bill revises requirements for direct supervision of an anesthesiologist assistant by an anesthesiologist by requiring the supervising anesthesiologist to be reasonably physically available as needed instead of immediately available to provide assistance and physically present in the room when an anesthesiologist is performing procedures.

The bill also authorizes anesthesiologist assistants to personally administer prescribed anesthetic and perform tasks and services specified in a written protocol under the revised direct supervision of an anesthesiologist.

Clinical Privileges

The bill prohibits hospitals from denying clinical privileges to anesthesiologist assistants, except for cause, so long as the supervising anesthesiologist is a staff member in good standing at the hospital.

The bill makes the above changes in both the allopathic physician practice act, ch. 458, F.S., and the osteopathic physician practice act, ch. 459, F.S.

Licensure

The bill removes the requirement that anesthesiologist assistant licensure applications contain sworn statements of any prior felony convictions and any prior discipline or denial of licensure or certification in any state. This allows applications for licensure to be completed electronically.

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

B. SECTION DIRECTORY:

**Section 1:** Amends s. 458.3475, F.S., relating to anesthesiologist assistants.
**Section 2:** Amends s. 459.023, F.S., relating to anesthesiologist assistants.
**Section 3:** 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:

   None. This 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 anesthesiologist assistants; amending ss. 458.3475 and 459.023, F.S.; revising the definitions of the terms "anesthesiologist" and "direct supervision"; revising requirements for the written protocol between an anesthesiologist assistant and a supervising anesthesiologist; revising provisions related to duties and functions anesthesiologist assistants may perform; providing that a certain applicant for clinical hospital privileges may not be denied such privileges if the applicant's supervising anesthesiologist is a staff member in good standing at that hospital, with an exception; revising licensure requirements for anesthesiologist assistants; providing an effective date.

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

Section 1. Paragraphs (a) and (g) of subsection (1), paragraph (b) of subsection (2), subsection (3), and paragraphs (a) and (b) of subsection (6) of section 458.3475, Florida Statutes, are amended to read:

458.3475 Anesthesiologist assistants.—

(1) DEFINITIONS.—As used in this section, the term:



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

(a) "Anesthesiologist" means an allopathic or osteopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education or its equivalent; and who is certified by the American Board of Anesthesiology, is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialists.

(g) "Direct supervision" means the physical presence of a supervising anesthesiologist on the premises such that the supervising anesthesiologist is reasonably available as needed ~~onsite, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed~~.

(2) PERFORMANCE OF SUPERVISING ANESTHESIOLOGIST.—

(b) An anesthesiologist or group of anesthesiologists must, upon establishing a supervisory relationship with an anesthesiologist assistant, file with the board a written protocol that includes, at a minimum:

1. The name, address, and license number of the anesthesiologist assistant.

2. The name, address, license number, and federal Drug Enforcement Administration number of each physician who will be supervising the anesthesiologist assistant.

3. The address of the anesthesiologist assistant's primary practice location and the address of any other locations where the anesthesiologist assistant may practice.

4. The date the protocol was developed and the dates of all revisions.

5. The signatures of the anesthesiologist assistant and either the single supervising anesthesiologist or a supervising anesthesiologist designated by the group, as applicable ~~all supervising physicians~~.

6. The duties and functions of the anesthesiologist assistant.

7. The conditions or procedures that require the personal provision of care by an anesthesiologist.

8. The procedures to be followed in the event of an anesthetic emergency.

The protocol must be on file with the board before the anesthesiologist assistant may practice with the anesthesiologist or group. An anesthesiologist assistant may not practice unless a written protocol has been filed for that

anesthesiologist assistant in accordance with this paragraph, and the anesthesiologist assistant may only practice under the direct supervision of an anesthesiologist who is identified in the ~~has~~ signed ~~the~~ protocol. The protocol must be updated biennially.

(3) PERFORMANCE OF ANESTHESIOLOGIST ASSISTANTS.—

(a) An anesthesiologist assistant may assist an anesthesiologist in developing and implementing an anesthesia care plan for a patient, may personally administer the prescribed anesthetic under the direct supervision of an anesthesiologist, and may perform tasks and services as specified in a written protocol approved by the supervising anesthesiologist, including, but not limited to, any of the following~~. In providing assistance to an anesthesiologist, an anesthesiologist assistant may perform duties established by rule by the board in any of the following functions that are included in the anesthesiologist assistant's protocol while under the direct supervision of an anesthesiologist~~:

1. Obtain a comprehensive patient history and present the history to the supervising anesthesiologist.

2. Pretest and calibrate anesthesia delivery systems and monitor, obtain, and interpret information from the systems and monitors.

3. Assist the supervising anesthesiologist with the implementation of medically accepted monitoring techniques.

4. Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.

5. Administer intermittent vasoactive drugs and start and adjust vasoactive infusions.

6. Administer anesthetic drugs, adjuvant drugs, and accessory drugs.

7. Assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures.

8. Administer blood, blood products, and supportive fluids.

9. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

10. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

11. Participate in management of the patient while in the postanesthesia recovery area, including the administration of any supporting fluids or drugs.

12. Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

(b) Nothing in this section or chapter prevents third-

party payors from reimbursing employers of anesthesiologist assistants for covered services rendered by such anesthesiologist assistants.

(c) After 90 days following the submission of a completed application for clinical privileges at a hospital, an anesthesiologist assistant may not be denied clinical hospital privileges, except for cause, if the supervising anesthesiologist is a staff member in good standing at that hospital.

(d) An anesthesiologist assistant must clearly convey to the patient that he or she is an anesthesiologist assistant.

(e) ~~(d)~~ An anesthesiologist assistant may perform anesthesia tasks and services within the framework of a written practice protocol developed between the supervising anesthesiologist and the anesthesiologist assistant.

(f) ~~(e)~~ An anesthesiologist assistant may not prescribe, order, or compound any controlled substance, legend drug, or medical device, nor may an anesthesiologist assistant dispense sample drugs to patients. Nothing in this paragraph prohibits an anesthesiologist assistant from administering legend drugs or controlled substances; intravenous drugs, fluids, or blood products; or inhalation or other anesthetic agents to patients which are ordered by the supervising anesthesiologist and administered while under the direct supervision of the supervising anesthesiologist.

(6) ANESTHESIOLOGIST ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as an anesthesiologist assistant must apply to the department. The department shall issue a license to any person certified by the board to:

1. Be at least 18 years of age.

2. Have satisfactorily passed a proficiency examination with a score established by the National Commission on Certification of Anesthesiologist Assistants.

3. Be certified in advanced cardiac life support.

4. Have completed the application form and remitted an application fee, not to exceed $1,000, as set by the boards. An application must include:

a. A certificate of completion of an approved graduate level program.

b. An acknowledgment ~~A sworn statement~~ of any prior felony convictions.

c. An acknowledgment ~~A sworn statement~~ of any prior discipline or denial of licensure or certification in any state.

d. Two letters of recommendation from anesthesiologists.

(b) A license must be renewed biennially. Each renewal must include:

1. A renewal fee, not to exceed $1,000, as set by the boards.

2. An acknowledgment ~~A sworn statement~~ of no felony

convictions in the immediately preceding 2 years.

Section 2. Paragraphs (a) and (g) of subsection (1), paragraph (b) of subsection (2), subsection (3), and paragraphs (a) and (b) of subsection (6) of section 459.023, Florida Statutes, are amended to read:

459.023 Anesthesiologist assistants.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Anesthesiologist" means an osteopathic or allopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education, or its equivalent, or the American Osteopathic Association; and who is certified by the American Osteopathic Board of Anesthesiology or is eligible to take that board's examination, is certified by the American Board of Anesthesiology or is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialists.

(g) "Direct supervision" means the physical presence of a supervising anesthesiologist on the premises such that the supervising anesthesiologist is reasonably available as needed ~~onsite, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite~~

~~when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed~~.

(2) PERFORMANCE OF SUPERVISING ANESTHESIOLOGIST.—

(b) An anesthesiologist or group of anesthesiologists must, upon establishing a supervisory relationship with an anesthesiologist assistant, file with the board a written protocol that includes, at a minimum:

1. The name, address, and license number of the anesthesiologist assistant.

2. The name, address, license number, and federal Drug Enforcement Administration number of each physician who will be supervising the anesthesiologist assistant.

3. The address of the anesthesiologist assistant's primary practice location and the address of any other locations where the anesthesiologist assistant may practice.

4. The date the protocol was developed and the dates of all revisions.

5. The signatures of the anesthesiologist assistant and either the single supervising anesthesiologist or a supervising anesthesiologist designated by the group, as applicable ~~all supervising physicians~~.

6. The duties and functions of the anesthesiologist

assistant.

7. The conditions or procedures that require the personal provision of care by an anesthesiologist.

8. The procedures to be followed in the event of an anesthetic emergency.

The protocol must be on file with the board before the anesthesiologist assistant may practice with the anesthesiologist or group. An anesthesiologist assistant may not practice unless a written protocol has been filed for that anesthesiologist assistant in accordance with this paragraph, and the anesthesiologist assistant may only practice under the direct supervision of an anesthesiologist who is identified in the ~~has~~ signed ~~the~~ protocol. The protocol must be updated biennially.

(3) PERFORMANCE OF ANESTHESIOLOGIST ASSISTANTS.—

(a) An anesthesiologist assistant may assist an anesthesiologist in developing and implementing an anesthesia care plan for a patient, may personally administer the prescribed anesthetic under the direct supervision of an anesthesiologist, and may perform tasks and services as specified in a written protocol approved by the supervising anesthesiologist, including, but not limited to, any of the following~~. In providing assistance to an anesthesiologist, an anesthesiologist assistant may perform duties established by~~

~~rule by the board in any of the following functions that are included in the anesthesiologist assistant's protocol while under the direct supervision of an anesthesiologist~~:

1. Obtain a comprehensive patient history and present the history to the supervising anesthesiologist.

2. Pretest and calibrate anesthesia delivery systems and monitor, obtain, and interpret information from the systems and monitors.

3. Assist the supervising anesthesiologist with the implementation of medically accepted monitoring techniques.

4. Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.

5. Administer intermittent vasoactive drugs and start and adjust vasoactive infusions.

6. Administer anesthetic drugs, adjuvant drugs, and accessory drugs.

7. Assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures.

8. Administer blood, blood products, and supportive fluids.

9. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of

fluid, electrolyte, and blood component balances.

10. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

11. Participate in management of the patient while in the postanesthesia recovery area, including the administration of any supporting fluids or drugs.

12. Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

(b) Nothing in this section or chapter prevents third-party payors from reimbursing employers of anesthesiologist assistants for covered services rendered by such anesthesiologist assistants.

(c) After 90 days following the submission of a completed application for clinical privileges at a hospital, an anesthesiologist assistant may not be denied clinical hospital privileges, except for cause, if the supervising anesthesiologist is a staff member in good standing at that hospital.

(d) An anesthesiologist assistant must clearly convey to the patient that she or he is an anesthesiologist assistant.

(e) ~~(d)~~ An anesthesiologist assistant may perform anesthesia tasks and services within the framework of a written practice protocol developed between the supervising anesthesiologist and the anesthesiologist assistant.

(f) ~~(e)~~ An anesthesiologist assistant may not prescribe, order, or compound any controlled substance, legend drug, or medical device, nor may an anesthesiologist assistant dispense sample drugs to patients. Nothing in this paragraph prohibits an anesthesiologist assistant from administering legend drugs or controlled substances; intravenous drugs, fluids, or blood products; or inhalation or other anesthetic agents to patients which are ordered by the supervising anesthesiologist and administered while under the direct supervision of the supervising anesthesiologist.

(6) ANESTHESIOLOGIST ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as an anesthesiologist assistant must apply to the department. The department shall issue a license to any person certified by the board to:

1. Be at least 18 years of age.

2. Have satisfactorily passed a proficiency examination with a score established by the National Commission on Certification of Anesthesiologist Assistants.

3. Be certified in advanced cardiac life support.

4. Have completed the application form and remitted an application fee, not to exceed $1,000, as set by the boards. An application must include:

a. A certificate of completion of an approved graduate level program.

b. An acknowledgment ~~A sworn statement~~ of any prior felony convictions.

c. An acknowledgment ~~A sworn statement~~ of any prior discipline or denial of licensure or certification in any state.

d. Two letters of recommendation from anesthesiologists.

(b) A license must be renewed biennially. Each renewal must include:

1. A renewal fee, not to exceed $1,000, as set by the boards.

2. An acknowledgment ~~A sworn statement~~ of no felony convictions in the immediately preceding 2 years.

Section 3. 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 Altman offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Paragraphs (a) and (g) of subsection (1), paragraph (a) of subsection (3), and paragraphs (a) and (b) of subsection (6) of section 458.3475, Florida Statutes, are amended to read:

458.3475 Anesthesiologist assistants.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Anesthesiologist" means an allopathic or osteopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical

Education or its equivalent; and who is certified by the American Board of Anesthesiology, is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialists.

(g) "Direct supervision" means the physical presence of a supervising anesthesiologist on the premises such that the supervising anesthesiologist is immediately available as needed ~~onsite, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed~~.

