Tab 2	**SB 292** by **Polsky (CO-INTRODUCERS) Book**; Newborn Screenings

Tab 3	**SB 358** by **Rodriguez**; Professional Counselors Licensure Compact

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Tab 4	**SB 296** by **Garcia**; Health Care Expenses

Tab 5	**SB 330** by **Brodeur**; Medicaid Modernization

Tab 6	**SB 312** by **Diaz**; (Compare to H 00017) Telehealth

Tab 7	**SPB 7000** by **HP**; OGSR/Nonviable Birth Certificates

Tab 8	**SPB 7002** by **HP**; OGSR/Information Relating to Medical Marijuana Held by the Department of Health

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Diaz, Chair
Senator Brodeur, Vice Chair

MEETING DATE: Wednesday, November 3, 2021
TIME: 11:30 a.m.—2:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Diaz, Chair; Senator Brodeur, Vice Chair; Senators Albritton, Baxley, Bean, Book, Cruz, Garcia, Jones, and Powell

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Agency for Health Care Administration Implementation Update on HB 19 (2019)		Presented
2	**SB 292** Polsky	Newborn Screenings; Revising requirements for the Department of Health's rules related to newborn screenings; requiring hospitals and other state-licensed birthing facilities to test for congenital cytomegalovirus in newborns under certain circumstances, etc. HP 11/03/2021 Favorable AHS AP	Favorable Yeas 10 Nays 0
3	**SB 358** Rodriguez (Linked S 590)	Professional Counselors Licensure Compact; Creating the Professional Counselors Licensure Compact; providing for recognition of the privilege to practice licensed professional counseling in member states; providing for the recognition of the practice of professional counseling through telehealth in member states; providing for the development of the data system, reporting procedures, and the exchange of specified information between member states; specifying that licensees practicing in a remote state under the compact must adhere to the laws and rules of the remote state, etc. HP 11/03/2021 Fav/CS AHS AP	Fav/CS Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 296** Garcia	Health Care Expenses; Requiring a licensed facility to establish, update, and make public a list of the facility's charges for services which meets certain federal requirements; prohibiting consumer reporting agencies from publishing a consumer report containing a medical debt credit impairment under certain circumstances; requiring the consumer reporting agency to remove the credit impairment, free of charge, under certain circumstances; authorizing patient-consumers to initiate legal proceedings for violations; prohibiting persons from reporting certain consumer debt to a consumer reporting agency without the express written consent of the creditor, etc. HP 11/03/2021 Temporarily Postponed AHS AP	Temporarily Postponed
5	**SB 330** Brodeur	Medicaid Modernization; Authorizing Medicaid to reimburse providers for certain remote evaluation and patient monitoring services, etc. HP 11/03/2021 Favorable AHS AP	Favorable Yeas 10 Nays 0
6	**SB 312** Diaz (Compare H 17)	Telehealth; Revising the definition of the term "telehealth"; narrowing the prohibition on prescribing controlled substances through telehealth to include only specified controlled substances, etc. HP 11/03/2021 Favorable BI RC	Favorable Yeas 10 Nays 0
	Consideration of proposed bill:		
7	**SPB 7000**	OGSR/Nonviable Birth Certificates; Amending a provision which provides an exemption from public records requirements for certain information included in nonviable birth certificates; removing the scheduled repeal of the exemption, etc.	Submitted and Reported Favorably as Committee Bill Yeas 10 Nays 0
8	**SPB 7002**	OGSR/Information Relating to Medical Marijuana Held by the Department of Health; Provides an exemption from public records requirements for personal identifying information relating to medical marijuana held by the Department of Health; removing the scheduled repeal of the exemption, etc.	Submitted and Reported Favorably as Committee Bill Yeas 10 Nays 0
	Other Related Meeting Documents		

Committee on Health Policy

CS/HB 19 — Prescription Drug Importation Programs

by Health and Human Services Committee and Rep. Leek and others (CS/CS/SB 1528 by Appropriations Committee; Health Policy Committee; and Senators Bean and Gruters)

The bill establishes two programs to import prescription drugs approved by the federal Food and Drug Administration (FDA) into the state, contingent on federal approval:

- The Canadian Prescription Drug Importation Program (CPDI Program) established by the Agency for Health Care Administration (AHCA) and the International Prescription Drug Importation Program (IPDI Program) established by the Department of Business and Professional Regulation (DBPR) in collaboration with the Department of Health (DOH).
- The CPDI Program focuses on providing savings and options for specific public programs identified in the bill:
  - Recipients in the Medicaid program;
  - Clients of free clinics and county health departments;
  - Inmates in the custody of the Department of Corrections;
  - Clients treated in developmental disability centers; and
  - Patients treated in certain state mental health facilities.
- The bill establishes eligibility criteria for the types of prescription drugs which may be imported and the requirements for entities that may export or import prescription drugs. The eligibility criteria cover:
  - Importation process;
  - Safety standards;
  - Testing requirements;
  - Drug distribution requirements; and
  - Penalties for violations of program requirements.
- Both programs must also adhere to federal product tracing requirements known as *track and trace* as described in Title II of the Drug Quality and Security Act, Drug Supply Chain Security Act, 21 U.S.C. 351 et seq. The bill includes a testing process with random sampling and batch testing of drugs as they enter the state under either program.
- Bond requirements and other financial responsibility requirements provisions were added for the following program contractors with their program noted:
  - Vendors (CPDI Program);
  - Pharmacy permittees (IPDI Program);
  - Wholesale distributor permittees (IPDI);
  - Nonresident prescription drug manufacturer licensees or permittees (IPDI); and
  - International prescription drug wholesale distribution permittees (IPDI).

  The fees for the new licenses and permits that are created under this bill are handled in a separate fee bill as required by the State Constitution. The specific financial requirements for each of these licenses or permits will be set by rule by the AHCA and DBPR.
- Both programs have an immediate suspension provision allowing either the AHCA or the DBPR to immediately suspend the importation of a specific drug or the importation of drugs by a specific importer if either a specific drug or a specific importer is in violation of any provision of the bill or any federal or state law or regulation. The suspension may

be lifted if, after conducting an investigation, the AHCA or DBPR determines that the public is adequately protected from counterfeit or unsafe drugs being imported into the state.

- The bill requires federal approval, followed by state legislative review of an implementation and funding plan, before either program can begin. The IPDI Program requires specific federal approval as there is not any current federal legislation authorizing such a program.
- CS/HB 19 is linked to HB 7073, which authorizes DBPR and DOH to charge fees relating to new permits created in this bill for the IPDI Program.

If approved by the Governor, these provisions take effect July 1, 2019.
Vote: Senate 27-13; House 93-20

Canadian Prescription Drug Importation Program

Senate Health Policy Committee

Simone Marstiller, Secretary
Agency for Health Care Administration

November 3, 2021

AGENCY OVERVIEW

MISSION

- Better Health Care for all Floridians

CORE FUNCTIONS

- State's Chief Health Policy and Planning Entity
- Administering the Florida Medicaid Program
- Licensure and Regulation of nearly 50,000 health care facilities

- We leverage technology to support these core functions and all agency operations.

AGENCY OBJECTIVES

ONE AHCA

- We are one agency, one team.

COST EFFECTIVE

- We leverage Florida's buying power in delivering high quality care at the lowest cost to taxpayers.

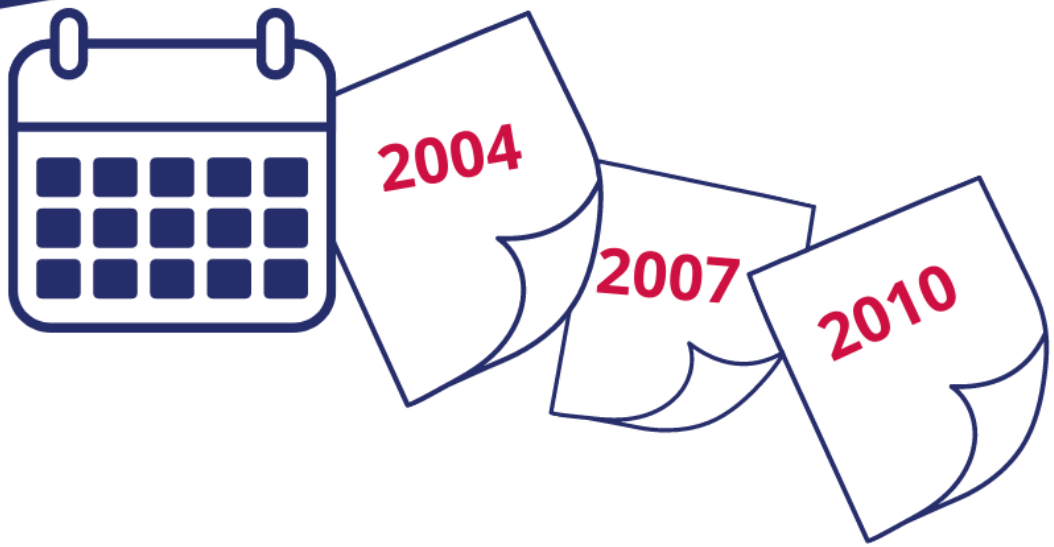
TRANSPARENT

- We support initiatives that promote transparency and empower consumers in making well informed healthcare decisions.

HIGH QUALITY

- We emphasize quality in all that we do to improve health outcomes, always putting the individual first.

In 2003, Congress passed the Medicare Modernization Act



After 16 years of FEDERAL INACTION, Governor DeSantis called on the Federal government to Act on Canadian Drug Importation.

Outpatient prescription drug prices increased

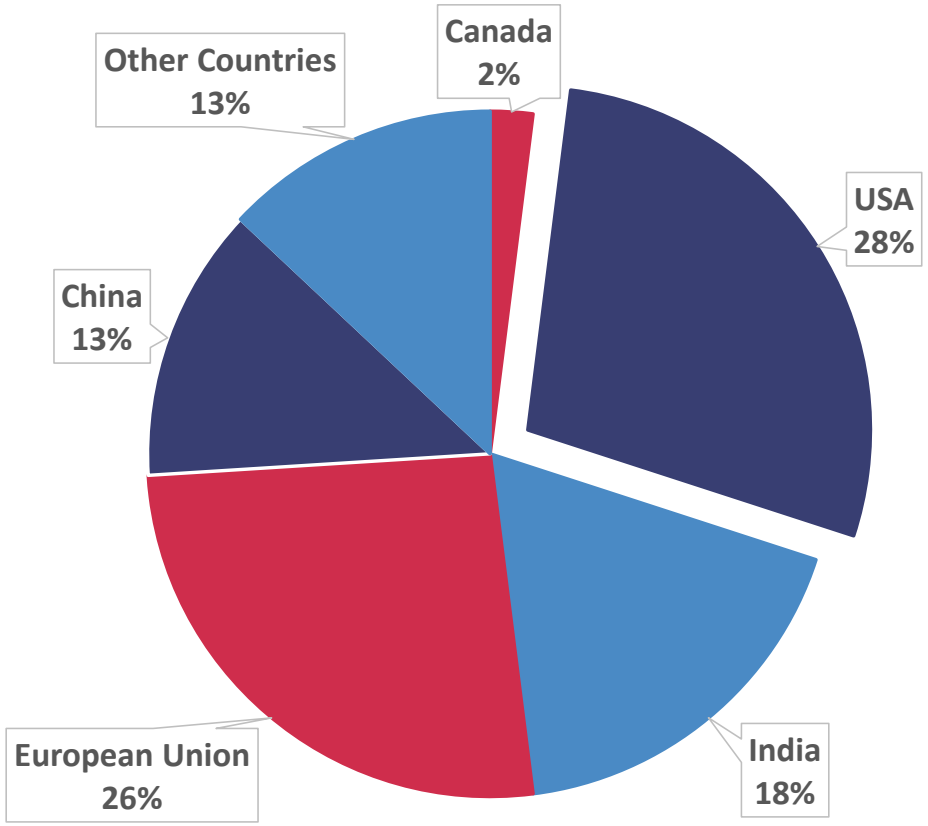
...nearly 181% from 2003 to 2020

$177 Billion to approximately **$500 Billion**

MEDICARE MODERNIZATION ACT

- In 2003, Congress passed the Medicare Modernization Act which was then signed into law by President George W. Bush
- The Act authorizes a wholesaler or pharmacist to import prescription drugs from Canada under certain conditions with HHS approval.
- The bill did not allow for the expansion of importation outside of Canada.
- From 2003-2019, there was no concerted effort at the federal level to fully implement these provisions.

MANUFACTURING SITES FOR ACTIVE PHARMACEUTICAL INGREDIENTS



PROGRAM OVERVIEW

PROGRAM PURPOSE

SELECTED DRUGS

IMPORTATION & DISTRIBUTION

ESTIMATED SAVINGS

NEXT STEPS

CS/HB 19 OVERVIEW

- Sec. 381.02035, F.S, directs the Agency to contract with a vendor to:
  - Develop a Wholesale Prescription Drug Importation List for Agency approval.
  - Consider which prescription drugs will provide the greatest cost savings to state programs.
  - Verify that Canadian suppliers meet all requirements of the program.
  - Contract with eligible Canadian suppliers.
  - Maintain a list of registered importers that participate in the program.
  - Ensure program participant compliance with Title II of the federal Drug Quality and Security Act.

TIMELINE

- In 2019, Governor DeSantis called for legislation allowing importation in Florida.
- In June 2019, Governor DeSantis signed CS/HB 19 (2019-99, L.O.F.) into law, establishing Florida's program.
- At the direction of President Trump and Governor DeSantis, AHCA worked with Federal HHS to draft a Federal regulatory framework.
- The FDA rule took final effect on December 1, 2020, allowing states to implement the program by submitting a Section 804 Importation Program (SIP).
- In November 2020 Florida became the first state to submit a SIP.

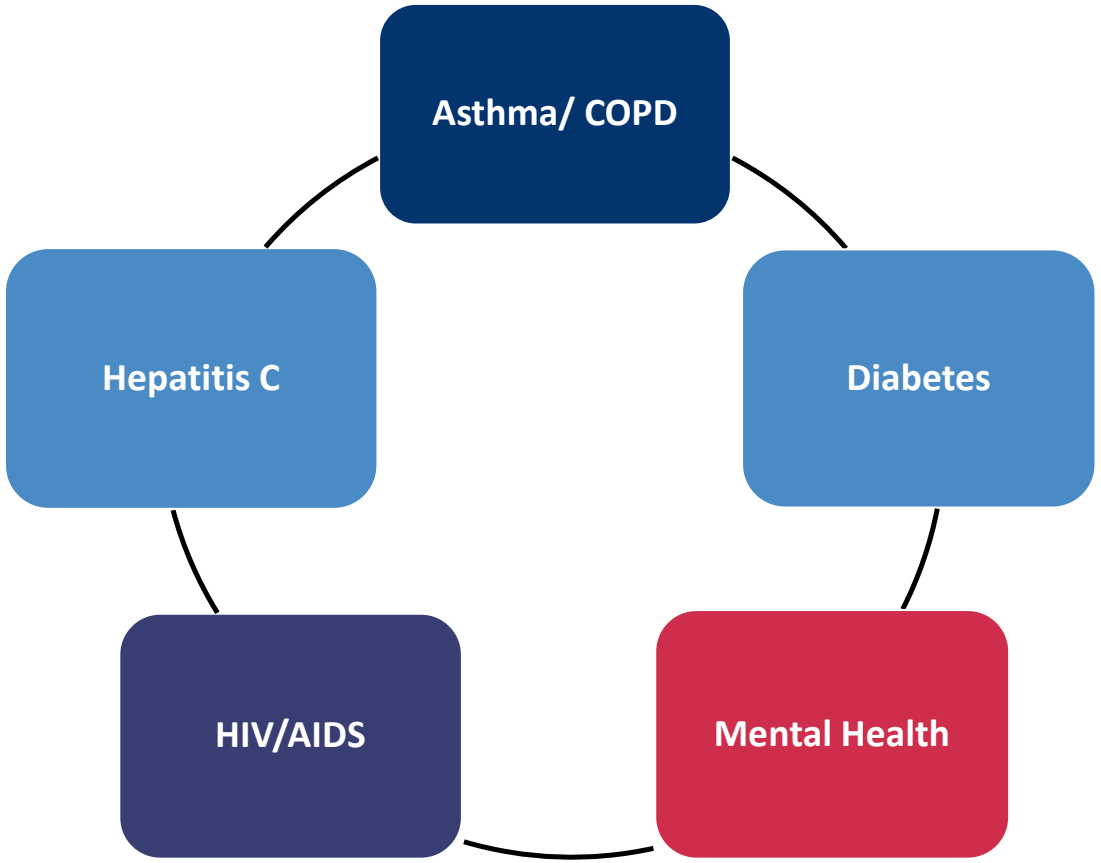
TIMELINE

- In December 2020, AHCA contracted with LifeScience Logistics to support program operations.
- In May, Governor DeSantis announced that the State's importation facility was licensed by DBPR and called on the FDA to approve Florida's SIP.
- In July, President Biden directed the FDA to work with all states on drug importation.
- Last month, AHCA provided additional information to the FDA.

HOW ARE DRUGS SELECTED?

- The Agency selected the Wholesale Prescription Drug Importation List based on:
  - Current cost per pill for Florida Medicaid and the participating State agencies
  - Utilization during CYs 2018, 2019, and 2020
  - Federal and supplemental rebates available
  - Having a Health Canada-approved equivalent
  - Available pricing from Canadian manufacturers
  - Sharing identical Health Canada and FDA labeling information
- The SIP can be updated throughout the program as additional drugs are identified for importation.

WHAT DRUGS WILL FLORIDA IMPORT?



DRUGS INELIGIBLE FOR IMPORTATION

- Current law prohibits the following drug classes from importation:
  - Controlled substances (e.g., opioids)
  - Biological products (e.g., insulin)
  - Injectables (e.g., epinephrine)
  - Infused drugs and drugs inhaled during surgery
  - Drug Safety Program/High Risk Drugs (e.g., retinoids)

IMPORTATION PROCESS OVERVIEW

Canadian Manufacturers

- Produce drugs for the Canadian market
- Sell drugs to the Foreign Seller

Foreign Seller

- Purchases drugs from Canadian manufacturers
- Sells drugs to the Importer

Importer

- Purchases drugs from the Foreign Seller
- Imports drugs into the U.S.
- Distributes drugs to State agencies

State Agencies

- Purchase drugs from the Importer
- Dispense to individuals under the care of State programs

CANADIAN MANUFACTURERS

- Canadian drug manufacturers sell to the Foreign Seller for U.S. importation.
  - All prescription drugs must be labeled and intended for sale for the Canadian market.
  - Canadian manufacturers must:
    - sell prescription drugs in accordance with Canadian laws and regulations.
    - either sell surplus supply to Florida or produce additional quantities.
- Initially, the FDA rule allows Florida to work with only one Canadian manufacturer.
  - Upon successful implementation, Florida can add additional manufacturers.