(3) PERFORMANCE OF ANESTHESIOLOGIST ASSISTANTS.—

(a) An anesthesiologist assistant may assist an anesthesiologist in developing and implementing an anesthesia care plan for a patient, may personally administer the prescribed anesthetic under the direct supervision of an anesthesiologist, and may perform tasks and services as specified in a written protocol approved by the supervising anesthesiologist which may include any of the following functions~~. In providing assistance to an anesthesiologist, an~~

~~anesthesiologist assistant may perform duties established by rule by the board in any of the following functions that are included in the anesthesiologist assistant's protocol while under the direct supervision of an anesthesiologist~~:

1. Obtain a comprehensive patient history and present the history to the supervising anesthesiologist.

2. Pretest and calibrate anesthesia delivery systems and monitor, obtain, and interpret information from the systems and monitors.

3. Assist the supervising anesthesiologist with the implementation of medically accepted monitoring techniques.

4. Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.

5. Administer intermittent vasoactive drugs and start and adjust vasoactive infusions.

6. Administer anesthetic drugs, adjuvant drugs, and accessory drugs.

7. Assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures.

8. Administer blood, blood products, and supportive fluids.

9. Support life functions during anesthesia health care, including induction and intubation procedures, the use of

appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

10. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

11. Participate in management of the patient while in the postanesthesia recovery area, including the administration of any supporting fluids or drugs.

12. Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

(6) ANESTHESIOLOGIST ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as an anesthesiologist assistant must apply to the department. The department shall issue a license to any person certified by the board to:

1. Be at least 18 years of age.

2. Have satisfactorily passed a proficiency examination with a score established by the National Commission on Certification of Anesthesiologist Assistants.

3. Be certified in advanced cardiac life support.

4. Have completed the application form and remitted an application fee, not to exceed $1,000, as set by the boards. An application must include:

a. A certificate of completion of an approved graduate level program.

b. An acknowledgment ~~A sworn statement~~ of any prior felony convictions.

c. An acknowledgment ~~A sworn statement~~ of any prior discipline or denial of licensure or certification in any state.

d. Two letters of recommendation from anesthesiologists.

(b) A license must be renewed biennially. Each renewal must include:

1. A renewal fee, not to exceed $1,000, as set by the boards.

2. An acknowledgment ~~A sworn statement~~ of no felony convictions in the immediately preceding 2 years.

Section 2. Paragraphs (a) and (g) of subsection (1), paragraph (a) of subsection (3), and paragraphs (a) and (b) of subsection (6) of section 459.023, Florida Statutes, are amended to read:

459.023 Anesthesiologist assistants.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Anesthesiologist" means an osteopathic or allopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education, or its equivalent, or the American Osteopathic Association; and who is certified by the American Osteopathic Board of Anesthesiology or is eligible to take that board's examination, is certified by the American Board of

Anesthesiology or is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialists.

(g) "Direct supervision" means the physical presence of a supervising anesthesiologist on the premises such that the supervising anesthesiologist is immediately available as needed ~~onsite, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed~~.

(3) PERFORMANCE OF ANESTHESIOLOGIST ASSISTANTS.—

(a) An anesthesiologist assistant may assist an anesthesiologist in developing and implementing an anesthesia care plan for a patient, may personally administer the prescribed anesthetic under the direct supervision of an anesthesiologist, and may perform tasks and services as specified in a written protocol approved by the supervising anesthesiologist which may include any of the following functions~~. In providing assistance to an anesthesiologist, an anesthesiologist assistant may perform duties established by~~

~~rule by the board in any of the following functions that are included in the anesthesiologist assistant's protocol while under the direct supervision of an anesthesiologist~~:

1. Obtain a comprehensive patient history and present the history to the supervising anesthesiologist.

2. Pretest and calibrate anesthesia delivery systems and monitor, obtain, and interpret information from the systems and monitors.

3. Assist the supervising anesthesiologist with the implementation of medically accepted monitoring techniques.

4. Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.

5. Administer intermittent vasoactive drugs and start and adjust vasoactive infusions.

6. Administer anesthetic drugs, adjuvant drugs, and accessory drugs.

7. Assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures.

8. Administer blood, blood products, and supportive fluids.

9. Support life functions during anesthesia health care, including induction and intubation procedures, the use of

appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

10. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

11. Participate in management of the patient while in the postanesthesia recovery area, including the administration of any supporting fluids or drugs.

12. Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

(6) ANESTHESIOLOGIST ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as an anesthesiologist assistant must apply to the department. The department shall issue a license to any person certified by the board to:

1. Be at least 18 years of age.

2. Have satisfactorily passed a proficiency examination with a score established by the National Commission on Certification of Anesthesiologist Assistants.

3. Be certified in advanced cardiac life support.

4. Have completed the application form and remitted an application fee, not to exceed $1,000, as set by the boards. An application must include:

a. A certificate of completion of an approved graduate level program.

b. An acknowledgment ~~A sworn statement~~ of any prior felony convictions.

c. An acknowledgment ~~A sworn statement~~ of any prior discipline or denial of licensure or certification in any state.

d. Two letters of recommendation from anesthesiologists.

(b) A license must be renewed biennially. Each renewal must include:

1. A renewal fee, not to exceed $1,000, as set by the boards.

2. An acknowledgment ~~A sworn statement~~ of no felony convictions in the immediately preceding 2 years.

Section 3. This act shall take effect July 1, 2022.

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

Remove everything before the enacting clause and insert: An act relating to anesthesiologist assistants; amending ss. 458.3475 and 459.023, F.S.; revising the definitions of the terms "anesthesiologist" and "direct supervision"; revising requirements for the written protocol between an anesthesiologist assistant and a supervising anesthesiologist; revising provisions relating to duties and functions anesthesiologist assistants may perform; revising licensure requirements for anesthesiologist assistants; providing an effective date.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1209 Administration of Vaccines
**SPONSOR(S):** Tuck and others
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1892

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

## SUMMARY ANALYSIS

Current law authorizes pharmacists and registered interns who meet certain educational requirements to administer vaccines to adults within an established protocol with a supervising physician. A pharmacist or a pharmacy intern may administer:

- Immunizations or vaccines listed on the U.S. Centers for Disease Control and Prevention (CDC) Adult Immunization Schedule as of April 20, 2021;
- Vaccines recommended by the CDC for international travel as of April 30, 2021;
- Immunizations or vaccines licensed for use in the United States by the U.S. Food and Drug Administration (FDA) as of April 30, 2021;
- Immunizations or vaccines authorized for emergency use by the FDA as of April 30, 2021;
- Immunizations or vaccines approved by the Board of Pharmacy (Board) in rule; and
- Immunizations or vaccines approved by the Board of Pharmacy in response to a state of emergency declared by the Governor.

Pharmacy technicians are not currently authorized by law to administer immunizations or vaccines.

HB 1209 authorizes qualified Florida-registered pharmacy technicians to administer to adults the above-referenced immunizations or vaccines under the supervision of a certified pharmacist.

The bill requires pharmacy technicians to become certified to administer such immunizations and vaccines. To become certified, a registered pharmacy technician must complete at least six hours of immunization-related training. The training curriculum must, at a minimum, include instruction on the safe and effective administration of vaccines and potential allergic reactions to such vaccines. Upon registration renewal, pharmacy technicians must have completed at least two hours of additional continuing education.

The bill updates the authorized immunizations or vaccines that may be administered from those listed in the CDC Recommended Immunization Schedule for adults, the CDC's Health Information for International Travel, and those licensed or authorized for emergency use by the FDA as of April 30, 2021 to those listed or approved as of March 31, 2022.

The bill has an insignificant, negative fiscal impact on the Department of Health. 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**

Vaccinations

*CDC Immunization Recommendations*

The Advisory Committee on Immunization Practices (ACIP) develops recommendations on the use of vaccines in the United States.[1] The ACIP is comprised of medical and public health experts, and works with professional organizations, such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Physicians to develop annual childhood and adult immunization schedules.[2] The Centers for Disease Control and Prevention (CDC) reviews the ACIP's recommendations; once approved by the CDC Director and the U.S. Department of Health and Human Services, they are published as the CDC's official recommendations for immunizations of the U.S. population.[3]

The current recommended immunization schedule for adults includes:[4]

- Influenza (annually)
- Measles, mumps, rubella (if born in 1957 or later)
- Zoster
- Pneumococcal polysaccharide
- Haemophilus influenza type b
- Hepatitis B
- Meningococcal B
- Varicella (if born in 1980 or later)
- Tetanus, diphtheria, pertussis (booster every 10 years)
- Human papillomavirus
- Pneumococcal conjugate
- Hepatitis A
- Meningococcal A, C, W, Y

New vaccines are considered for addition to the schedule after licensure by the United States Food and Drug Administration.[5] Not all newly licensed vaccines are added to the schedule. Some licensed vaccines are only recommended for people who are traveling to areas where other vaccine preventable diseases occur, such as yellow fever, cholera, dengue, Japanese encephalitis, plague, rabies, smallpox, and typhoid.[6]

The CDC's Health Information for International Travel, commonly called the Yellow Book (Book), is published biannually by the CDC as a reference for those who advise international travelers about

[1] Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP), *General Committee-Related Information*, available at https://www.cdc.gov/vaccines/acip/committee/index.html (last visited Jan. 28, 2022). Established under Title 42 U.S.C. § 217a, ACIP members are appointed by the Secretary of the Department of Health and Human Services and consist of a mix of medical and public health experts from private industry and the public sector. There are 15 voting members (14 are industry experts and one consumer member), 6 non-voting, ex-officio members consisting of specific federal government employees, and 30 non-voting representatives from professional health care organizations.
[2] Centers for Disease Control and Prevention, Advisory Committee on Immunization Practices (ACIP), *ACIP Recommendations*, available at https://www.cdc.gov/vaccines/acip/recommendations.html (last visited Jan. 28, 2022).
[3] Id.
[4] Centers for Disease Control and Prevention, *Recommended Adult Immunization Schedule for Ages 19 Years or Older, United States, 2021*, available at https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html (last visited Jan. 28, 2022). The schedule provides the recommended age, as well as the administration intervals for vaccines that require multiple doses. Some vaccines are recommended only for populations with special situations that put these individuals at higher risk.
[5] College of Physicians of Philadelphia, *The History of Vaccines: The Development of the Immunization Schedule,* available at http://www.historyofvaccines.org/content/articles/development-immunization-schedule (last visited Jan. 28, 2022).
[6] Id. For a complete list of FDA-licensed vaccines, *see* U.S. Food & Drug Administration, *Vaccines Licensed for Use in the United States*, (as of Dec. 1, 2021), available at https://www.fda.gov/vaccines-blood-biologics/vaccines/vaccines-licensed-use-united-states (last visited Jan. 28, 2022).

health risks.[7] The Book includes the CDC's most current travel health guidelines, including pre-travel vaccine recommendations and destination-specific health advice. The Book is authored by subject-matter experts both within and outside the CDC and the guidelines in the Book are evidence-based and supported by best practices.[8]

Vaccinations are recommended by the CDC to protect international travelers from illness and prevent the importation of infectious diseases across international borders. The Book recommends that persons traveling internationally should be up to date on all CDC-recommended vaccines.[9] Additionally, the Book may recommend additional vaccinations based on traveler's destination and other factors. Examples of additional vaccines required for travelers based on the country of entry is yellow fever, meningococcal, and polio.[10] An example of a vaccine the CDC recommends travelers obtain to protect their health, even if they are not required for entry into the country, is the typhoid vaccine.[11]

*FDA Licensure and Emergency Use Authorization*

The United States Food and Drug Administration (FDA) oversees the safety, effectiveness, and quality of vaccines used in the United States. Once a vaccine is developed, the pre-clinical phase begins, which consists of laboratory research and testing on animals. If the pre-clinical phase shows the vaccine is likely to be safe and work well in humans, it is tested on humans through clinical trials. While clinical trials are underway, the FDA assesses the manufacturing process to ensure that the vaccine can be produced reliably and consistently. Once a manufacturing process is developed and pre-clinical and clinical trials are successfully completed, developers submit a Biologics License Application to the FDA, which includes details on the manufacturing process and data from pre-clinical and clinical trials. The FDA evaluates the application and decides whether to license the vaccine for use in the United States. The FDA continues to monitor and regulate vaccines and manufacturers after licensing.[12] All vaccines must be licensed (approved) by the FDA in order to be marketed in the United States.[13] However, during public health emergencies, the FDA may authorize vaccines for emergency use, which speeds up the process of bringing a vaccine to market.[14]

Emergency use authorization (EUA) allows the FDA to help strengthen the nation's public health protections against chemical, biological, radiological, and nuclear threats including infectious diseases, by facilitating the availability and use of medical countermeasures need during public health emergencies.[15] Under section 564 of the Federal Food, Drug, and Cosmetic Act,[16] when the Secretary of the United States Department of Health and Human Services (HHS) declares that an emergency use authorization is appropriate, the FDA may authorize unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious life-threatening diseases or conditions caused by chemical, biological, radiological, and nuclear threats.[17]

Vaccine manufacturers seeking EUA must follow the same processes as a license applicant, but instead of submitting a license application, the manufacturer files for EUA.[18] The FDA expects all manufacturers who receive an EUA to pursue licensure.[19]

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[7] Centers for Disease Control and Prevention. *CDC Yellow Book 2020: Health Information for International Travel*, available at https://wwwnc.cdc.gov/travel/page/yellowbook-home (last visited Jan. 28, 2022).
[8] Id.
[9] Id.
[10] Centers for Disease Control and Prevention, *Travelers' Health Most Frequently Asked Questions,* available at https://wwwnc.cdc.gov/travel/page/faq (last visited Jan. 28, 2022).
[11] Id.
[12] U.S. Food and Drug Administration, *Vaccine Development – 101,* https://www.fda.gov/vaccines-blood-biologics/development-approval-process-cber/vaccine-development-101 (last visited Jan. 28, 2022).
[13] U.S. Food and Drug Administration, *Ensuring the Safety of Vaccines in the United States,* https://www.fda.gov/files/vaccines,%20blood%20&%20biologics/published/Ensuring-the-Safety-of-Vaccines-in-the-United-States.pdf (last visited Jan. 28, 2022).
[14] Food and Drug Administration, *Emergency Use Authorization,* https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization (last visited Jan. 28, 2022). Medical countermeasures are FDA-regulated products (biologics, drugs, and devices) that may be used in the event of a public health emergency.
[15] Id.
[16] 21 U.S.C. § 360bbb-3.
[17] *Supra,* note 14. A determination that a public health emergency exists does not enable the FDA to issue EUAs.
[18] Id.