FOREIGN SELLER

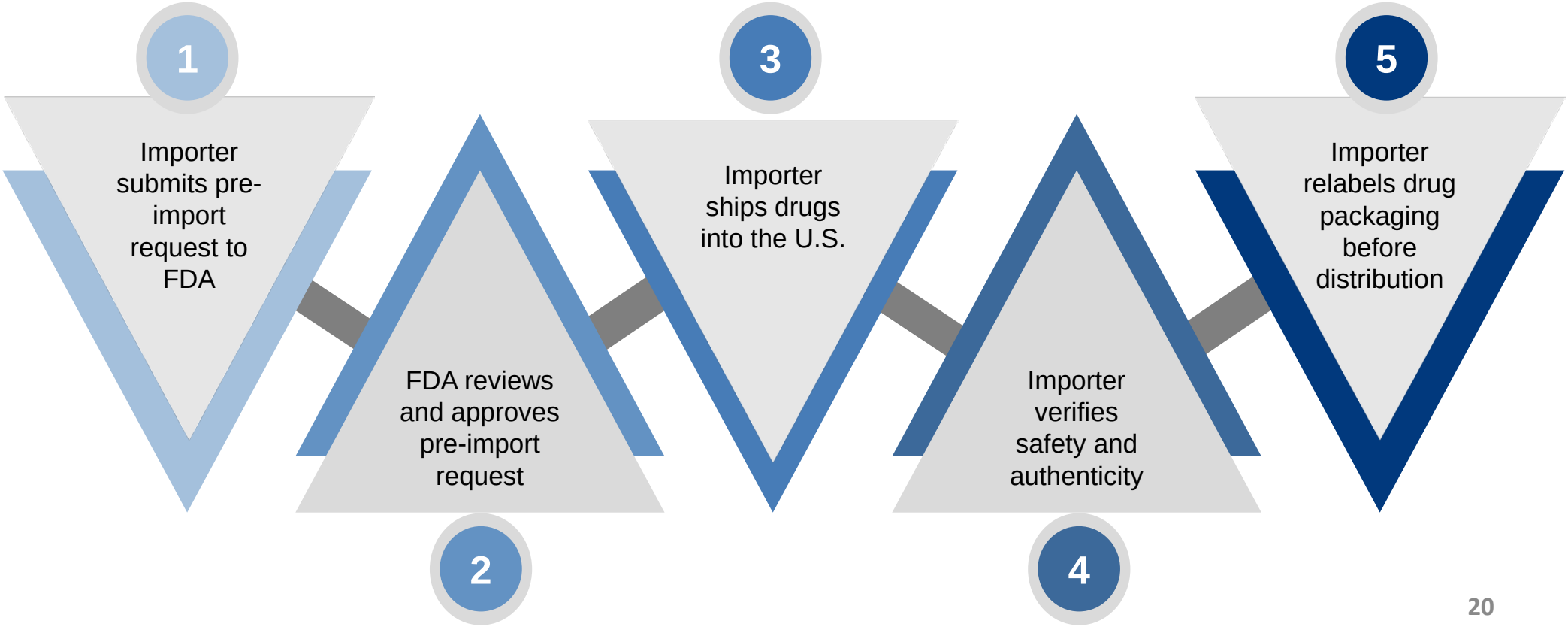
- The Foreign Seller is a Canadian wholesaler that purchases prescription drugs from Canadian manufacturers.
  - The FDA requires all importation programs to have a Foreign Seller.
  - The Foreign Seller is responsible for attaching Section 804 Serial Identifiers (SSI labels) to each lot of prescription drugs intended for importation.
  - SSI labels are required by the FDA to meet track and trace requirements as established by the U.S. Drug Supply Chain Security Act.
  - The Foreign Seller will sell Canadian prescription drugs directly to the importer.
- In April 2021, Methapharm, based in Cyprus, Toronto, and Fort Lauderdale, was selected as the state's foreign seller.

IMPORTER

- The Importer is responsible for shipping Canadian prescription drugs into the U.S. and distributing them to State agencies.
- The Importer must:
  - Submit pre-import requests to the FDA
  - Arrange prescription drug entry into the U.S. via the U.S. Customs and Border Patrol
  - Verify safety and authenticity for each shipment
  - Repackage and relabel the imported prescription drugs as approved by the FDA
  - Distribute imported prescription drugs to State agencies
- The State's distribution and supply chain vendor, LifeScience Logistics, will also serve as the Importer.

AGENCY PARTNERS

IMPORTATION PROCESS



LOWER PRESCRIPTION COSTS FOR FLORIDA

SAFETY AND AUTHENTICITY

- The Importer ensures imported prescription drugs are authentic and safe.
- Actions to ensure safety and authenticity include the following:
  - Laboratory testing using industry-standard techniques
  - Stability testing to ensure adequate shelf-life prior to dispensing
  - Visual inspection to assess for counterfeits

RELABELING & REPACKAGING

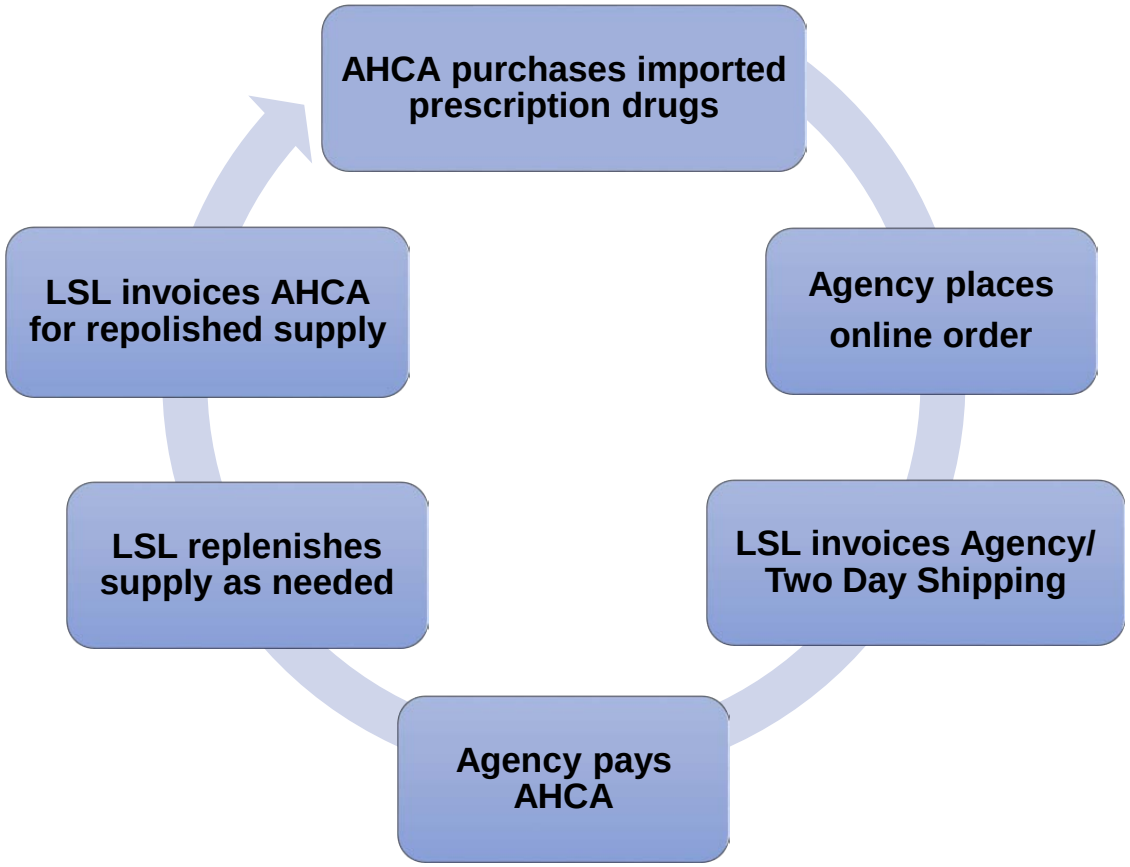
- The importation process requires the Importer to repackage and relabel all imported prescription drug packages with FDA-approved labeling.
  - Relabeling requires attaching a label that lists a National Drug Code (NDC) specifically created for a drug's imported Canadian equivalent.
  - Every prescription drug in the U.S. market has its own NDC.
  - The imported drug's NDC differs from the FDA-approved version's NDC.
- The Importer's labels must identify that the prescription drug was imported from Canada.