Practice of Pharmacy

*Licensure*

Pharmacy is the third largest health profession behind nursing and medicine.[20] The Board of Pharmacy (Board), in conjunction with the Department of Health (DOH), regulates the practice of pharmacists pursuant to ch. 465, F.S.[21] To be licensed as a pharmacist, a person must:[22]

- Complete an application and remit an examination fee;
- Be at least 18 years of age;
- Hold a degree from an accredited and approved school or college of pharmacy;[23]
- Have completed a Board-approved internship; and
- Successfully complete the Board-approved examination.

A pharmacist must complete at least 30 hours of Board-approved continuing education during each biennial renewal period.[24] Pharmacists who are certified to administer vaccines or epinephrine autoinjections must complete a 3-hour continuing education course on the safe and effective administration of vaccines and epinephrine injections as a part of the biennial licensure renewal.[25] Pharmacists who administer long-acting antipsychotic medications must complete an approved 8-hour continuing education course as a part of the continuing education for biennial licensure renewal.[26]

*Scope of Practice*

In Florida, the practice of the profession of pharmacy includes:[27]

- Compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of a medicinal drug;
- Consulting concerning therapeutic values and interactions of patent or proprietary preparations;
- Monitoring a patient's drug therapy and assisting the patient in the management of his or her drug therapy, including the review of the patient's drug therapy and communication with the patient's prescribing health care provider or other persons specifically authorized by the patient, regarding the drug therapy;
- Transmitting information from prescribers to their patients;
- Administering vaccines to adults;[28]
- Administering epinephrine injections;[29] and
- Administering antipsychotic medications by injection.[30]

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[19] U.S. Food and Drug Administration, *Emergency Use Authorization for Vaccines Explained,* https://www.fda.gov/vaccines-blood-biologics/vaccines/emergency-use-authorization-vaccines-explained (last visited Jan. 28, 2022).
[20] American Association of Colleges of Pharmacy, *About AACP*, available at https://www.aacp.org/about-aacp (last visited Jan. 28, 2022).
[21] Sections 465.004 and 465.005, F.S.
[22] Section 465.007, F.S. DOH may also issue a license by endorsement to a pharmacist who is licensed in another state upon meeting the applicable requirements set forth in law and rule. *See* s. 465.0075, F.S.
[23] If the applicant has graduated from a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, the applicant must demonstrate proficiency in English, pass the board-approved Foreign Pharmacy Graduate Equivalency Examination, and complete a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a DOH-licensed pharmacist
[24] Section 465.009, F.S.
[25] Section 465.009(6), F.S.
[26] Section 465.1893, F.S.
[27] Section 465.003(13), F.S.
[28] *See* s. 465.189, F.S.
[29] Id.
[30] Section 465.1893, F.S.

*Pharmacy Interns*

A pharmacy intern is a person enrolled in a college of pharmacy and actively pursuing a pharmacy degree. To become a pharmacy intern, a person must be certified by the Board as enrolled in an intern program at an accredited school or college of pharmacy or as a graduate of an accredited school or college of pharmacy and not yet licensed as a pharmacist in Florida.[31] The Board's rules outline the registration process for pharmacy interns and the internship program requirements for U.S. pharmacy students or graduates and foreign pharmacy graduates.[32]

A pharmacist is responsible for any delegated act performed by a registered pharmacy intern employed or supervised by the pharmacist.[33]

*Pharmacy Technicians*

Pharmacy technicians assist, and work under the supervision of, licensed pharmacists. Section 465.014, F.S., authorizes a licensed pharmacist to delegate to registered pharmacy technicians those duties, tasks, and functions that do not fall within the definition of the practice of the profession of pharmacy. Registered pharmacy technicians' responsibilities include delegable tasks assigned by a pharmacist which do not require the technician to exercise independent professional judgment relating to the practice of pharmacy.[34] Examples include: retrieval of prescription files; data entry; counting, weighing, measuring, pouring, and mixing prescription medication; and acceptance of authorization for prescription renewals.

A pharmacist is responsible for acts performed by persons under his or her supervision.[35]

Pharmacy technicians must be over the age of 17, registered with the Board, and complete a Board-approved training program to practice in this state.[36] The training program includes classroom study and clinical instruction on:[37]

- Introduction to pharmacy and health care system;
- Pharmacy law;
- Pharmaceutical-medical terminology, abbreviations, and symbols;
- Records management and inventory control;
- Interpersonal relations, communications, and ethics; and
- Pharmaceutical calculations.

Registered pharmacy technicians must complete 20 hours of biennial continuing education upon registration renewal.[38] Such continuing education must include subject matter on:[39]

- Pharmacy technician practice areas and special health care problems;
- Biological, physical, behavioral and social sciences;
- The legal aspects of health care;
- Management and administration of health care personnel and patient care; and
- Teaching and learning processes of health care personnel and patient care.

The Board specifies by rule certain acts that pharmacy technicians are prohibited from performing, which includes:[40]

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[31] Section 465.013, F.S.
[32] Rule 64B16-26.2032, F.A.C. (U.S. pharmacy students/graduates); Rule 64B16-26.2033, F.A.C. (foreign pharmacy graduates).
[33] Rule 64B16-27.4001, F.A.C.
[34] Rule, 64B16-27.420, F.A.C.
[35] Rule 64B16-27.1001(7), F.A.C.
[36] Section 465.014(2), F.S., and Rule 64B16-26.350, F.A.C.
[37] Rule 64B16-26.351, F.A.C.
[38] Section 465.014(6), F.S.
[39] Rule 65B16-26.355, F.A.C.
[40] *Supra,* note 34.

- Receiving new verbal prescriptions or any change in the medication, strength, or directions;
- Interpreting a prescription or medication order for therapeutic acceptability and appropriateness;
- Conducting a final verification of dosage and directions;
- Engaging in prospective drug review;
- Providing patient counseling;
- Transfer a prescription;
- Preparing copies of prescriptions or reading a prescription to any patient for the purpose of providing reference to the treatment of the patient;
- Receiving therapy or blood product procedures permitted in a nuclear pharmacy;
- Monitoring prescription drug usage;
- Overriding clinical alerts without first notifying the pharmacist; and
- Engaging in any other act which requires a pharmacist's professional judgment.

Pharmacy technicians are not currently authorized by law to administer immunizations or vaccines.

*Pharmacist Vaccine Administration*

Current law authorizes a pharmacist, or a registered pharmacy intern under the supervision of a certified pharmacist at a ratio of 1:1, to administer immunizations and vaccines to adults within an established protocol under a licensed supervising physician.[41] The protocol between the pharmacist and the supervising physician dictates which types of patients to whom the pharmacist may administer allowable vaccines.[42] The terms, scope, and conditions set forth in the protocol must be appropriate to the pharmacist's training and certification. A supervising physician must review the administration of vaccines by the pharmacist.[43]

To be certified to administer vaccines, a pharmacist or registered pharmacy intern must successfully complete a Board-approved vaccine administration certification program. The certification program requires a pharmacist or registered intern to complete 20 hours of Board-approved continuing education that addresses:[44]

- Mechanisms of action for vaccines, contraindications, drug interactions, and monitoring after vaccine administration;
- Immunization schedules;
- Immunization screening questions, provision of risk/benefit information, informed consent, recordkeeping, and electronic reporting into the state immunization registry;
- Vaccine storage and handling;
- Bio-hazardous waste disposal and sterile technique;
- Entering, negotiating, and performing pursuant to physician oversight protocols;
- Community immunization resources and programs;
- Identifying, managing and responding to adverse incidents including but not limited to potential allergic reactions associated with vaccine administration;
- Procedures and policies for reporting to the Vaccine Adverse Event Reporting System;
- Reimbursement procedures and vaccine coverage by federal, state, and local governmental jurisdictions and private third party payers;
- Administration techniques;
- Administration of epinephrine using an autoinjector delivery system;
- The April 30, 2021 CDC Recommended Adult Immunization Schedule;
- The immunizations or vaccines recommended for international travel as of April 30, 2021 found in the CDC Health Information for International Travel (2020 Edition);

[41] Section 468.189(1), F.S.
[42] Section 465.189(7), F.S.
[43] Id.
[44] Rule 64B16-26.1031, F.A.C.

- State of emergency administration of immunizations or vaccines;
- Current law permitting a pharmacist to administer vaccinations and epinephrine; and
- CPR training.

A pharmacist must also pass an examination and demonstrate vaccine administration technique.[45] Pharmacists who are certified to administer vaccines must maintain at least $200,000 of professional liability insurance.[46] A pharmacist is permitted to administer epinephrine to treat any allergic reaction resulting from a vaccine.

Current law restricts the vaccines a pharmacist may administer to adults to those vaccines listed in the April 30, 2021, CDC Recommended Adult Immunization Schedule. No additional vaccines have been added to such list since April 30, 2021.

However, current law authorizes the Board to add additional vaccines a pharmacist may administer by rule.[47] The Board added the Meningococcal B vaccine in 2016 and the Zoster vaccine in 2018.[48] The Board may authorize pharmacists to administer vaccines in response to a declared state of emergency.[49]

Currently, 15,091 pharmacists and 3,802 pharmacy interns are certified to administer vaccines.[50]

**Effect of Proposed Changes**

HB 1209 authorizes certified registered pharmacy technicians to administer vaccines to adults. To become certified, a registered pharmacy technician must have at least six hours of Board-approved or Accredited Council for Pharmacy Education-approved (ACPE) immunization-related training. The training curriculum must, at a minimum, include instruction on the safe and effective administration of vaccines and potential allergic reactions to such vaccines. Upon registration renewal, registered pharmacy technicians must have at least two hours of additional continuing education approved by the Board or ACPE.

The bill requires registered pharmacy interns and registered pharmacy technicians who administer vaccines to adults to do so under the supervision of a certified pharmacist who has an established protocol with a supervising physician.

The bill updates the authorized immunizations or vaccines that may be administered from those listed in the CDC Recommended Immunization Schedule for adults, the CDC's Health Information for International Travel, and those licensed or authorized for emergency use by the FDA as of April 30, 2021 to those listed or approved as of March 31, 2022. Such CDC-recommended vaccines, and vaccines licensed or authorized for emergency use by the FDA have not changed since April 30, 2021. However, vaccines may be added to the CDC-recommend lists for adults or authorized for emergency use by the FDA on or before March 31, 2022.

The bill authorizes the Board to determine the number of technicians a pharmacist may supervise related to the administration of vaccines, but specifies the ratio must be one pharmacist to no more than six pharmacy technicians.

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

B. SECTION DIRECTORY:

**Section 1:** Amends s. 465.014, F.S., relating to pharmacy technician.

[45] Id.
[46] Section 465.189(3), F.S.
[47] Section 465.189, F.S.
[48] Rule 64B16-27.630, F.A.C.
[49] Section 465.189(1)(c), F.S.
[50] E-mail from Gangul Gabadage, Legislative Planning Coordinator, Department of Health, Pharmacist Administered Vaccines dated Jan. 28, 2022.

**Section 2:** Amends s. 465.189, F.S., relating to administration of vaccines and epinephrine autoinfection.

**Section 3:** 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 3 full-time equivalent (FTE) position will be needed to implement the provisions of the bill at a total cost of $170,674 ($156,727 recurring and $13,947 nonrecurring).[51]

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 and the bill provide sufficient rulemaking authority to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

[51] Department of Health Agency Analysis of 2022 House Bill 1209 (Jan. 28, 2022).

A bill to be entitled

An act relating to administration of vaccines; amending s. 465.014, F.S.; authorizing registered pharmacy technicians to administer specified vaccines under certain circumstances; providing requirements for registration renewal; amending s. 465.189, F.S.; authorizing certified pharmacists to administer specified vaccines under certain circumstances; revising the immunizations or vaccines that certified pharmacists, registered interns, and registered pharmacy technicians may administer; revising and providing continuing education requirements for registered pharmacy technicians; providing that the Board of Pharmacy may authorize by rule a staffing ratio for a registered pharmacy technician to administer certain immunizations or vaccines; providing an effective date.

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

Section 1. Subsections (7) and (8) of section 465.014, Florida Statutes, are renumbered as subsections (8) and (9), respectively, and a new subsection (7) is added to that section, to read:

465.014 Pharmacy technician.—



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

(7) A registered pharmacy technician seeking to administer vaccines under s. 465.189 must have at least 6 hours of immunization-related training approved by the board or the Accreditation Council for Pharmacy Education that shall, at a minimum, have curriculum of instruction concerning the safe and effective administration of such vaccines, including, but not limited to, potential allergic reactions to such vaccines. As a condition of registration renewal, a registered pharmacy technician seeking to administer vaccines under s. 465.189 must have at least 2 hours of continuing education approved by the board or the Accreditation Council for Pharmacy Education in addition to the biennial continuing education required in subsection (6).

Section 2. Subsections (1), (4), (5), and (7) of section 465.189, Florida Statutes, are amended to read:

465.189 Administration of vaccines and epinephrine autoinjection.—

(1) In accordance with guidelines of the Centers for Disease Control and Prevention for each recommended immunization or vaccine, a pharmacist who is certified under subsection (7) may administer the following vaccines to an adult within the framework of an established protocol under a supervising physician licensed under chapter 458 or chapter 459. ~~or~~ A registered intern or a registered pharmacy technician under the supervision of a pharmacist who is certified under subsection

(7) may administer the following immunizations or vaccines to an adult within the framework of an established protocol under a supervising physician licensed under chapter 458 or chapter 459:

(a) Immunizations or vaccines listed in the Adult Immunization Schedule as of March 31, 2022 ~~April 30, 2021~~, by the United States Centers for Disease Control and Prevention. The board may authorize by rule additional immunizations or vaccines as they are added to the Adult Immunization Schedule.

(b) Immunizations or vaccines recommended by the United States Centers for Disease Control and Prevention for international travel as of March 31, 2022 ~~April 30, 2021~~. The board may authorize by rule additional immunizations or vaccines as they are recommended by the United States Centers for Disease Control and Prevention for international travel.

(c) Immunizations or vaccines licensed for use in the United States, or which have been authorized for emergency use, by the United States Food and Drug Administration as of March 31, 2022 ~~April 30, 2021~~. The board may authorize by rule additional immunizations or vaccines as they are so licensed or authorized.

(d) Immunizations or vaccines approved by the board in response to a state of emergency declared by the Governor pursuant to s. 252.36.

A registered intern who administers an immunization or vaccine

under this subsection must be supervised by a certified pharmacist at a ratio of one pharmacist to one registered intern. The board may authorize by rule the ratio of one certified pharmacist to no more than six registered pharmacy technicians, specific to the administration of vaccines.

(4) A pharmacist may not enter into a protocol under a supervising physician licensed under chapter 458 or chapter 459 or administer an immunization or vaccine under this section unless he or she maintains at least $200,000 of professional liability insurance and has completed training in administering vaccines authorized under this section.

(5) A pharmacist administering immunizations or vaccines under this section shall maintain and make available patient records using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057. These records shall be maintained for a minimum of 5 years.

(7) Any pharmacist, ~~or~~ registered intern, or registered pharmacy technician seeking to administer vaccines under this section must be certified to administer such vaccines pursuant to a certification program approved by the board ~~of Pharmacy~~ in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist attend at least 20 hours of continuing education classes approved by the board and the

registered intern complete at least 20 hours of coursework approved by the board. The registered pharmacy technician shall have immunization-related training and continuing education as provided in s. 465.014. The certification programs ~~program~~ shall, at a minimum, have a curriculum of instruction concerning the safe and effective administration of such vaccines, including, but not limited to, potential allergic reactions to such vaccines.

Section 3. 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 Tuck offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Subsections (7) and (8) of section 465.014, Florida Statutes, are renumbered as subsections (8) and (9), respectively, and a new subsection (7) is added to that section, to read:

465.014 Pharmacy technician.—

(7) A registered pharmacy technician seeking to administer vaccines under s. 465.189 must be certified to administer such vaccines pursuant to a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program

must have at least 6 hours of immunization-related training approved by the board that shall, at a minimum, have curriculum of instruction concerning the safe and effective administration of such vaccines, including, but not limited to, potential allergic reactions to such vaccines. As a condition of registration renewal, a registered pharmacy technician seeking to administer vaccines under s. 465.189 must have at least 2 hours of continuing education approved by the board in addition to the biennial continuing education required in subsection (6).

Section 2. Subsections (1), (4), (5), and (7) of section 465.189, Florida Statutes, are amended to read:

465.189 Administration of vaccines and epinephrine autoinjection.—

(1) In accordance with guidelines of the Centers for Disease Control and Prevention for each recommended immunization or vaccine, a pharmacist who is certified under subsection (7), or a registered intern or pharmacy technician under the supervision of such a pharmacist, ~~who is certified under subsection (7)~~ may administer the following immunizations or vaccines to an adult within the framework of an established protocol under a supervising physician licensed under chapter 458 or chapter 459:

(a) Immunizations or vaccines listed in the Adult Immunization Schedule as of March 31, 2022 ~~April 30, 2021~~, by the United States Centers for Disease Control and Prevention.

The board may authorize by rule additional immunizations or vaccines as they are added to the Adult Immunization Schedule.

(b) Immunizations or vaccines recommended by the United States Centers for Disease Control and Prevention for international travel as of March 31, 2022 ~~April 30, 2021~~. The board may authorize by rule additional immunizations or vaccines as they are recommended by the United States Centers for Disease Control and Prevention for international travel.

(c) Immunizations or vaccines licensed for use in the United States, or which have been authorized for emergency use, by the United States Food and Drug Administration as of March 31, 2022 ~~April 30, 2021~~. The board may authorize by rule additional immunizations or vaccines as they are so licensed or authorized.

(d) Immunizations or vaccines approved by the board in response to a state of emergency declared by the Governor pursuant to s. 252.36.

A registered intern who administers an immunization or vaccine under this subsection must be supervised by a certified pharmacist at a ratio of one pharmacist to one registered intern.

(4) A pharmacist may not enter into a protocol under a supervising physician licensed under chapter 458 or chapter 459 or administer an immunization or vaccine under this section

unless he or she maintains at least $200,000 of professional liability insurance and has completed training in administering vaccines authorized under this section.

(5) A pharmacist administering immunizations or vaccines under this section shall maintain and make available patient records using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057. These records shall be maintained for a minimum of 5 years.

(7) Any pharmacist, ~~or~~ registered intern, or registered pharmacy technician seeking to administer vaccines under this section must be certified to administer such vaccines pursuant to a certification program approved by the board ~~of Pharmacy~~ in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist attend at least 20 hours of continuing education classes approved by the board and the registered intern complete at least 20 hours of coursework approved by the board. The registered pharmacy technician shall have immunization-related training and continuing education as provided in s. 465.014. The certification programs ~~program~~ shall, at a minimum, have a curriculum of instruction concerning the safe and effective administration of such vaccines, including, but not limited to, potential allergic reactions to such vaccines.

Section 3. This act shall take effect July 1, 2022.

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

Remove everything before the enacting clause and insert:
An act relating to administration of vaccines; amending s. 456.014, F.S.; authorizing registered pharmacy technicians to administer specified vaccines under certain circumstances; providing requirements for registration renewal; amending s. 465.189, F.S.; authorizing certified pharmacists to administer specified vaccines under certain circumstances; revising the immunizations or vaccines that certified pharmacists, registered interns, and registered pharmacy technicians may administer; revising and providing continuing education requirements for registered pharmacy technicians; providing an effective date.

HB 1521

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1521 Professional Counselors Licensure Compact
**SPONSOR(S):** Koster
**TIED BILLS:** HB 1523 **IDEN./SIM. BILLS:** CS/SB 358

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Professions & Public Health Subcommittee | | Morris | McElroy |
| 2) Government Operations Subcommittee | | | |
| 3) Health Care Appropriations Subcommittee | | | |
| 4) 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 clinical social workers, marriage and family therapists, and mental health counselors, to use telehealth to provide services to out-of-state patients.

The Professional Counselors Licensure Compact (PCLC) is an interstate compact, which is an agreement between states to enact legislation and enter into a contract for a specific, limited purpose. In 2020, the National Center for Interstate Compacts adopted model legislation for the compact which authorizes both telehealth and in-person practice across state lines in compact 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. The compact becomes effective on the date of enactment by the tenth state and currently has two member states. HB 1521 enacts the PCLC and authorizes Florida to enter into the compact. The Department of Health must notify the Division of Law Revision when the compact is enacted into law by ten states.

Professional counselors licensed in compact states may apply to other compact states for the privilege to practice through either telehealth or in-person. Thus, under the compact a Florida licensed clinical social worker, marriage and family therapist, or mental health counselor is eligible to provide services to out-of-state patients through either telehealth or in-person. It also allows out-of-state licensed professional counselors in compact states to provide services to Florida patients through telehealth and in-person.

The compact requires all participating states to report certain licensure information to a data system, including identifying information, licensure data, and adverse actions taken against a professional counselor'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 data system as confidential, prohibiting disclosure to the public without express permission of the reporting state.

The bill has a significant, negative fiscal impact on DOH and no fiscal impact on local governments.

The bill is effective upon enactment of the Professional Counselors Licensure Compact into law by ten states.

## 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 mental health counselors by 2030, producing a shortage of approximately 6,870 mental health counselors nationwide.[5] In Florida, HRSA estimates a shortage of 3,400 mental health counselors 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]

Mental Health Counselor Licensure in Florida

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.[8] To qualify for licensure as a mental health counselor, 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. 30, 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. 30, 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. 30, 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. 30, 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. 30, 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] Sections 491.003(6) and (9), F.S.

[9] Section 491.005(4), F.S.

- 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.[10]

Telehealth

A Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[11] or a registered out-of-state-health care provider to provide health care services to Florida patients via telehealth.[12] 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.[13]

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 mental health counselors, to use telehealth to provide services to out-of-state patients.

Sovereign Immunity

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through an enactment of general law. [14]

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.[15] 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.

[10] Section 491.005(4), F.S., and r. 64B4-3.0035, F.A.C.
[11] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[12] S. 456.47(4), F.S.
[13] S. 456.47(2), F.S.
[14] Fla. Const. art. X, s. 13.
[15] Chapter 73-313, L.O.F., codified at s. 768.28, F.S.

Impaired Practitioner Program

The impaired practitioner treatment program was created to provide resources to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or both, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety.[16] For a profession that does not have a program established within its individual practice act, DOH is required to designate an approved program by rule.[17] 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.[18]

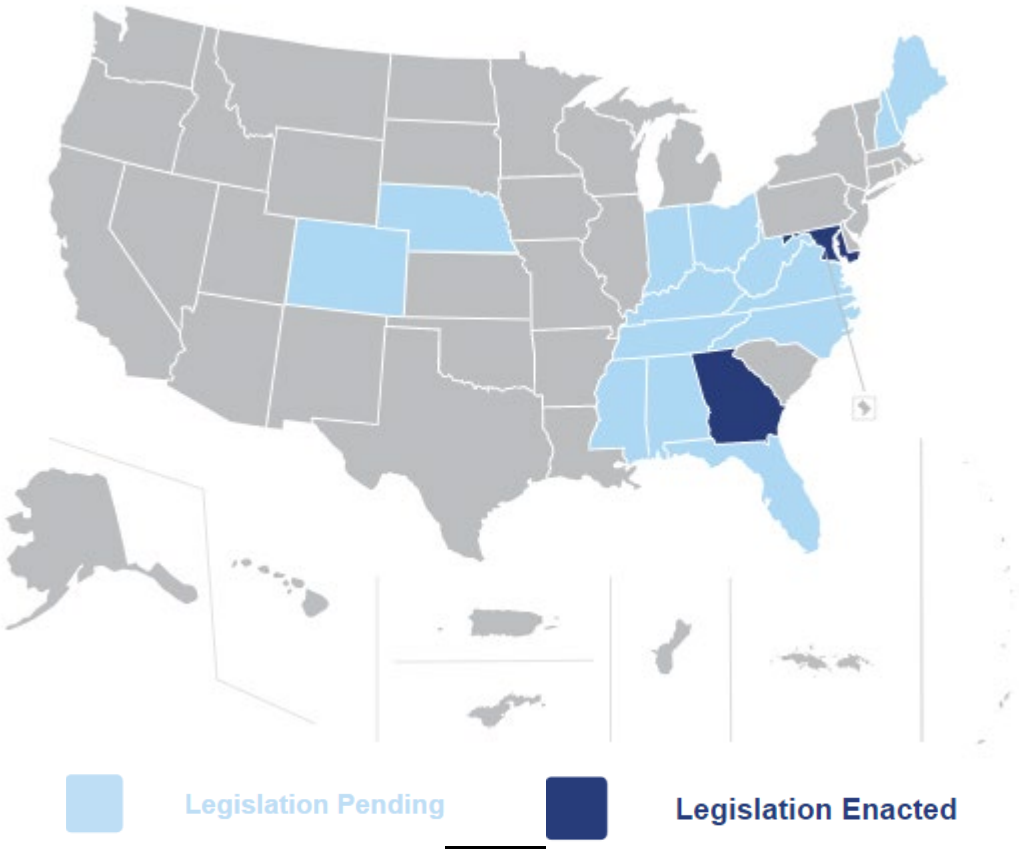
Interstate Compacts

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.[19] 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.[20] Florida is a party to multiple interstate compacts, including the Nurse Licensure Compact,[21] Driver's License Compact,[22] Compact on Adoption and Medical Assistance,[23] and the Interstate Compact on Educational Opportunity for Military Children.[24]