LABEL COMPARISON

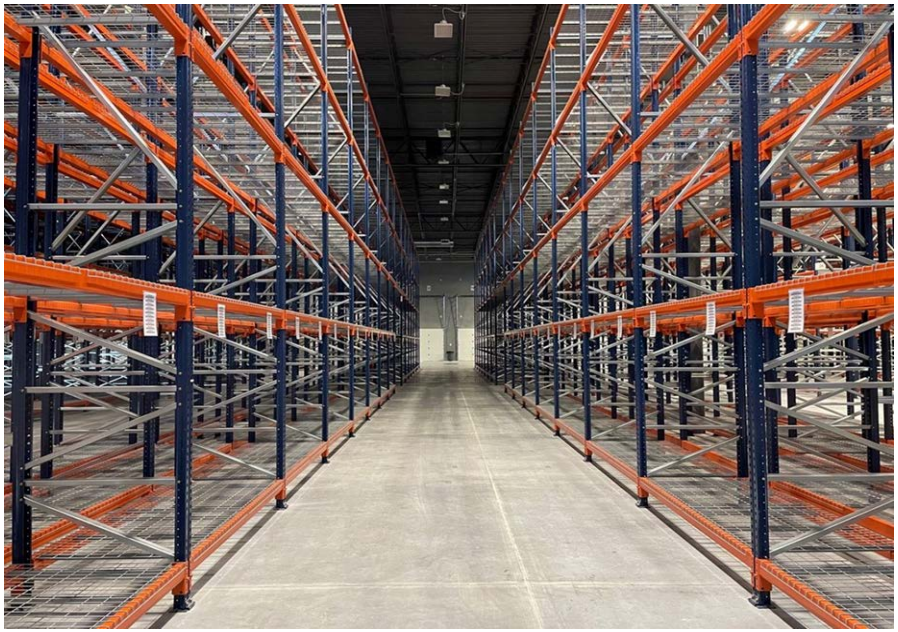
DISTRIBUTION IN FLORIDA

- Following importation into the U.S., the Importer will ship all Canadian prescription drugs to a distribution facility in Lakeland, Florida.
  - DBPR licensed facility
- To distribute imported prescription drugs, state agencies will use an online portal to place orders, which the Importer will then ship to designated facilities and providers.
- State agencies will then support last-mile delivery mechanisms based on their constituency and specified needs.
- AHCA continues to finalize last-mile delivery mechanisms for the Medicaid program.

STATE AGENCY ORDERING



DISTRIBUTION WAREHOUSE



ESTIMATED SAVINGS

- The State can expect to save up to $150 million in the first year alone.
- Estimate based on agency utilization, cost per prescription, any rebates/discounts.
- This is contingent on the Importer negotiating prices at or below the price Canadians pay retail for a specific drug.
- The $150 million estimate may vary following implementation due to fluctuations in prescription drug pricing, additional drugs identified as importation candidates, rebates secured, and availability of supply.

NEXT STEPS

Quarterly Review

- State agencies will provide a refreshed list of all drugs currently dispensed within their program, which will be reviewed by AHCA.
- Selected drugs will then be incorporated in the State's SIP and submitted to the FDA for approval.

Reconciliation

- Monthly financial reconciliation will be conducted through inter-agency agreements.
- A report will be developed to compare new costs to comparable costs during previous timeframes.

Reporting

- AHCA is required to submit an annual report on the operation of the program during the previous fiscal year to the Governor and Legislature.

NEXT STEPS

- Upon FDA approval, the Agency will begin the final implementation steps, including a pre-import request with the FDA.
- AHCA will implement a phased approach to distribution, beginning with partner agencies, to ensure safety and compliance with all FDA guidelines.
- Upon successful implementation of Phase 1, AHCA will initiate Phase 2 for Medicaid members.
- AHCA is exploring opportunities to expand to additional state funded programs following Phase 2.

LOWER PRESCRIPTION COSTS FOR FLORIDA

The Florida Senate

APPEARANCE RECORD

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

November 3, 2021
Meeting Date

S. Health Policy
Committee

Canadian Drug Importation
Bill Number or Topic Presentation

Amendment Barcode (if applicable)

Name Simone Marstiller (Secretary) Phone (850) 412-3622

Address 2727 Mahan Drive Email lindsey.zander@ahca.myflorida.com
Street

Tallahassee FL 32308
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Agency for Health Care Administration

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

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

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 292
INTRODUCER:	Senator Polsky
SUBJECT:	Newborn Screenings
DATE:	November 2, 2021
REVISED:	11/4/2020

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 292 amends s. 383.14, F.S., to require that each newborn be tested for cytomegalovirus before becoming three weeks of age. Additionally, the bill amends s. 383.145, F.S., to require a hospital or other state-licensed birthing facility to administer a urine polymerase chain reaction test, or other diagnostically equivalent test, on a newborn to screen for cytomegalovirus should the newborn fail his or her screening for hearing loss. The screening for hearing loss is required under current law to be administered prior to being discharged from the hospital or birthing facility.

The bill also 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.

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

II. Present Situation:

Cytomegalovirus

Cytomegalovirus (CMV) is a common virus for people of all ages; however, a healthy person's immune system usually keeps the virus from causing illness.[1] 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 (variety) of the virus. Most people with CMV infection have no symptoms and aren't aware that they have been infected.[2]

[1] About Cytomedalovirus (CMV), Centers for Disease Control and Prevention, available at https://www.cdc.gov/cmv/overview.html (last visited Oct. 29, 2021).
[2] *Id.*

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 baby. This can happen when a pregnant woman is infected with CMV for the first time or is infected with CMV again during pregnancy.[3]

Some babies 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 baby (pregnancy loss).

Some babies with congenital CMV infection have signs at birth. These signs include:
- Rash
- Jaundice (yellowing of the skin or whites of the eyes)
- Microcephaly (small head)
- Low birth weight
- Hepatosplenomegaly (enlarged liver and spleen)
- Seizures
- Retinitis (damaged eye retina)

Some babies with signs of congenital CMV infection at birth may have long-term health problems, such as:
- Hearing loss
- Developmental and motor delay
- Vision loss
- Microcephaly (small head)
- Seizures

Some babies 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 babies who passed the newborn hearing test.[4]

CMV is the most common infectious cause of birth defects in the United States. About one out of 200 babies is born with congenital CMV. One out of five babies 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.

Babies who show signs of congenital CMV disease can be treated with medicines called antivirals. Antivirals may decrease the severity of hearing loss. Babies who get treated with antivirals should be closely monitored by their doctor because of possible side effects.[5]

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[3] Babies Born with Conginital Cytomegalovirus (CMV), Centers for Disease Control and Prevention, available at https://www.cdc.gov/cmv/congenital-infection.html, (last visited Oct. 29, 2021).
[4] *Id.*
[5] Congenital CMV and Hearing Loss, Centers for Disease Control and Prevention, available at https://www.cdc.gov/cmv/hearing-loss.html, (last visited Oct. 29, 2021).

Florida's Newborn Screening Program

Florida's Newborn Screening Program (NBS) was established in 1965, and the processes are governed by ss. 383.14 and 383.145, F.S. The NBS currently screens for 57 conditions prior to discharge of the newborn from the hospital or other licensed birthing facility. Of the conditions screened, 55 conditions are screened through the collection of blood spots. Screening of the two remaining conditions, hearing loss and critical congenital heart defect, are completed at the birthing facility through point of care testing.[6]

The newborn screening specimen card, which includes the drops of blood and the results of the hearing and CCHD screen, is sent to the DOH Bureau of Public Health Laboratory (BPHL) Jacksonville location. On average, the BPHL in Jacksonville tests 250,000 specimens per year. When an abnormal blood screening result occurs, additional testing is required. The DOH Division of Children's Medical Services NBS Follow-up Program contacts health care providers and parents to ensure confirmatory testing occurs.[7]

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.[8]

Before a newborn is discharged from the hospital or other state-licensed birthing facility that provides maternity and newborn care services, and unless objected to by the parent or legal guardian,[9] the newborn must be screened for the detection of hearing loss to prevent the consequences of unidentified disorders.[10] Additionally, within 30 days of discharge from the hospital, each such facility must refer the newborn to a licensed audiologist, physician, or hospital for screening for detection of hearing loss.[11] If the birth is a home birth, the health care provider in attendance must provide the referral to a licensed audiologist, hospital, or other newborn hearing screening provider within 30 days.[12]

The section also requires that all screenings be conducted by a licensed audiologist, a licensed physician, or appropriately supervised individual who has completed documented training specifically for newborn hearing screening.[13] When ordered by the treating physician, screening of a newborn's hearing must include auditory brainstem responses, or evoked otacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration.[14]

[6] Department of Health analysis of SB 292, 11/2/2021, on file with Senate Health Policy Committee staff.
[7] *Id*.
[8] s. 383.145(3)(i), F.S.
[9] s. 383.145(3)(c), F.S.
[10] s. 383.145(3)(a), F.S.
[11] s. 383.145(3)(b), F.S.
[12] s. 383.145(3)(d), F.S.
[13] s. 383.145(3)(e), F.S.
[14] s. 383.145(3)(h), F.S.

A child who is diagnosed as having a permanent hearing impairment must be referred 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 serving the geographical area in which the child resides.[15] Any person who is 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.[16]

III. Effect of Proposed Changes:

SB 292 amends s. 383.14, F.S., to require that each newborn be tested for cytomegalovirus before becoming three weeks of age.

Additionally, the bill amends s. 383.145, F.S., to require a hospital or other state-licensed birthing facility to administer a urine polymerase chain reaction test, or other diagnostically equivalent test, on a newborn to screen for cytomegalovirus should the newborn fail his or her screening for hearing loss that is required under current law to be administered prior to being discharged from the hospital or birthing facility. The bill also 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.

The bill also defines the terms audiologist, hospital, and physician for clarity in the section and makes other conforming changes.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

[15] Section. 383.145(3)(k), F.S.
[16] Section. 383.145(3)(l), F.S.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Given the clarity issues detailed in the "Related Issues" section of this analysis, the DOH has provided a range of potential fiscal impacts on the state, from $286,037 to $19,603,864 (mix of recurring and nonrecurring).

The DOH indicates that if the bill intends that only newborns who fail their hearing screenings be tested for CMV and that the tests be fully conducted by the hospital or other licensed birthing facility, then the department estimates a potential fiscal impact of $222,090 recurring and $63,947 nonrecurring.

If the bill intends that only newborns who fail their hearing screenings be tested for CMV and that the tests be conducted by the BPHL in Jacksonville, then the DOH estimates a potential fiscal impact of $1,494,036 recurring and $988,792 nonrecurring.

Finally, if the bill intends that all newborns be screened for CMV and those tests be conducted by the BPHL in Jacksonville, then the DOH estimates a potential fiscal impact of $18,551,125 recurring, and $1,052,739 nonrecurring.[17]

VI. Technical Deficiencies:

None.

VII. Related Issues:

SB 292 requires both that all newborns in the state be screened for CMV by three weeks of age (lines 23-24), and that newborns be screened for CMV if they fail the hearing screening conducted prior to discharge from the hospital or other state licensed birthing facility (lines 95-100). As such, it is unclear whether the intent of the bill is to require all newborns be screened for CMV regardless of whether they have failed the hearing screening test, or whether the bill intends that only those newborns who fail the hearing screening should be tested.

[17] *Supra* n. 6.

Additionally, SB 292 requires on lines 95-100 that the hospital or other licensed birthing facility conduct a specified test for CMV on a newborn who has failed his or her hearing screening prior to the newborn being discharged. In general, newborn screening test specimens are collected by the hospital or other state licensed birthing facility and sent to the BPHL in Jacksonville for analysis. Given this context, it is unclear whether the bill intends for the hospital or other licensed birthing facility to fully perform the testing for CMV or whether the facility would simply collect the specimen to be tested at the BPHL in Jacksonville.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 383.14 and 383.145.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Polsky

29-00372-22 2022292__

A bill to be entitled

An act relating to newborn screenings; amending s. 383.14, F.S.; revising requirements for the Department of Health's rules related to newborn screenings; amending s. 383.145, F.S.; defining terms; requiring hospitals and other state-licensed birthing facilities to test for congenital cytomegalovirus in newborns under certain circumstances; making technical and conforming changes; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) of section 383.14, Florida Statutes, is amended to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(2) RULES.—

(a) After consultation with the Genetics and Newborn Screening Advisory Council, the department shall adopt and enforce rules requiring that every newborn in this state shall:

1. Before becoming 1 week of age, be subjected to a test for phenylketonuria;

2. Before becoming 3 weeks of age, be subjected to a test for congenital cytomegalovirus;

3. Be tested for any condition included on the federal Recommended Uniform Screening Panel which the council advises the department should be included under the state's screening program. After the council recommends that a condition be included, the department shall submit a legislative budget

29-00372-22 2022292__

request to seek an appropriation to add testing of the condition to the newborn screening program. The department shall expand statewide screening of newborns to include screening for such conditions within 18 months after the council renders such advice, if a test approved by the United States Food and Drug Administration or a test offered by an alternative vendor is available. If such a test is not available within 18 months after the council makes its recommendation, the department shall implement such screening as soon as a test offered by the United States Food and Drug Administration or by an alternative vendor is available; and

4.~~3.~~ At the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary from time to time.

Section 2. 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 impairment screening, identification, and followup care for newborns. The goal is to screen all newborns for hearing 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) "Agency" means the Agency for Health Care Administration.

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

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

(d) ~~(c)~~ "Hearing 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.

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

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

(g) ~~(e)~~ "Licensed health care provider" means a physician licensed under ~~pursuant to~~ chapter 458 or chapter 459, a nurse licensed under ~~pursuant to~~ chapter 464, or an audiologist licensed under part I of ~~pursuant to~~ chapter 468~~,~~ rendering services within the scope of his or her license.

(h) ~~(f)~~ "Management" means the habilitation of the hearing-impaired child.

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

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

(k) ~~(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 urine polymerase chain reaction test or other diagnostically equivalent test on the newborn to screen for congenital cytomegalovirus.

(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 must ~~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 may ~~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 30 days after the birth. In cases in which the home birth is not attended by a primary health care provider, a referral to an ~~a licensed~~ audiologist, a physician ~~licensed pursuant to chapter 458 or chapter 459~~, a hospital, or another ~~other~~ newborn hearing screening provider must be made by the health care provider within the first 3 months after the child's birth.

(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 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.

(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 30 days after 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.

(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.

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

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

(j) The initial procedure for screening the hearing of the newborn or infant and any medically necessary followup reevaluations leading to diagnosis shall be a covered benefit, 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 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.

(k) A child who is diagnosed as having a permanent hearing impairment must ~~shall~~ be referred to the primary care physician for medical management, treatment, and 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 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 must ~~shall~~ be given a list of newborn hearing screening providers who provide the necessary testing free of charge.

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

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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11/3/21
Meeting Date

HEALTH POLICY
Committee

292
Bill Number or Topic

Amendment Barcode (if applicable)

Name DAVID CULLEN

Phone 941-323-2404

Address 9830 ELM ST.
Street

Email cullenasea@gmail.com

OCEAN CITY — MD — 21842
City — *State* — *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
ADVOCACY INSTITUTE FOR CHILDREN

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

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

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S-001 (08/10/2021)

The Florida Senate

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11-3-21
Meeting Date

Health Policy
Committee

292
Bill Number or Topic

Amendment Barcode (if applicable)

Name Alisa Demico

Phone 904 534 8111

Address 6179 Eclipse Cir
Street

Jacksonville FL 32258
City State Zip

Email ademico@clarkeschools.org

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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11-03-2024
Meeting Date

Health Policy
Committee

292
Bill Number or Topic

Amendment Barcode (if applicable)

Name Kathleen Vergara Phone 305-972-8012

Address 5335 Oak Lane Email Kvergara@med.miami.edu
Street

Coral Gables Florida 33156
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

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11/3/21
Meeting Date

Health Policy
Committee

292
Bill Number or Topic

Amendment Barcode (if applicable)

Name Theresa Buker

Phone 904 880 9063

Address Suite #211 N Monroe
Street

Tallahassee FL 32303
City State Zip

Email tb@deafkids.com.org

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: FLAA, Coalition For Spoken Languages

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

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

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11/3/21
Meeting Date

292
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Lynn Miskiel

Phone 305-318-0029

Address 5841 SW 51 Terrace
Street

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Miami FL 33155
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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11/3/21
Meeting Date

292
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Debra Galinski Phone 727-863-9477

Address 6728 Driftwood Dr Email debra@familyhearingcenter.org

Street

Hudson FL 34667

City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

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11/03/2021
Meeting Date

292
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Amanda Santos

Phone 504 559-1616

Address 206 Quail ave
Street

Email Amandalize-HE75@icloud.com

Sebring FL 33870
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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11/3/21
Meeting Date

292
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Narssis Alexandra Guardiguí

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Street

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Sebring FL 3387
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

11/03/2021
Meeting Date

The Florida Senate

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292
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Narssis Mejia

Phone 504-559-1416

Address 206 Quail ave
Street

Email narssismejia@yahoo.es

Sebring, Fl. 33870
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

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11/3/21
Meeting Date

Health Policy
Committee

6292
Bill Number or Topic

Amendment Barcode (if applicable)

Name Terri Fisk

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Address 601 Grand Parke Dr
Street

Email TFisk@deafkidscan.org

St. Johns FL 32259
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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Nov. 3. 2021
Meeting Date

Health Policy
Committee

SB 292
Bill Number or Topic

Amendment Barcode (if applicable)

Name Megan Harvey

Phone 904-657-1648

Address 500 Chapel Dr.
Street

Email mehmen1154@gmail.com

Tallahassee FL 32304
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[X] I am appearing without compensation or sponsorship.

[ ] I am a registered lobbyist, representing:

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

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

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S-001 (08/10/2021)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Agriculture
Appropriations Subcommittee on Education
Community Affairs
Education
Ethics and Elections
Judiciary

SENATOR TINA SCOTT POLSKY
29th District

October 27, 2021

Chairman Manny Diaz
Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chairman Diaz,

Thank you for placing SB 292, relating to Newborn Screenings, on the agenda of the Committee on Health Policy, November 3 at 11:30am.

Unfortunately, due to a matter that needs my attention, I will not be able to present the bill at the committee meeting. Senator Lauren Book, my prime co-sponsor, has graciously accepted my request to present my legislation.

I sincerely apologize for any inconvenience this may cause and thank you for your consideration.

Please feel free to contact me at 850-487-5029 if you have any questions.

Kindest Regards,

Senator Tina S. Polsky
Florida Senate, District 29

cc: Allen Brown, Staff Director
Tori Denson, Administrative Assistant

REPLY TO:
❒ 5301 North Federal Highway, Suite 135, Boca Raton, Florida 33487 (561) 443-8170
❒ 222 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5029

Senate's Website: *www.flsenate.gov*

WILTON SIMPSON
President of the Senate

AARON BEAN
President Pro Tempore

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Agriculture
Appropriations Subcommittee on Education
Community Affairs
Education
Ethics and Elections
Judiciary

SENATOR TINA SCOTT POLSKY
29th District

October 13, 2021

Chairman Manny Diaz, Jr.
Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chairman Diaz,

I respectfully request that you place SB 292, relating to Newborn Screenings, on the agenda of the Committee on Health Policy at your earliest convenience.

Should you have any questions or concerns, please feel free to contact me or my office. Thank you in advance for your consideration.