Professional Counselors Licensure Compact

The Professional Counselors Licensure Compact (PCLC) was created by the National Center for Interstate Compacts as an interstate compact which authorizes professional counselors to practice via telehealth and in-person across state lines in compact states.[25] The compact establishes the Counseling Compact Commission (Commission) made up of member states which is responsible for creating and finalizing rules and enforcing the compact. Licensed professional counselors must obtain the privilege to practice from other compact states in order to provide services to clients in such states.[26] Nothing in the compact is to be construed as a waiver of sovereign immunity. The PCLC currently has two member states (Georgia and Maryland).[27]

[16] 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.
[17] Section 456.076(1), F.S.
[18] Rule 64B31-10.001(1)(a), F.A.C.
[19] National Center for Interstate Compacts, *What Are Interstate Compacts?,* https://compacts.csg.org/compacts/ (last visited Jan. 30, 2022).
[20] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[21] Section 464.0095, F.S.
[22] Section 322.44, F.S.
[23] Section 409.406, F.S.
[24] Section 1000.36, F.S.
[25] Counseling Compact, *Counseling Compact Finalized,* https://counselingcompact.org/first-post/ (last visited Jan. 30, 2022).
[26] Counseling Compact, Counseling Compact Model Legislation (Dec. 2020), https://counselingcompact.org/wp-content/uploads/2021/06/Final_Counseling_Compact_With_Cover.pdf (last visited Jan. 30, 2022).
[27] Counseling Compact, *Map*, https://counselingcompact.org/map/ (last visited Jan. 30, 2022).




The compact is arranged in 15 sections and addresses the following issues:[28]

*Purpose (Section 1)*

The primary purposes of the PCLC are:

- Provide for the mutual recognition of other compact state licenses;
- Enhance states' abilities to protect the public's health and safety;
- Encourage the cooperation of member states in regulating multistate practice for licensed professional counselors;
- Support active duty military personnel and their spouses;
- Enhance the exchange of licensure, investigative, and disciplinary information among member states;
- Allow for the use of telehealth to increase access to counseling services;
- Support the uniformity of professional counseling licensure requirements throughout states;
- Eliminate the necessity for licenses in multiple states; and
- Facilitate interstate practice by licensed professional counselors who meet uniform requirements.

*Definitions (Section 2)*

The compact provides definitions for terms used in the model legislation.

[28] *Supra*, note 26.

*State Participation in the Compact (Section 3)*

To participate in the compact, a state must:

- License and regulate professional counselors;
- Require passage of a commission-approved, nationally recognized exam;
- Require licensees to meet specified educational and post graduate professional experience standards;
- Have a mechanism in place for receiving and investigating complaints;
- Participate in the Commission's data system;
- Notify the commission of any adverse action or the availability of investigative information regarding a licensee;
- Implement a process for considering the criminal history of applicants;
- Comply with the rules of the Commission;
- Require applicants to obtain or retain a license in his or her home state and meet the home state's qualifications for licensure or renewal of licensure; and
- Provide for the state's representative to the commission to attend the commission meetings.

Additionally, compact states are authorized to charge a fee for granting the privilege to practice. Licensed professional counselors may only utilize the compact if their home state joins the compact.

*Obtaining a New Home State License Based on a Privilege to Practice (Section 5)*

The PCLC requires a professional counselor to hold a home state license in only one compact state at a time. A licensee who moves from one compact state to another compact state may obtain a new, expedited home state license in the new state of residence if he or she holds a privilege to practice in the new state. A licensee must complete a new background screening, any required state-level background check, and any other requirements to obtain licensure in the new home state.

If a professional counselor moves from a non-compact state to a compact state, or from a compact state to a non-compact state, he or she must apply for licensure in the new state under such state's requirements. Licensees may hold more multiple state licenses, but only the license tied to his or her primary state of residence serves as the home state license under the compact.

*Active Duty Military Personnel or Their Spouses (Section 6)*

The PCLC allows an active duty service member or his or her spouse to designate a home state where he or she has a current license in good standing, which serves as the home state for the duration of the service member's active duty.

*Compact Privilege to Practice Telehealth (Section 7)*

The PCLC establishes providing telehealth services to patients in remote states as a privilege to practice. Professional counselors practicing via telehealth in a remote state must follow the laws and regulations of the remote state.

*Adverse Actions (Section 8)*

Only the home state has the power to take adverse action against a professional counselor's home state license. The compact authorizes remote states to take adverse actions against a licensed professional counselor's privilege to practice within that compact state and issue subpoenas for witnesses and evidence from other compact states. Under the compact, compact states are authorized to initiate joint investigations of licensees and must share investigative materials in furtherance of a joint investigation initiated under the compact. Adverse actions must be reported to the data system which alerts the home state of such action. Compact states are authorized to take adverse actions based on the factual findings of a remote state.

If a licensee changes his or her home state while under active investigation of the former home state, the former home state must complete the investigation, take appropriate action under its laws, and report its findings to the data system.

Nothing in the compact overrides a compact state's decision to require a licensee to participate in an alternative program in lieu of adverse action.

*Establishment of Counseling Compact Commission (Section 9)*

The compact establishes the Counseling Compact Commission. Each compact state has one delegate selected by that state's licensing board. The delegate must be a current member or an administrator of the licensing board. The Commission must establish term limits, a code of ethics, bylaws, rules, and a budget in order to carry out the compact. The Commission must elect an executive committee of up to 11 members, at least seven of which must be from the Commission and up to four must be ex-officio, nonvoting members from recognized national professional counselor organizations. All Commission meetings must be open to the public except for when the Commission must discuss:

- Noncompliance of a compact 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; and
- Matters specifically exempted from disclosure by federal law or the laws of any party state.

Commission members are immune from liability related to their positions except in cases of wanton misconduct.

*Data System (Section 10)*

The compact requires all compact states to share licensee information. Compact states must submit a uniform dataset to the data system on all counselors to whom the compact applies, as required by the rules of the Commission. The data system allows for expedited sharing of adverse action or significant investigative information against professional counselors with privilege to practice under the compact. Data system information must be expunged according to the laws of the reporting compact state.

*Rulemaking (Section 11)*

The PCLC provides rulemaking 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 30 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,

- 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;
- A state or federal governmental entity; or
- An association having at least 25 members.

If a hearing is held, the Commission must publish the place, time, and date of the 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. All hearings must be recorded and a copy of the recording must be made available upon request. 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.

*Oversight, Dispute Resolution, and Enforcement (Section 12)*

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 the compact, 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 District of Columbia or the federal district in which the compact's principal office is located. The compact's principal office is located in Lexington, Kentucky. 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.

*Date of Implementation of the Counseling Compact Commission and Associated Rules, Withdrawal, and Amendment (Section 13)*

The compact takes effect on the date of enactment by the tenth state. States that join after such date are subject to the rules of the Commission as they exist on the date when the compact becomes law in that state.

To withdraw from the PCLC, 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 (Section 14)*

This compact is to be liberally construed to effectuate its purposes. The PCLC 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.

*Binding Effect of Compact and Other Laws (Section 15)*

This section reiterates that licensees must adhere to the laws and regulations, including scope of practice, of the state in which they are practicing. The compact requires that all rules and bylaws of the Commission are binding on compact states. In the event of a conflict between a law of a compact state and the compact, the state law is superseded to the extent of the conflict.

## Effect of the Bill

### Professional Counselors Licensure Compact

HB 1521 enacts the Professional Counselors Licensure 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 clinical social workers, marriage and family therapists, and mental health counselors to provide services to out-of-state patients through either telehealth or in-person across compact states. It also allows out-of-state licensed professional counselors in compact states to provide services to Florida patients through telehealth and in-person.

The bill amends current law to allow compact implementation. It requires DOH to report any significant investigation information relating to a professional counselor's practicing under the compact to the data system. It requires counselors 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 Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling (Board) to appoint an individual to serve on the Commission and exempts out-of-state licensed clinical social workers, marriage and family therapists, and mental health counselors who practice under the compact from licensure requirements in this state. The bill authorizes the Board to take adverse action against a mental health counselor'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, is considered an agent of the state. The bill also requires the Commission to pay any claims or judgments up to the statutory waived amount of sovereign immunity and authorizes it to maintain insurance coverage to pay any such claims or judgements.

The bill is effective upon enactment of the Professional Counselors Licensure Compact into law by ten states

B. SECTION DIRECTORY:

**Section 1:** Creates s. 491.017, F.S., relating to Professional Counselors Licensure 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 programs.
**Section 4:** Amends s. 491.004, F.S., relating to Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.
**Section 5:** Amends s. 491.005, F.S., relating to licensure by examination.
**Section 6:** Amends s. 491.006, F.S., relating to licensure by endorsement.
**Section 7:** Amends s. 491.009, 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:** Requires DOH to notify the Division of Law Revision upon enactment of the Professional Counselors Licensure Compact into law by 10 states.
**Section 10:** Provides the bill shall take effect upon enactment of the Professional Counselors Licensure Compact into law by 10 states.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The compact allows states to collect fees for granting privilege to practice under the compact. If DOH chooses to collects such fees, a fee bill is needed.

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, and $306/Human Resources).[29]

   DOH may also experience an increase in cost related to annual membership with the PCLC, additional complaints and investigations, rulemaking, and updating licensure systems, which can be absorbed within current resources.[30]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

[29] Department of Health Agency Analysis of 2022 House Bill 1521 (Jan. 25, 2022).
[30] Id.

Applicants for the Florida Interstate Licensed Professional Counselors compact will be required to pay a fee to participate in the compact, as well as incurring cost for a background check.[31]

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.[32][33] Under this holding, the constitutionality of the bill's 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).[34] 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."[35] 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.[36] 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.*

[31] Id.
[32] *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).
[33] 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).
[34] 801 So.2d 1047 (Fla. 1st DCA 2001).
[35] Id at 1052.
[36] Id.

*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.[37]

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.[38]

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.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill includes mental health counselors licensed under ch. 491, F.S., as licensed professional counselors. The model compact legislation does not contain this language and the compact requires states to adopt the model langue in its entirety in order to utilize the compact. Additionally, this language excludes clinical social workers and marriage and family therapists, who are also licensed under ch. 491, F.S., from the privilege to practice under the compact.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

[37] Id.

[38] 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).

A bill to be entitled

An act relating to Professional Counselors Licensure Compact; creating s. 491.017, F.S.; creating the Professional Counselors Licensure Compact; providing purposes and objectives; defining terms; specifying requirements for state participation in the compact; specifying duties of member states; specifying that the compact does not affect an individual's ability to apply for, and a member state's ability to grant, a single state license pursuant to the laws of that state; providing construction; providing for recognition of the privilege to practice licensed professional counseling in member states; specifying criteria a licensed professional counselor must meet for the privilege to practice under the compact; providing for the expiration and renewal of the privilege to practice; providing construction; specifying that a licensee with a privilege to practice in a remote state must adhere to the laws and rules of that state; authorizing member states to act on a licensee's privilege to practice under certain circumstances; specifying the consequences and parameters of practice for a licensee whose privilege to practice has been acted on or whose home state license is encumbered; specifying that a licensed

professional counselor may hold a home state license in only one member state at a time; specifying requirements and procedures for changing a home state license designation; providing construction; authorizing active duty military personnel or their spouses to keep their home state designation during active duty; specifying how such individuals may subsequently change their home state license designation; providing for the recognition of the practice of professional counseling through telehealth in member states; specifying that licensees must adhere to the laws and rules of the remote state in which they provide professional counseling through telehealth; authorizing member states to take adverse actions against licensees and issue subpoenas for hearings and investigations under certain circumstances; providing requirements and procedures for adverse action; authorizing member states to engage in joint investigations under certain circumstances; providing that a licensee's privilege to practice must be deactivated in all member states for the duration of an encumbrance imposed by the licensee's home state; providing for notice to the data system and the licensee's home state of any adverse action taken against a licensee; providing

construction; establishing the Counseling Compact Commission; providing for the jurisdiction and venue for court proceedings; providing construction; providing for membership, meetings, and powers of the commission; specifying powers and duties of the commission's executive committee; providing for the financing of the commission; providing commission members, officers, executive directors, employees, and representatives immunity from civil liability under certain circumstances; providing exceptions; requiring the commission to defend the commission's members, officers, executive directors, employees, and representative in civil actions under certain circumstances; providing construction; requiring the commission to indemnify and hold harmless such individuals for any settlement or judgment obtained in such actions under certain circumstances; providing for the development of the data system, reporting procedures, and the exchange of specified information between member states; requiring the commission to notify member states of any adverse action taken against a licensee or applicant for licensure; authorizing member states to designate as confidential information provided to the data system; requiring the commission to remove information from the data system

under certain circumstances; providing rulemaking procedures for the commission; providing for member state enforcement of the compact; specifying that the compact and commission rules have standing as statutory law in member states; specifying that the commission is entitled to receive notice of process, and has standing to intervene, in certain judicial and administrative proceedings; rendering certain judgments and orders void as to the commission, the compact, or commission rules under certain circumstances; providing for defaults and termination of compact membership; providing procedures for the resolution of certain disputes; providing for commission enforcement of the compact; providing for remedies; providing construction; providing for implementation of, withdrawal from, and amendment to the compact; providing construction; specifying that licensees practicing in a remote state under the compact must adhere to the laws and rules of the remote state; providing construction; specifying that the compact, commission rules, and commission actions are binding on member states; providing construction and severability; amending s. 456.073, F.S.; requiring the Department of Health to report certain investigative information to the data system; amending

s. 456.076, F.S.; requiring monitoring contracts for impaired practitioners participating in treatment programs to contain certain terms; amending s. 491.004, F.S.; requiring the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling to appoint an individual to serve as the state's delegate on the commission; amending ss. 491.005 and 491.006, F.S.; exempting certain persons from licensure requirements; amending s. 491.009, F.S.; authorizing certain disciplinary action under the compact for specified prohibited acts; amending s. 768.28, F.S.; designating the state delegate and other members or employees of the commission as state agents for the purpose of applying waivers of sovereign immunity; requiring the commission to pay certain claims or judgments; authorizing the commission to maintain insurance coverage to pay such claims or judgments; requiring the department to notify the Division of Law Revision upon enactment of the compact into law by 10 states; providing a contingent effective date.