Kindest Regards,

Senator Tina S. Polsky
Florida Senate, District 29

cc: Allen Brown, Staff Director
Tori Denson, Administrative Assistant

REPLY TO:
❒ 5301 North Federal Highway, Suite 135, Boca Raton, Florida 33487 (561) 443-8170
❒ 222 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5029

Senate's Website: *www.flsenate.gov*

WILTON SIMPSON
President of the Senate

AARON BEAN
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 358
INTRODUCER:	Health Policy Committee and Senator Rodriguez
SUBJECT:	Professional Counselors Licensure Compact
DATE:	November 4, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

PLEASE MAKE SELECTION

I. Summary:

CS/SB 358 authorizes Florida to participate in the Professional Counselors Licensure Compact (counseling compact or compact) for the licensure of mental health counselors. The compact takes effect upon its enactment by ten states, and to date, only two states have enacted the compact. The bill grants a licensed professional counselor who is licensed in his or her primary state of residence (the licensee's "home state") the ability to apply and be granted a privilege to practice professional counseling in another member state, both in-person and through telehealth.

The bill also:

- Requires the Department of Health (DOH) to report any significant investigatory information relating to a health care practitioner practicing under the compact to the compact's licensure data system.
- Provides for the participation of impaired practitioners who are practicing under the compact in impaired practitioner programs.
- Requires the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling (Board) to appoint an individual to serve as Florida's delegate on the counseling compact commission.
- Authorizes the Board to take adverse action against a social worker's, a marriage and family therapist's, or a mental health counselor's privilege to practice under the compact and authorizes the Board to impose grounds for discipline.
- Designates the state delegate and other members or employees of the commission as state agents for the purpose of applying waivers of sovereign immunity.

According to the DOH, the bill will have a significant fiscal impact on the department that would require one additional full-time equivalent (FTE) position to support the workload associated with processing applications and issuing initial and renewal licenses and privileges to practice. The bill authorizes member states to charge a fee for granting a privilege to practice under the compact. The number of applicants for compact licensure is indeterminate and DOH indicates that the fiscal impact cannot be calculated.[1]

The commission may collect an annual assessment from each member state or impose fees on other parties to cover the cost of operations and activities. The annual membership cost with the Licensed Professional Counselors Compact is unknown at this time.

The bill provides an effective date contingent on the enactment of the compact into law by 10 states and requires the DOH to notify the Division of Law Revision in that event.

II. Present Situation:

Occupational Licensure Compacts

Interstate compacts are authorized under the U.S. Constitution, Article I, Section 10, cl. 3.[2] Compacts that affect a power delegated to the federal government or that affect or alter the political balance within the federal system require the consent of Congress.[3] The licensing of professions is predominantly a state responsibility as each state has developed its own regulations, oversight boards, and requirements for dozens of professions and occupations.

In September 2018, the Federal Trade Commission (FTC) looked at the issue of state-by-state occupational licensure and its unintended consequences. In particular, the FTC noted that state-by-state licensing can have a particularly hard effect on those in the military and their spouses who are required to move frequently, those who provide services across state lines, or deliver services through telehealth.[4] The FTC also suggested that improved licensed portability would enhance competition, choice, and access for consumers, especially where services may be in short supply.[5]

According to the Council of State Governments (CSG), since January 2016, 170 separate pieces of licensure compact legislation have been passed in the United States.[6] To date, 42 states and territories have enacted occupational licensure compacts for nurses, physicians, physical therapists, emergency medical technicians, psychologists, speech therapists, audiologists, occupational therapists, and counselors.[7]

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[1] Department of Health, 2022 Senate Bill 358 Legislative Bill Analysis (Oct. 25, 2021) (on file with the Senate Committee on Health Policy).
[2] "No state shall, without the Consent of Congress…enter into any Agreement or Compact with another State, or with a foreign Power[.]" *see* U.S. CONST. art. I, s. 10, cl. 3. While the language of the provision says congressional approval is required, not all compacts require congressional approval.
[3] *Virginia v. Tennessee*, 148 U.S. 503 (1893).
[4] Federal Trade Commission, *Policy Perspectives, Options to Enhance Occupational License Portability* (September 2018), *available at* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Oct. 31, 2021).
[5] *Id*.
[6] *Supra* note 1.
[7] *Id*.

Nurse Licensure Compact

On January 19, 2018, licensed Florida nurses became eligible to apply for a multi-state license under the enhanced Nurse Licensure Compact (eNLC.)[8] The eNLC allows registered nurses and licensed practical nurses who hold licensure in one Compact state to practice in any of the 27 Compact states without obtaining additional state licenses. The DOH reports that the eNLC has effectively reduced regulatory requirements by eliminating the need for nurses to obtain a separate license to practice in different states.[9] Florida joined the Nurse Licensure Compact upon the passage of HB 1061 during the 2016 regular Legislative Session.[10] The eNLC was officially enacted when North Carolina Governor Roy Cooper, signed legislation to become the 26th state to join the compact on July 20, 2017.[11] That date became the effective date for the start of the compact commission, an agency governing the compact.[12]

Interstate Compact for Licensed Professional Counselors

The Interstate Compact for Licensed Professional Counselors (counseling compact or compact) will become effective after 10 states enact the legislation for the compact. The counseling compact has passed and been signed into law in two states. On May 10, 2021, Georgia Governor Brian Kemp signed HB 395 and subsequently on May 18, 2021, Maryland Gov. Larry Hogan signed SB 571/HB 736.[13] The compact has also been introduced this year in Tennessee (SB 1027 HB 0959), Nebraska (LB 554), Ohio (SB 204), and North Carolina (HB 791).[14]

Interstate Licensure Compact for Social Work[15]

The National Association of Social Workers is beginning to pursue its own Interstate Licensure Compact for Social Work. That draft compact has not yet been finalized.

Model of Marriage and Family Therapy License Portability[16]

Rather than pursue a compact, the American Association for Marriage and Family Therapy has created a Model of Marriage and Family Therapy (MFT) License Portability. This portability model is a full endorsement model, meaning that a state will license an applicant as a licensed marriage and family therapist the applicant has a valid and unrestricted license to practice marriage and family therapy in another state.

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[8] *Id*.
[9] *Id*.
[10] Chapter 2016-139, Laws of Fla.
[11] Debra Wood, RN., *The Enhanced Nurse Licensure* (July 28, 2017) *available at* https://www.nursechoice.com/blog/profiles-and-features/the-enhanced-nurse-licensure-compact-explained/ (last visited Oct. 31, 2021).
[12] *Id.*
[13] Counseling Compact, *News*, *available at* https://counselingcompact.org/news/ (last visited Oct. 31, 2021).
[14] Counseling Compact, *Maps*, *available at* https://counselingcompact.org/map/ (last visited Oct. 31, 2021).
[15] National Association of Social Workers, *Interstate Licensure Compact*, https://www.socialworkers.org/Advocacy/Social-Justice/Interstate-Licensure-Compact-for-Social-Work (last visited Oct. 31, 2021).
[16] American Association for Marriage and Family Therapy, *MFT License Portability*, https://www.aamft.org/AAMFT/ADVANCE_the_Profession/License_Portability/Advocacy/MFT%20License%20Portability.aspx (last visited Nov. 4, 2021).

Mental Health Counseling in Florida

The licensed Mental Health Counseling profession continues to expand in Florida and has reported an average growth in recent years of more than 1,000 new licensees per year, increasing the total licensed population to 15,518 practitioners.[17]

Florida law delineates between an application by examination for initial licensure and application by endorsement for mental health counselors who have previously held an active, unencumbered, license in another state. The application for licensure as a mental health counselor includes a mandatory disclosure of criminal history, but applicants are not required to submit fingerprints to complete a criminal background check.[18] Section 456.0135, F.S., provides the DOH with authority to mandate criminal background checks for specified professions and mental health professions regulated by ch. 491, F.S., are not included in the list of specified professions.

Licensure of Mental Health Counselors by Examination

Pursuant to s. 491.005(4), F.S., the DOH shall license an applicant as a mental health counselor, if he or she:

- Pays the appropriate fee;
- Possesses a minimum of a master's degree from a regionally accredited program in Mental Health Counseling or a closely related field that consists of at least 60 semester hours or 80 quarter hours and specific graduate coursework, including: Counseling Theories and Practice, Human Growth and Development, Diagnosis and Treatment of Psychopathology, Human Sexuality, Group Theories and Practice, Individual Evaluation and Assessment, Career and Lifestyle Assessment, Research and Program Evaluation, Social and Cultural Foundations, Substance Abuse, and Legal, Ethical, and Professional Standards Issues. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) which consists of at least 60 semester hours or 80 quarter hours to be licensed;[19]
- Has had at least two years of clinical experience in mental health counseling. Initial applicants must provide documentation to demonstrate completion of a 700-hour university-sponsored clinical practicum or internship with at least 280 hours of direct client services. After graduation, registered mental health counselor interns are required to complete post-graduate supervised experience conducted under the supervision of a board-approved qualified supervisor with at least 100 hours of supervision in no less than 100 weeks. Supervision experience hours are accrued on an hour-for-hour basis by providing face-to-face psychotherapy with clients. Registered interns are required to meet with their qualified supervisor every two weeks to review cases and to receive guidance;
- Has passed the National Clinical Mental Health Counseling Examination (NCMHCE) developed by the National Board for Certified Counselors (NBCC);[20]
- Completes a three-hour course on HIV/Aids pursuant to s. 491.0065, F.S.; and
- Agrees to complete a two-hour domestic violence course within six months of licensure.[21]

[17] *Supra* note 1.
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] Florida Board of Clinical Social Work, Marriage & Family Therapy, and Mental Health Counseling, *Licensed Mental Health Counselor: Requirements available at* https://floridasmentalhealthprofessions.gov/licensing/licensed-mental-health-counselor/#tab-requirements (last accessed Oct. 31, 2021).