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

Section 1. Section 491.017, Florida Statutes, is created



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

to read:

491.017 Professional Counselors Licensure Compact.—The Professional Counselors Licensure Compact is hereby enacted and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

ARTICLE I

PURPOSE

The compact is designed to achieve the following purposes and objectives:

(1) Facilitate interstate practice of licensed professional counseling to increase public access to professional counseling services by providing for the mutual recognition of other member state licenses.

(2) Enhance the member states' ability to protect the public's health and safety.

(3) Encourage the cooperation of member states in regulating multistate practice of licensed professional counselors.

(4) Support spouses of relocating active duty military personnel.

(5) Facilitate the exchange of information between member states regarding licensure, investigations, adverse actions, and disciplinary history of licensed professional counselors.

(6) Allow for the use of telehealth technology to

facilitate increased access to professional counseling services.

(7) Support the uniformity of professional counseling licensure requirements throughout member states to promote public safety and public health benefits.

(8) Provide member states with the authority to hold a licensed professional counselor accountable for meeting all state practice laws in the state in which the client is located at the time care is rendered through the mutual recognition of member state licenses.

(9) Eliminate the necessity for licensed professional counselors to hold licenses in multiple states and provide opportunities for interstate practice by licensed professional counselors who meet uniform licensure requirements.

ARTICLE II

DEFINITIONS

As used in this compact, the term:

(1) "Active duty military" means full-time duty status in the active uniformed service of the United States, including, but not limited to, members of the National Guard and Reserve on active duty orders pursuant to 10 U.S.C. chapters 1209 and 1211.

(2) "Adverse action" means any administrative, civil, or criminal action authorized by a state's laws which is imposed by a licensing board or other authority against a licensed professional counselor, including actions against an

individual's license or privilege to practice, such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, issuance of a cease and desist action, or any other encumbrance on licensure affecting a licensed professional counselor's authorization to practice.

(3) "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a professional counseling licensing board to address impaired practitioners.

(4) "Continuing education" means a requirement, as a condition of license renewal, to participate in or complete educational and professional activities relevant to the licensee's practice or area of work.

(5) "Counseling Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact.

(6) "Current significant investigative information" means:

(a) Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the licensed professional counselor to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

(b) Investigative information that indicates that the licensed professional counselor represents an immediate threat

to public health and safety, regardless of whether the licensed professional counselor has been notified and had an opportunity to respond.

(7) "Data system" means a repository of information about licensees, including, but not limited to, information relating to continuing education, examinations, licensure statuses, investigations, the privilege to practice, and adverse actions.

(8) "Encumbered license" means a license in which an adverse action restricts the practice of licensed professional counseling by the licensee and said adverse action has been reported to the National Practitioner Data Bank.

(9) "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of licensed professional counseling by a licensing board.

(10) "Executive committee" means a group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the commission.

(11) "Home state" means the member state that is the licensee's primary state of residence.

(12) "Impaired practitioner" means an individual who has a condition that may impair his or her ability to safely practice as a licensed professional counselor without intervention. Such impairment may include, but is not limited to, alcohol or drug dependence, mental health conditions, and neurological or physical conditions.

(13) "Investigative information" means information, records, or documents received or generated by a professional counseling licensing board pursuant to an investigation.

(14) "Jurisprudence requirement," if required by a member state, means the assessment of an individual's knowledge of the laws and rules governing the practice of professional counseling in a state.

(15) "Licensed professional counselor" means a mental health counselor licensed under chapter 491 or a counselor licensed by a member state, regardless of the title used by that state, to independently assess, diagnose, and treat behavioral health conditions.

(16) "Licensee" means an individual who currently holds an authorization from the state to practice as a licensed professional counselor.

(17) "Licensing board" means the agency of a state, or equivalent, that is responsible for the licensing and regulation of licensed professional counselors.

(18) "Member state" means a state that has enacted the compact.

(19) "Privilege to practice" means a legal authorization, which is equivalent to a license, authorizing the practice of professional counseling in a remote state.

(20) "Professional counseling" means the assessment, diagnosis, and treatment of behavioral health conditions by a

licensed professional counselor.

(21) "Remote state" means a member state, other than the home state, where a licensee is exercising or seeking to exercise the privilege to practice.

(22) "Rule" means a regulation adopted by the commission which has the force of law.

(23) "Single state license" means a licensed professional counselor license issued by a member state which authorizes practice only within the issuing state and does not include a privilege to practice in any other member state.

(24) "State" means any state, commonwealth, district, or territory of the United States of America which regulates the practice of professional counseling.

(25) "Telehealth" means the application of telecommunication technology to deliver professional counseling services remotely to assess, diagnose, and treat behavioral health conditions.

(26) "Unencumbered license" means a license that authorizes a licensed professional counselor to engage in the full and unrestricted practice of professional counseling.

ARTICLE III

STATE PARTICIPATION

(1) To participate in the compact, a state must currently do all of the following:

(a) License and regulate licensed professional counselors.

(b) Require licensees to pass a nationally recognized exam approved by the commission.

(c) Require licensees to have a 60 semester hour, or 90 quarter hour, master's degree in counseling or 60 semester hours, or 90 quarter hours, of graduate coursework including all of the following topic areas:

1. Professional counseling orientation and ethical practice.

2. Social and cultural diversity.

3. Human growth and development.

4. Career development.

5. Counseling and helping relationships.

6. Group counseling and group work.

7. Diagnosis, assessment, testing, and treatment.

8. Research and program evaluation.

9. Other areas as determined by the commission.

(d) Require licensees to complete a supervised postgraduate professional experience as defined by the commission.

(e) Have a mechanism in place for receiving and investigating complaints about licensees.

(2) A member state shall do all of the following:

(a) Participate fully in the commission's data system, including using the commission's unique identifier as defined in

rules adopted by the commission.

(b) Notify the commission, in compliance with the terms of the compact and rules adopted by the commission, of any adverse action or the availability of investigative information regarding a licensee.

(c) Implement or utilize procedures for considering the criminal history records of applicants for an initial privilege to practice. These procedures must include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

1. A member state must fully implement a criminal background check requirement, within a timeframe established by rule, by receiving the results of the Federal Bureau of Investigation record search and shall use the results in making licensure decisions.

2. Communication between a member state and the commission and among member states regarding the verification of eligibility for licensure through the compact may not include any information received from the Federal Bureau of Investigation relating to a federal criminal records check performed by a member state under Public Law 92-544.

(d) Comply with the rules adopted by the commission.

(e) Require an applicant to obtain or retain a license in the home state and meet the home state's qualifications for licensure or renewal of licensure, as well as all other applicable state laws.

(f) Grant the privilege to practice to a licensee holding a valid unencumbered license in another member state in accordance with the terms of the compact and rules adopted by the commission.

(g) Provide for the attendance of the state's commissioner at the commission meetings.

(3) Individuals not residing in a member state may continue to apply for a member state's single state license as provided under the laws of each member state. However, the single state license granted to these individuals may not be recognized as granting a privilege to practice professional counseling under the compact in any other member state.

(4) Nothing in this compact affects the requirements established by a member state for the issuance of a single state license.

(5) A professional counselor license issued by a home state to a resident of that state must be recognized by each member state as authorizing that licensed professional counselor to practice professional counseling, under a privilege to practice, in each member state.

ARTICLE IV

PRIVILEGE TO PRACTICE

(1) To exercise the privilege to practice under the terms and provisions of the compact, the licensee must meet all of the following criteria:

(a) Hold a license in the home state.

(b) Have a valid United States Social Security Number or national provider identifier.

(c) Be eligible for a privilege to practice in any member state in accordance with subsections (4), (7), and (8).

(d) Have not had any encumbrance or restriction against any license or privilege to practice within the preceding 2 years.

(e) Notify the commission that the licensee is seeking the privilege to practice within a remote state.

(f) Meet any continuing education requirements established by the home state.

(g) Meet any jurisprudence requirements established by the remote state in which the licensee is seeking a privilege to practice.

(h) Report to the commission any adverse action, encumbrance, or restriction on a license taken by any nonmember state within 30 days after the action is taken.

(2) The privilege to practice is valid until the expiration date of the home state license. The licensee must

continue to meet the criteria specified in subsection (1) to renew the privilege to practice in the remote state.

(3) For purposes of the compact, the practice of professional counseling occurs in the state where the client is located at the time of the counseling services. The compact does not affect the regulatory authority of states to protect public health and safety through their own system of state licensure.

(4) A licensee providing professional counseling in a remote state under the privilege to practice must adhere to the laws and regulations of the remote state.

(5) A licensee providing professional counseling services in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, remove a licensee's privilege to practice in the remote state for a specified period of time, impose fines, or take any other action necessary to protect the health and safety of its residents. The licensee may be ineligible for a privilege to practice in any member state until the specific time for removal has passed and all fines are paid.

(6) If a home state license is encumbered, a licensee loses the privilege to practice in any remote state until both of the following conditions are met:

(a) The home state license is no longer encumbered.

(b) The licensee has not had any encumbrance or restriction against any license or privilege to practice within

the preceding 2 years.

(7) Once an encumbered license in the licensee's home state is restored to good standing, the licensee may obtain a privilege to practice in any remote state if he or she meets the requirements of subsection (1).

(8) If a licensee's privilege to practice in any remote state is removed, the individual may lose the privilege to practice in all other remote states until all of the following conditions are met:

(a) The specified period of time for which the privilege to practice was removed has ended.

(b) The licensee has paid all fines imposed.

(c) The licensee has not had any encumbrance or restriction against any license or privilege to practice within the preceding 2 years.

(9) Once the requirements of subsection (8) have been met, the licensee may obtain a privilege to practice in a remote state if he or she meets the requirements in subsection (1).

ARTICLE V

OBTAINING A NEW HOME STATE LICENSE BASED ON A PRIVILEGE TO PRACTICE

(1) A licensed professional counselor may hold a home state license, which allows for a privilege to practice in other member states, in only one member state at a time.

(2) If a licensed professional counselor changes his or her primary state of residence by moving between two member states, then the licensed professional counselor must file an application for obtaining a new home state license based on a privilege to practice and notify the current and new home state in accordance with applicable rules adopted by the commission.

(3) Upon receipt of an application for obtaining a new home state license based on a privilege to practice, the new home state must verify that the licensed professional counselor meets the criteria outlined in article IV through the data system. The new home state does not need to seek primary source verification for information obtained from the data system, except for the following:

(a) A Federal Bureau of Investigation fingerprint-based criminal background check, if not previously performed or updated pursuant to applicable rules adopted by the commission in accordance with Public Law 92-544;

(b) Any other criminal background check as required by the new home state; and

(c) Proof of completion of any requisite jurisprudence requirements of the new home state.

(4) The former home state shall convert the former home state license into a privilege to practice once the new home state has activated the new home state license in accordance with applicable rules adopted by the commission.

(5) Notwithstanding any other provision of the compact, if the licensed professional counselor does not meet the criteria in article IV, the new home state may apply its own requirements for issuing a new single state license.

(6) If a licensed professional counselor changes his or her primary state of residence by moving from a member state to a nonmember state or from a nonmember state to a member state, the new state's own criteria apply for issuance of a single state license in the new state.

(7) The compact does not interfere with a licensee's ability to hold a single state license in multiple states. However, for the purposes of the compact, a licensee may have only one home state license.