Licensure of Mental Health Counselors by Endorsement

Applicants by endorsement who have practiced mental health counseling in another state for at least three out of the last five years are considered to have completed all minimum education, practicum, and supervision requirements and are required to provide limited documentation to become licensed.[22] As a method to streamline licensure for experienced mental health counselors, Florida law does not require endorsement candidates to provide proof of education nor demonstrate completion of supervised experience.[23] Pursuant to s. 491.006, F.S., the DOH shall license an applicant as a mental health counselor if he or she:

- Pays the appropriate fee;
- Holds a valid license to practice in another state and have practiced for at least 3 out of the last 5 years preceding licensure;
- Demonstrates, in a manner designated by rule of the Board, knowledge of the laws and rules governing the practice of mental health counseling in Florida. Rule 64B4-3.0035 requires these applicants to complete an 8 hour course and obtain a passing score on a corresponding examination;
- Has passed the NCMHCE or a licensing examination substantially equivalent to the NCMHCE in another state or in this state;
- Completes a 3-hour course on HIV/Aids pursuant to s. 491.0065, F.S.;
- Agrees to complete a 2-hour domestic violence course within six months of licensure;[24] and
- Holds a license in good standing and is not under investigation in Florida or another jurisdiction for an act which would constitute a violation of ch. 491, F.S.

Mental Health Counseling in Florida Through Telehealth

In 2019, the Legislature passed and the Governor approved CS/CS/HB 23, which created s. 456.47, F.S. The bill became effective on July 1, 2019.[25] It authorized Florida-licensed health care providers, including mental health counselors who are either Florida-licensed or licensed under a multi-state health care licensure compact of which Florida is a member state,[26] to use telehealth to deliver health care services within their respective scopes of practice.

The bill also authorized out-of-state health care providers to use telehealth to deliver health care services to Florida patients if they register with the DOH or the applicable board[27] and meet certain eligibility requirements.[28] A registered out-of-state telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

[22] *Supra* note 1.
[23] *Id.*
[24] *Id.* at 20.
[25] Chapter 2019-137, s. 6, Laws of Fla.
[26] Section 456.47(1)(b), F.S.
[27] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH's Division of Medical Quality Assurance. The
[28] Section 456.47(4), F.S.

The Legislature also passed HB 7067 in 2019 that would have required an out-of-state telehealth provider to pay an initial registration fee of $150 and a biennial registration renewal fee of $150, but the bill was vetoed by the Governor and did not become law.[29]

On March 21, 2020, Surgeon General Scott Rivkees executed DOH Emergency Order 20-003[30] to authorize certain out-of-state clinical social workers, marriage and family therapists, mental health counselors, and psychologists to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S. These emergency orders were extended and expired on June 26, 2021.[31] Out-of-state health care practitioners are no longer authorized to perform telehealth services for patients in Florida unless they become licensed or registered in Florida.

Florida-licensed providers may not provide health care services to clients located in other states without express authorization from each state.

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.[32]

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.[33] 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.

III. Effect of Proposed Changes:

Section 1 of the bill creates the Professional Counseling Licensure Compact as s. 491.017, F.S., which enters Florida into the compact. The compact has 15 articles that establish the compact's administration and components and prescribe how the commission will oversee the compact and conduct its business. The table below summarizes the new statutory language, by article, which creates the components of the compact.

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[29] Transmittal Letter from Governor Ron DeSantis to Secretary of State Laurel Lee (June 27, 2019) *available at* https://www.flgov.com/wp-content/uploads/2019/06/06.27.2019-Transmittal-Letter-3.pdf (last visited Feb. 14, 2021).
[30] Department of Health, State of Florida, *Emergency Order DOH No. 20-003* (Mar. 21, 2020) *available at* https://s33330.pcdn.co/wp-content/uploads/2020/03/DOH-EO-20-003-3.21.2020.pdf (last visited Oct. 21, 2021).
[31] Florida Board of Medicine, *Important Updates for Health Care Providers Regarding Expiration of Emergency Orders* (July 1, 2021) *available at* https://r.bulkmail.flhealthsource.gov/mk/mr/JV-U0AMitwBXlP7zcFx3Djqu1KfE1B57JaGN-nnNySmOjEY5xGSsIyII28XjOGeZ4yKv9rWQUryqAibmdrixNZdgE9Q61dmUoHRF1Rnyijg-ewyAl_rZBT8c (last visited Oct. 18, 2021).
[32] FLA. CONST. art. X, s. 13.
[33] Chapter 73-313, L.O.F., codified at s. 768.28, F.S.

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
I	Purpose	The primary purpose of the compact is to facilitate the interstate practice of licensed professional counselors with the goal of improving public access to professional counselling services.
II	Definitions	Definitions are provided for the following terms: • "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. • "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. • "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a professional counseling licensing board to address impaired practitioners. • "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. • "Counseling Compact Commission" or "commission" means the national administrative body whose membership consists of all states that have enacted the compact. • "Current significant investigative information" means: o 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 o 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. • "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.

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
		• "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. • "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of licensed professional counseling by a licensing board. • "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. • "Home state" means the member state that is the licensee's primary state of residence. • "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. • "Investigative information" means information, records, or documents received or generated by a professional counseling licensing board pursuant to an investigation. • "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. • "Licensed professional counselor" means a mental health counselor licensed under ch. 491, F.S., 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. • "Licensee" means an individual who currently holds an authorization from the state to practice as a licensed professional counselor. • "Licensing board" means the agency of a state, or equivalent that is responsible for the licensing and regulation of licensed professional counselors. • "Member state" means a state that has enacted the compact. • "Privilege to practice" means a legal authorization, which is equivalent to a license, authorizing the practice of professional counseling in a remote state. • "Professional counseling" means the assessment, diagnosis, and treatment of behavioral health conditions by a licensed professional counselor.

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
		• "Remote state" means a member state, other than the home state, where a licensee is exercising or seeking to exercise the privilege to practice. • "Rule" means a regulation adopted by the commission which has the force of law. • "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. • "State" means any state, commonwealth, district, or territory of the United States of America which regulates the practice of professional counseling. • "Telehealth" means the application of telecommunication technology to deliver professional counseling services remotely to assess, diagnose, and treat behavioral health conditions. • "Unencumbered license" means a license that authorizes a licensed professional counselor to engage in the full and unrestricted practice of professional counseling.
III	State Participation	To participate in the compact, a state must currently do all of the following: • License and regulate licensed professional counselors. • Require licensees to pass a nationally recognized exam. • 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 in relevant areas. • Require licensees to complete a supervised postgraduate professional experience, *as defined by the commission*. • Have a mechanism in place for receiving and investigating complaints about licensees. (Initial Florida applicants must possess a master's degree from a regionally accredited program in mental health counseling or a closely related field that consists of at least 60 semester hours or 80 quarter hours and required graduate coursework. Initial Florida applicants must also complete two years of clinical experience in mental health counseling as a registered mental health counselor intern.) A member state must: • Participate fully in the compact commission's licensure data system. • Notify the commission of any adverse action against or of current significant investigative information regarding a licensee.

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
		• Conduct criminal background checks of candidates for an initial privilege to practice. • Comply with rules of the commission, established in article IX. • Grant the privilege to practice professional counseling to a licensee holding a valid, unencumbered license in another member state. • Provide for the state's commissioner to attend the meetings of the commission. A member state may charge a fee for granting a privilege to practice. A licensed professional counselor may only utilize the compact if their home state joins the compact.
IV	Privilege to Practice	A licensee may seek a privilege to practice within a remote state. To exercise the privilege to practice professional counseling within a remote state, a licensee must: • Hold a license in his or her home state which must be a member of the compact. • Have had no encumbrance or restriction against any license or privilege to practice within the previous two years. • *Meet any continuing education and jurisprudence requirements of the remote state and pay all applicable fees*. • Report to the commission any adverse action, encumbrance, or restriction imposed on the licensee by a non-member state within 30 days from the date of the action. A privilege to practice is valid until the expiration date of the practitioner's home state license. 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. If a licensee's home state license is encumbered, the licensee loses the privilege to practice in any remote state for the next two years. If a licensee's privilege to practice is removed by a member state, the licensee may lose their privilege to practice in member states for the next two years.

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
V	Obtaining a New Home State License based on a Privilege to Practice	A licensee may hold a home state license in only one member state at a time. A licensee who moves from one member state to another member 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. The licensee will be required to complete a new FBI fingerprint-based criminal background check if not previously performed, complete any required state-level background check, *meet any jurisprudence requirements of the new home state*, and pay all applicable fees. (Florida-licensed mental health counselors are not currently required to be fingerprinted and background-screened as a condition of licensure. See s. 456.0135, F.S. If the compact is enacted in Florida, single-state applicants and registered interns would not be required to submit to a criminal history check, but applicants under the compact would be.) If a new home state license is granted, the former home state must convert the former home state license into a privilege to practice.
VI	Active Duty Military Personnel and their Spouses	Active duty military personnel, or their spouse, may designate a home state where the individual has a current license in good standing. This state serves as the individual's home state for the duration of the service member's active duty.
VII	Compact Privilege to Practice Telehealth	Member states must recognize the right of a licensed professional counselor to practice professional counseling in any member state through telehealth under a privilege to practice. A licensee providing telehealth services in a remote state must adhere to the laws and regulations of that state.
VIII	Adverse Actions	Only a practitioner's home state has the power to take adverse action against a home state license. Home states must 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 must apply its own state laws to determine appropriate action in such cases. Remote states may take adverse action against a counselor's privilege to practice within that member state and may issue enforceable subpoenas for witnesses and evidence from other member states. A member state, if authorized by state law, may recover from the affected licensed professional counselor the costs of investigations