(8) The compact does not affect the requirements established by a member state for the issuance of a single state license.

ARTICLE VI

ACTIVE DUTY MILITARY PERSONNEL AND THEIR SPOUSES

Active duty military personnel, or their spouse, shall designate a home state where the individual has a current license in good standing. The individual may retain the home state license designation during the period the service member is on active duty. Subsequent to designating a home state, the individual may change his or her home state only through

application for licensure in the new state or through the process outlined in article V.

ARTICLE VII

COMPACT PRIVILEGE TO PRACTICE TELEHEALTH

(1) Member states shall recognize the right of a licensed professional counselor, licensed by a home state in accordance with article III and under rules adopted by the commission, to practice professional counseling in any member state through telehealth under a privilege to practice as provided in the compact and rules adopted by the commission.

(2) A licensee providing professional counseling services in a remote state through telehealth under the privilege to practice must adhere to the laws and rules of the remote state.

ARTICLE VIII

ADVERSE ACTIONS

(1) In addition to the other powers conferred by state law, a remote state has the authority, in accordance with existing state due process law, to do any of the following:

(a) Take adverse action against a licensed professional counselor's privilege to practice within that member state.

(b) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses or the production of evidence. Subpoenas issued by a licensing board in

a member state for the attendance and testimony of witnesses or the production of evidence from another member state must be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state in which the witnesses or evidence is located.

(2) Only the home state has the power to take adverse action against a licensed professional counselor's license issued by the home state.

(3) For purposes of taking adverse action, the home state shall give the same priority and effect to reported conduct received from a member state as it would if the conduct had occurred within the home state. The home state shall apply its own state laws to determine appropriate action in such cases.

(4) The home state shall complete any pending investigations of a licensed professional counselor who changes primary state of residence during the course of the investigations. The home state may also take appropriate action and shall promptly report the conclusions of the investigations to the administrator of the data system. The administrator of the data system shall promptly notify the new home state of any adverse actions.

(5) A member state, if authorized by state law, may recover from the affected licensed professional counselor the costs of investigations and dispositions of any cases resulting from adverse action taken against that licensed professional counselor.

(6) A member state may take adverse action against a licensed professional counselor based on the factual findings of a remote state, provided that the member state follows its own statutory procedures for taking adverse action.

(7)(a) In addition to the authority granted to a member state by its respective professional counseling practice act or other applicable state law, any member state may participate with other member states in joint investigations of licensees.

(b) Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact.

(8) If adverse action is taken by the home state against the license of a professional counselor, the licensed professional counselor's privilege to practice in all other member states must be deactivated until all encumbrances have been removed from the home state license. All home state disciplinary orders that impose adverse action against the license of a professional counselor must include a statement that the licensed professional counselor's privilege to practice is deactivated in all member states while the order is in

effect.

(9) If a member state takes adverse action, it must promptly notify the administrator of the data system. The administrator shall promptly notify the licensee's home state of any adverse actions by remote states.

(10) Nothing in the compact overrides a member state's decision to allow a licensed professional counselor to participate in an alternative program in lieu of adverse action.

ARTICLE IX

ESTABLISHMENT OF COUNSELING COMPACT COMMISSION

(1) COMMISSION CREATED.—The compact member states hereby create and establish a joint public agency known as the Counseling Compact Commission.

(a) The commission is 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 the compact may be construed to be a waiver of sovereign immunity.

(2) MEMBERSHIP.—

(a) The commission shall consist of one voting delegate, appointed by each member state's licensing board. The commission, by rule, shall establish a term of office for delegates and may establish term limits.

(b) The delegate must be either:

1. A current member of the licensing board at the time of appointment, who is a licensed professional counselor or public member; or

2. An administrator of the licensing board.

(c) A delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed.

(d) The member state licensing board must fill any vacancy occurring on the commission within 60 days.

(e) Each delegate is entitled to one vote with regard to the adoption of rules and creation of bylaws and shall otherwise participate in the business and affairs of the commission.

(f) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

(3) MEETINGS OF THE COMMISSION.—

(a) The commission shall meet at least once during each calendar year. Additional meetings must be held as set forth in the bylaws.

(b) All meetings must be open to the public, and public notice of meetings must be given in the same manner as required under the rulemaking provisions in article XI.

(c) The commission or the executive committee or other committees of the commission may convene in a closed, nonpublic meeting if the commission or executive committee or other committees of the commission must discuss any of the following:

1. Noncompliance of a member state with its obligations under the compact.

2. The employment, compensation, discipline, or other 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.

4. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.

5. Accusing any person of a crime or formally censuring any person.

6. Disclosure of trade secrets or commercial or financial information that is privileged or confidential.

7. Disclosure of information of a personal nature if disclosure would constitute a clearly unwarranted invasion of personal privacy.

8. Disclosure of investigative records compiled for law

enforcement purposes.

9. Disclosure of information related to any investigative reports prepared by or on behalf of or for use of the commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the compact.

10. Matters specifically exempted from disclosure by federal or member state law.

(d) If a meeting, or portion of a meeting, is closed under this subsection, the commission's legal counsel or designee must certify that the meeting may be closed and must reference each relevant exempting provision.

(e) 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, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action must be identified in such minutes. All minutes and documents of a closed meeting must remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

(4) POWERS.—The commission may do any of the following:

(a) Establish the fiscal year of the commission.

(b) Establish bylaws.

(c) Maintain its financial records in accordance with the bylaws.

(d) Meet and take actions that are consistent with the compact and bylaws.

(e) Adopt rules that are binding to the extent and in the manner provided for in the compact.

(f) Initiate and prosecute legal proceedings or actions in the name of the commission, provided that the standing of any state licensing board to sue or be sued under applicable law is not affected.

(g) Purchase and maintain insurance and bonds.

(h) Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state.

(i) Hire employees and elect or appoint officers; fix compensation for, define duties of, and grant appropriate authority to such employees and officers 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.

(j) Accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services, and receive, utilize, and dispose of the same, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(k) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use, any property, real,

personal, or mixed, provided that at all times the commission avoids any appearance of impropriety or conflict of interest.

(l) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(m) Establish a budget and make expenditures.

(n) Borrow money.

(o) Appoint committees, including standing 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 the compact and bylaws.

(p) Provide information to, receive information from, and cooperate with law enforcement agencies.

(q) Establish and elect an executive committee.

(r) Perform any other function that may be necessary or appropriate to achieve the purposes of the compact and is consistent with the state regulation of professional counseling licensure and practice.

(5) THE EXECUTIVE COMMITTEE.—

(a) The executive committee may act on behalf of the commission according to the terms of the compact and shall consist of up to 11 members, as follows:

1. Seven voting members who are elected by the commission from the current membership of the commission.

2. Up to four ex officio, nonvoting members from four recognized national professional counselor organizations. The ex officio members shall be selected by their respective organizations.

(b) The commission may remove any member of the executive committee as provided in its bylaws.

(c) The executive committee shall meet at least annually.

(d) The executive committee shall do all of the following:

1. Make recommendations to the commission for any changes to the rules, bylaws, or compact legislation.

2. Ensure compact administration services are appropriately provided, contractually 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.

7. Perform any other duties provided for in the rules or bylaws.

(6) FINANCING OF THE COMMISSION.—

(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 appropriate revenue sources, donations, or grants of money, equipment, supplies,

materials, or services.

(c) The commission may not incur obligations of any kind before securing the funds adequate to meet the same; nor may the commission pledge the credit of any of the member states, except by and with the authority of the member state.

(d) The commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the commission are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission must be audited annually by a certified or licensed public accountant, and the report of the audit must 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 are 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. This paragraph may not 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, 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 the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct. This paragraph may not be construed to prohibit that person from retaining his or her own counsel.

(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, 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 X

DATA SYSTEM

(1) The commission shall provide for the development, operation, and maintenance of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed professional counselors in member states.

(2) Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the data system on all licensees to whom the compact is applicable, as required by the rules of the commission, including all of the following:

(a) Identifying information.

(b) Licensure data.

(c) Adverse actions against a license or privilege to practice.

(d) Nonconfidential information related to alternative program participation.

(e) Any denial of application for licensure and the reason for such denial.

(f) Current significant investigative information.

(g) Other information that may facilitate the administration of the compact, as determined by the rules of the commission.

(3) Investigative information pertaining to a licensee in any member state may be made available only to other member states.

(4) The commission shall promptly notify all member states of any adverse action taken against a licensee or an individual applying for a license. Adverse action information pertaining to a licensee in any member state must be made available to any other member state.

(5) Member states reporting information to the data system may designate information that may not be shared with the public without the express permission of the reporting state.

(6) Any information submitted to the data system which is subsequently required to be expunged by the laws of the member state reporting the information must be removed from the data system.

ARTICLE XI

RULEMAKING

(1) The commission shall adopt reasonable rules to effectively and efficiently achieve the purposes of the compact. If, however, the commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the compact, or the powers granted hereunder, then such an action by the commission is invalid and has no force or effect.

(2) 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.

(3) If a majority of the legislatures of the member states rejects a rule by enactment of a statute or resolution in the same manner used to adopt the compact within 4 years after the date of adoption of the rule, such rule does not have further force and effect in any member state.

(4) Rules or amendments to the rules must be adopted at a regular or special meeting of the commission.

(5) Before adoption of a final rule by the commission, and at least 30 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 or other publicly accessible platform; and

(b) On the website of each member state's professional counseling licensing board or other publicly accessible platform or in the publication in which each state would otherwise publish proposed rules.

(6) The notice of proposed rulemaking must 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.

(7) Before adoption of a proposed rule, the commission must allow persons to submit written data, facts, opinions, and arguments, which must be made available to the public.

(8) The commission shall grant an opportunity for a public hearing before it adopts a rule or an amendment if a hearing is requested by:

(a) At least 25 persons who submit comments independently of each other;

(b) A state or federal governmental subdivision or agency; or

(c) An association that has at least 25 members.

(9) If a hearing is held on the proposed rule or amendment, the commission must publish the place, time, and date of the scheduled public hearing. If the hearing is held through electronic means, the commission must publish the mechanism for access to the electronic hearing.

(a) All persons wishing to be heard at the hearing must 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 must be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity

to comment orally or in writing.

(c) All hearings must be recorded. A copy of the recording must be made available on request.

(d) This section may not be construed to require a separate hearing on each rule. Rules may be grouped at hearings required by this section for the convenience of the commission.

(10) If the commission does not receive a written notice of intent to attend the public hearing by interested parties, the commission may proceed with adoption of the proposed rule without a public hearing.

(11) 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.

(12) The commission, by majority vote of all members, shall 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.

(13) 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 are retroactively applied to the rule as soon as reasonably possible, but no later than 90 days after the effective date of the rule. For 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 member state funds;

(c) Meet a deadline for the adoption of an administrative rule established by federal law or rule; or

(d) Protect public health and safety.

(14) 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 revision must be posted on the website of the commission. Revisions are subject to challenge by any person for a period of 30 days after posting. A revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must 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 takes effect without further action. If a 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 member state shall enforce the compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The compact and the rules adopted thereunder 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 member state pertaining to the subject matter of the compact which may affect the powers, responsibilities, or actions of the commission.

(c) The commission is entitled to receive service of process in any judicial or administrative proceeding specified in paragraph (b) and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the commission renders a judgment or an order void as to the commission, the compact, or adopted rules.

(2) DEFAULT, TECHNICAL ASSISTANCE, AND TERMINATION.—

(a) If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact or adopted rules, the commission must:

1. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed

means of curing 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 cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states, and all rights, privileges, and benefits conferred by the compact are terminated on the effective date of termination. A cure 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 may 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 member state to that state's governor, to the majority and minority leaders of that state's legislature, and to each member state.

(d) A member 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 related to a member state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the commission and the defaulting member state.

(f) The defaulting member state may appeal the action of the commission by petitioning the United States District Court for the District of Columbia or the federal district where the commission has its principal offices. The prevailing party must be awarded all costs of such litigation, including reasonable attorney fees.

(3) DISPUTE RESOLUTION.—

(a) Upon request by a member state, the commission shall attempt to resolve disputes related to the compact which arise among member states and between member and nonmember states.

(b) The commission shall adopt rules providing for both mediation and binding dispute resolution for disputes as appropriate.

(4) ENFORCEMENT.—

(a) The commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the compact.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices against a member state in default to enforce compliance with the compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. If judicial enforcement is necessary, the prevailing party must be awarded all costs of such litigation, including

reasonable attorney fees.

(c) The remedies under this article are not the exclusive remedies to the commission. The commission may pursue any other remedies available under federal or state law.

ARTICLE XIII

DATE OF IMPLEMENTATION OF THE COUNSELING COMPACT COMMISSION AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

(1) The compact becomes effective on the date on which the compact is enacted into law in the 10th member state. The provisions that become effective at that time are limited to the powers granted to the commission relating to assembly and the adoption of rules. Thereafter, the commission shall meet and exercise rulemaking powers necessary for implementation and administration of the compact.

(2) Any state that joins the compact subsequent to the commission's initial adoption of the rules is 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 has the full force and effect of law on the day the compact becomes law in that state.

(3) Any member state may withdraw from the compact by enacting a statute repealing the compact.

(a) A member 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 professional counseling licensing board to comply with the investigative and adverse action reporting requirements of the compact before the effective date of withdrawal.

(4) The compact may not be construed to invalidate or prevent any professional counseling licensure agreement or other cooperative arrangement between a member state and a nonmember state which does not conflict with the compact.

(5) The compact may be amended by the member states. An amendment to the compact is not effective and binding upon any member state until it is enacted into the laws of all member states.

ARTICLE XIV

BINDING EFFECT OF COMPACT AND OTHER LAWS

(1) A licensee providing professional counseling services in a remote state under the privilege to practice shall adhere to the laws and regulations, including scope of practice, of the remote state.

(2) The compact does not prevent the enforcement of any other law of a member state which is not inconsistent with the compact.

(3) Any laws in a member state which conflict with the compact are superseded to the extent of the conflict.

(4) Any lawful actions of the commission, including all rules and bylaws properly adopted by the commission, are binding on the member states.

(5) All permissible agreements between the commission and the member states are binding in accordance with their terms.

(6) If any provision of the compact exceeds the constitutional limits imposed on the legislature of any member state, the provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

ARTICLE XV

CONSTRUCTION AND SEVERABILITY

The compact must be liberally construed so as to effectuate the purposes thereof. The provisions of the compact are severable, and if any phrase, clause, sentence, or provision of the compact is declared to be contrary to the constitution of any member state or of the United States or the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of the compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If the compact is held contrary to the constitution of any member state, the compact remains in full force and effect as to the remaining member states and in full force and effect as to the member state

affected as to all severable matters.

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 health care practitioner practicing under the Professional Counselors Licensure Compact to the data system pursuant to s. 491.017. 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 health care practitioner practicing under the Professional Counselors Licensure Compact pursuant to s. 491.017, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact.

Section 4. Subsection (8) is added to section 491.004, Florida Statutes, to read:

491.004 Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.—

(8) The board shall appoint an individual to serve as the state's delegate on the Counseling Compact Commission, as required under s. 491.017.

Section 5. Subsection (6) is added to section 491.005, Florida Statutes, to read:

491.005 Licensure by examination.—

(6) EXEMPTION.—A person licensed as a clinical social worker, marriage and family therapist, or mental health counselor in another state who is practicing under the Professional Counselors Licensure Compact pursuant to s. 491.017, and only within the scope provided therein, is exempt from the licensure requirements of this section, as applicable.

Section 6. Subsection (3) is added to section 491.006, Florida Statutes, to read:

491.006 Licensure or certification by endorsement.—

(3) A person licensed as a clinical social worker,

marriage and family therapist, or mental health counselor in another state who is practicing under the Professional Counselors Licensure Compact pursuant to s. 491.017, and only within the scope provided therein, is exempt from the licensure requirements of this section, as applicable.

Section 7. Section 491.009, Florida Statutes, is amended to read:

491.009 Discipline.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2) or s. 491.017:

(a) Attempting to obtain, obtaining, or renewing a license, registration, or certificate under this chapter by bribery or fraudulent misrepresentation or through an error of the board or the department.

(b) Having a license, registration, or certificate 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 of, regardless of adjudication, or having entered a plea of nolo contendere to, 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. However, in the case of a plea of nolo contendere, the board shall allow the person who is the subject of the

disciplinary proceeding to present evidence in mitigation 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, licensee, registered intern, or certificateholder knows, or has reason to believe, is in violation of this chapter or of a rule of the department or the board.

(g) Knowingly aiding, assisting, procuring, or advising any nonlicensed, nonregistered, or noncertified person to hold himself or herself out as licensed, registered, or certified under this chapter.

(h) Failing to perform any statutory or legal obligation placed upon a person licensed, registered, or certified 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, registered, or certified 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 pursuant to s. 491.0111.

(l) Making misleading, deceptive, untrue, or fraudulent representations in the practice of any profession licensed, registered, or certified 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 tests, reports, or documents in the possession or under the control of the licensee, registered intern, or certificateholder 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 or the board concerning any investigation by the department or the board, or failing to make available any relevant records with respect to any investigation about the licensee's, registered intern's, or certificateholder's conduct or background.

(p) Being unable to practice the profession for which he or she is licensed, registered, or certified 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, registered intern, or certificateholder is unable to practice the profession because of the reasons stated in this paragraph, the department shall have the authority to compel a licensee, registered intern, or certificateholder to submit to a mental or physical examination by psychologists, physicians, or other licensees under this chapter, designated by the department or board. If the licensee, registered intern, or certificateholder refuses to comply with such order, the department's order directing the examination may be enforced by filing a petition for enforcement in the circuit court in the

circuit in which the licensee, registered intern, or certificateholder resides or does business. The licensee, registered intern, or certificateholder against whom the petition is filed may ~~shall~~ not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee, registered intern, or certificateholder affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that he or she can resume the competent practice for which he or she is licensed, registered, or certified 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, registered intern, or certificateholder is not qualified by training or experience.

(s) Delegating professional responsibilities to a person whom the licensee, registered intern, or certificateholder 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 or the board previously entered in a disciplinary hearing.

(u) Failure of the licensee, registered intern, or certificateholder to maintain in confidence a communication made by a patient or client in the context of such services, except as provided in s. 491.0147.

(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 board or, in the case of certified master social workers, the department may enter an order denying licensure or imposing any of the penalties authorized in s. 456.072(2) against any applicant for licensure or any licensee who violates subsection (1) or s. 456.072(1).

(b) The board may take adverse action against a clinical social worker's, a marriage and family therapist's, or a mental health counselor's privilege to practice under the Professional Counselors Licensure Compact pursuant to s. 491.017 and may impose any of the penalties in s. 456.072(2) if the clinical social worker, marriage and family therapist, or mental health counselor 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. 491.004(8) as the state's delegate on the Counseling Compact Commission, when serving in that capacity pursuant to s. 491.017, and any administrator, officer, executive director, employee, or representative of the 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. The Department of Health shall notify the Division of Law Revision upon enactment of the Professional Counselors Licensure Compact into law by 10 states.

Section 10. This act shall take effect upon enactment of the Professional Counselors Licensure Compact into law by 10 states.

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 Koster offered the following:

**Amendment (with title amendment)**

Between lines 124 and 125, insert:

Section 1. Subsections (5) through (17) of section 491.003, Florida Statutes, are renumbered as subsections (6) though (18), respectively, and subsection (5) is added to that section, to read:

491.003 Definitions.—As used in this chapter:

(5) "Licensed professional counselor" means a clinical social worker, marriage and family therapist, or mental health counselor authorized to provide services under the Professional Counselors Licensure Compact.

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

Remove line 3 and insert:
Compact; amending s. 491.003, F.S.; defining "licensed professional counselor"; creating s. 491.017, F.S.; creating the

Amendment No. 2

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 Koster offered the following:

**Amendment**

Remove lines 233-235 and insert:

(15) "Licensed professional counselor" means a counselor licensed by a member state, regardless of the title used by that

HB 1523

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 1523 Pub. Rec. and Meetings/Professional Counselors Licensure Compact
**SPONSOR(S):** Koster
**TIED BILLS:** HB 1521 **IDEN./SIM. BILLS:** CS/SB 590

| 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 1521 authorizes Florida to enter into the Professional Counselors Licensure Compact (PCLC) enacting its provisions into the laws of the state. The PCLC is an interstate compact that facilitates the interstate practice of licensed professional counseling in person and through telehealth. In Florida, licensed clinical social workers, marriage and family therapists, and mental health counselors (counselors, collectively) are able to apply for privileges to practice under the PCLC. The PCLC requires compact states to submit counselor's licensure and regulation records, including any actions taken against a counselor's ability to practice, to a coordinated licensure information system (CLIS). The compact creates the Counseling Compact Commission (Commission) to oversee and administer the provisions of the PCLC and a licensure information data system (data system).

This bill, which is linked to the passage of HB 1521, creates public records and public meetings exemptions for certain records and meetings relating to the compact.

The bill creates a public records exemption for a counselor's personal identifying information, other than his or her name, licensure status, or licensure number, obtained from the data system and held by the Department of Health or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counselors, unless the laws of the state that originally reported the information authorizes its disclosure.

The bill also creates a public meeting exemption for Commission meetings, or portions of such meetings, in which a matter discussed is specifically exempted from disclosure by federal or state statute. The bill provides that any recordings, minutes, and records generated from such a meeting are also exempt from public records requirements.

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 1521 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]

Professional Counselors Licensure Compact

HB 1521 authorizes Florida to enter into the Professional Counselors Licensure Compact (PCLC or compact) by enacting its provisions into Florida law. The PCLC was created by the National Center for Interstate Compacts and is an interstate compact that facilitates the interstate practice of licensed professional counseling in person and through telehealth. Florida-licensed clinical social workers, marriage and family therapists, and mental health counselors (counselors, collectively) are eligible to apply for privileges to practice under the PCLC.

Under the compact, a counselor who is licensed in a compact state is permitted to practice in another compact state after obtaining a privilege to practice in that compact state. A counselor practicing under the compact practice privileges must comply with the practice laws of the state in which he or she is practicing or where the patient is located.

Under the PCLC, compact states are required to report a counselor's identifying information; licensure data; significant investigatory information; adverse actions[7] against a counselor's license;

[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.

nonconfidential information related to participation in alternative programs; denials of applications and reasons for such denials; and other information, determined by Commission rule, which may facilitate the administration of the compact to a coordinated licensure information system. A compact state may designate information it reports as confidential and therefore, cannot be shared with noncompact states or other entities without the express permission of the reporting state.

*Coordinated Licensure Information System*

The PCLC requires all compact states to share licensee information.[8] Compact states must submit a uniform dataset to a coordinated licensure information system on all counselors 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:[9]

- Identifying information;
- Licensure data;
- Significant investigatory information;
- Adverse actions against a counselor's license;
- 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 data system information must be expunged according to laws of the reporting compact state.[10]

*Commission Meetings*

The compact establishes the Counseling Compact Commission (Commission). Each compact state has one delegate selected by that state's licensing board. All Commission meetings must be open to the public except for when the Commission must discuss:[11]

- Noncompliance of a compact 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; and
- Matters specifically exempted from disclosure by federal law or the laws of any party state.

**Effect of the Bill**

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[7] Adverse action is any disciplinary action that is a matter of public record which is taken by a state's counselor regulatory authority against a counselor's license to practice in that state.
[8] Counseling Compact Model Legislation (Dec. 4, 2020), https://counselingcompact.org/wp-content/uploads/2021/06/Final_Counseling_Compact_With_Cover.pdf (last visited Jan. 29, 2022).
[9] Id.
[10] Id.
[11] Id.

The bill creates public record and public meeting exemptions related to the PCLC.

Specifically, the bill provides that personal identifying information of a counselor, other than the counselor's name, licensure status, or licensure number, obtained from the data system and held by the Department of Health or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counselors is exempt from public records requirements, unless the laws of the state that originally reported the information authorizes its disclosure. Disclosure under such circumstance is limited to the extent permitted under the laws of the reporting state.

The bill also creates a public meeting exemption for Commission meetings, or portions of such meetings, at which the Commission discusses matters specifically exempt from disclosure by state or federal law. 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 the PCLC requires any meeting in which 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 that the public records and public meeting exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2027, unless saved from repeal by reenactment by the Legislature.

The effective date of this bill is the same date that HB 1521 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. 491.018, F.S., relating to Professional Counselors Licensure Compact; public records and meeting exemptions.

**Section 2:** Provides that the bill is effective on the same date that HB 1521 (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:

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 public records and meetings; creating s. 491.018, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling pursuant to the Professional Counselors Licensure Compact; authorizing the disclosure of such information under certain circumstances; providing an exemption from public meetings requirements for certain meetings or portions of certain meetings of the Counseling Compact Commission or committees of the commission; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portions of such meetings; providing for future legislative review and repeal of the exemptions; providing statements of public necessity; providing a contingent effective date.

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

Section 1. Section 491.018, Florida Statutes, is created to read:

491.018 Professional Counselors Licensure Compact; public



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

records and meetings exemptions.—

(1) A counselor's personal identifying information, other than the counselor's name, licensure status, or licensure number, obtained from the data system, as described in article X of s. 491.017, and held by the department or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling 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 data 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 Counseling Compact Commission, established in article IX of s. 491.017, or the executive committee or other committees of the commission, 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 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 counselor's personal identifying information, other than the counselor's name, licensure status, or licensure number, obtained from the data system, as described in article X of s. 491.017, Florida Statutes, and held by the Department of Health or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Art. I of the State Constitution. Protection of such information is required under the Professional Counselors Licensure 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 Counseling Compact Commission or the executive committee or other committees of the commission held as provided in article IX of s. 491.017, Florida Statutes, at 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), Art. I of the State Constitution.

(b) The Professional Counselors Licensure Compact requires the closure of any meeting, or any portion of a meeting, in which the substance of paragraph (a) is discussed to be closed



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

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 article IX of s. 491.017, Florida Statutes, be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Art. I of the State Constitution. Release of such information would negate the public meetings 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 1521 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.