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
		and dispositions of any cases resulting from adverse action taken against that licensed professional counselor. Member states shall share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact. 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. The bill maintains the right for state boards to require licensees to participate in impaired practitioner programs.
IX	Establishment of Counseling Compact Commission	The Counseling Compact Commission (commission) is established by the member states as a joint public agency. Judicial proceedings by or against the commission must 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. *Nothing in the compact may be construed as a waiver of sovereign immunity.* Each member state is entitled to one delegate appointed by each member state's licensing board who must be either a licensed professional counselor, a public member, or an administrator of the board. Each delegate has one vote on commission affairs. The commission is directed to establish a term of office for delegates and may establish term limits. The commission must meet at least once during each calendar year and all meetings must be open to the public. The commission or the executive committee or other committees of the commission may convene in a closed, nonpublic meeting under certain circumstances. (See "Public Records/Open Meetings Issues" in Section IV of this analysis.) The commission must keep detailed minutes. The commission may establish and maintain a code of ethics, bylaws, rules, a budget, financial records, and may initiate or prosecute legal proceedings or actions in the name of the commission, in order to carry out the compact. The commission must select an executive committee composed of up to eleven members: seven members of the commission and up to

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
		four ex-officio, nonvoting members from four recognized national professional counselor organizations. The executive committee must meet at least annually and must, at a minimum, do all of the following: • Make recommendations to the commission for any changes to the rules, bylaws, compact legislation, fees paid by member states, and fees charged to licensees for the privilege to practice. • Prepare and recommend the budget. • Maintain financial records. • Monitor compliance of member states and provide compliance reports to the commission. • Establish additional committees as necessary. The commission must pay or provide for the payment of certain reasonable expenses and may accept appropriate revenue. The commission may not incur obligations of any kind before securing funds adequate to meet the same. Receipts and disbursements of funds handled by the commission must be audited annually be a certified or licensed public accountant. The commission may levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based on a formula to be determined by the commission, which must adopt a rule binding on all member states. Commission members and employees are immune from liability related to their positions except in cases of wanton misconduct.
X	Data System	The Commission must provide for the development, operation, and maintenance of a coordinated database and reporting system (the data system) containing licensure, adverse action, and investigative information on all licensed professional counselors in member states. A member state must 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. Investigative information pertaining to a licensee in any member state may be made available only to other member states. The commission must promptly notify all member states of any adverse

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
		action taken against a licensee or an individual applying for a license. 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. (See "Public Records/Open Meetings Issues" in Section IV of this analysis.)
XI	Rulemaking	The Commission shall adopt reasonable rules to effectively and efficiently achieve the purposes of the compact. If the commission issues a rule that exceeds its authority under the compact, such a rule is void and has no force or effect. Rules carry the force of law in all member states. If a majority of the legislatures of member states reject a rule by enactment of a statute or a resolution in the same manner used to adopt the compact within 4 years after the date of the adoption of a rule, such rule does not have further force or effect in any member state. 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 must file a notice of proposed rulemaking, which must include the text of the proposed rule, on the commission's website and on the website of each member state's professional licensing board. Interested persons may submit notice to the commission of their intention to attend a public hearing and may submit written comments before the commission may adopt a proposed rule. The commission must grant an opportunity for a public hearing if it is requested by at least 25 independent persons, a state or federal governmental subdivision or agency, or an association that has at least 25 members. Rules may be grouped at public hearings for the convenience of the commission. The commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing under certain circumstances.
XII	Oversight; Default, Technical Assistance, and Termination Dispute Resolution; and Enforcement	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 provide written notice, remedial training, and technical assistance to the state. If a state fails to cure a default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states and only after all other means of securing compliance have been exhausted. The commission shall attempt to resolve any compact-related disputes that may arise between states.

Provisions of the Professional Counselors Licensure Compact		
Article	**Title**	**Description**
		The commission is responsible for enforcing the provisions and rules of the compact.
XIII	Date of Implementation of the Counseling Compact Commission and Associated Rules, Withdrawal, and Amendment	The compact becomes effective on the date on which the compact is enacted into law in the 10th member state. Thereafter, the commission must met and exercise rulemaking powers necessary for the implementation and administration of the compact. States that join the compact after this date are subject to the rules of the commission as they exist on the date when the compact becomes law in that state. Member states withdraw from the compact by enacting a statute repealing the compact. *A state's withdrawal takes effect six months after enactment of the repealing statute.* The member states may amend the compact, but changes do not take effect until enacted into the laws of all member states.
XIV	Binding Effect of Compact and Other Laws	A licensee providing professional counseling services in a remote state under the privilege to practice must adhere to the laws and regulations, including scope of practice, of the remote state. All rules and bylaws properly adopted by the commission are binding on the member states. *In the event of a conflict between a law of a member state and the compact, the state law is superseded to the extent of the conflict*.
IV	Construction and Severability	The compact is to be liberally construed so as to effectuate its purposes. The compact's provisions are severable. If a provision of the compact is declared to conflict with the United States Constitution, all other provisions remain valid for all member states. If a provision is held contrary to a member state's constitution, the compact retains its full force in all other states, and all other provisions remain valid in the affected state.

Section 491.004(5), F.S., requires the Board of Clinical Social Work, Marriage & Family Therapy, and Mental Health Counseling to adopt rules to implement and enforce the provisions of ch. 491, F.S. Section 1 of the bill creates s. 491.017, F.S., thereby requiring the Board to adopt rules to implement and enforce the compact.

Section 2 of the bill amends s. 456.073, F.S., to require the DOH to report any significant investigatory information relating to a health care practitioner practicing under the compact to the data system. Investigatory information is typically gathered as the DOH investigates complaints and assesses the need to discipline a licensee.

Section 3 of the bill amends s. 456.076, F.S., to require a consultant (who operates an approved impaired practitioner program) entering into a participant contract with an impaired practitioner who is practicing under the compact, to establish terms in the monitoring contract that include the impaired practitioner's withdrawal from all practice under the compact.

Section 4 of the bill amends s. 491.004, F.S., to require the Board to appoint an individual to serve as the state's delegate on the commission.

Section 5 of the bill amends s. 495.005, F.S., to exempt a person licensed as a clinical social worker, marriage and family therapist, or mental health counselor in another state who is practicing under the compact pursuant to s. 491.017, F.S., and only within the scope provided therein, from licensure by examination requirements, as applicable.

Section 6 of the bill amends s. 491.006, F.S., to exempt a person licensed as a clinical social worker, marriage and family therapist, or mental health counselor in another state who is practicing under the compact pursuant to s. 491.017, F.S., and only within the scope provided therein, from licensure by endorsement requirements, as applicable.

Section 7 of the bill amends s. 491.009, F.S., to authorize the Board to take adverse action against a social worker's, a marriage and family therapist's, or a mental health counselor's privilege to practice under the compact and authorizes the Board impose grounds for discipline if the clinical social worker, marriage and family therapist, or mental health counselor commits an act specified in subsection (1) of this section or in s. 456.072(1), F.S.

Section 8 of the bill amends s. 768.28, F.S., to designate as agents of the state, the individual appointed as the state's delegate on the commission when serving in that capacity, and any administrator, officer, or executive director, employee, or representative of the commission when acting within the scope of his or her employment, duties, or responsibilities in this state, for the purpose of applying waivers of sovereign immunity. This section also requires the commission to pay certain claims or judgments and authorizes the commission to maintain insurance coverage to pay such claims or judgments.

Section 9 of the bill requires the DOH to notify the Division of Law Revision upon the enactment of the compact into law by 10 states.

Section 10 of the bill provides an effective date contingent on the enactment of the compact into law by 10 states.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

A counselor's personal identifying information, other than the counselor's name, licensure status, or licensure number, may be entered into the system by the DOH or the

Board or may be obtained by the DOH or the Board from the data system as reported by another state.

A meeting or a portion of a meeting of the commission, or the executive committee or other committees of the commission may be closed if the commission's legal counsel or designee has certified that the meeting may be closed because the commission or executive committee or other committees of the commission must discuss any of the following:

- Noncompliance of a member state with its obligations under the compact.
- 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.
- Current, threatened, or reasonably anticipated litigation.
- Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate.
- Accusing any person of a crime or formally censuring any person.
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential.
- Disclosure of information of a personal nature if disclosure would constitute a clearly unwarranted invasion of personal privacy.
- Disclosure of investigative records compiled for law enforcement purposes.
- 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.
- Matters specifically exempted from disclosure by federal or member state law.

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.

These issues are addressed in linked bill, SB 590.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

Article VII, Section 19, of the State Constitution requires that the imposition of, or the authorization of, a new state tax or fee, as well as an increased state tax or fee, must be approved by two-thirds of the membership of each house of the Legislature and must be contained in a separate bill that contains no other subject. Article VII, Section 19(d)(1) of the State Constitution defines "fee" to mean "any charge or payment required by law, including any fee for service, fee or cost for licenses, and charge for service." The bill authorizes the counseling compact commission and the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling to impose a new state tax or fee.

Lines 334-335 of the bill authorize member states to charge a fee for granting a privilege to practice in their state. Lines 365-366 of the bill require a licensee seeking to practice under the compact to pay any applicable fees, including any state fee, for the privilege to practice. Lines 427-433 and 457-459 of the bill require a compact counselor who changes his or her primary state of residence by moving between two member states to pay all applicable fees to his or her new home state.

Lines 734-742 of the bill authorize the commission to levy and collect an annual assessment from each member state or impose fees *on other parties* to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based on a formula to be determined by the commission, which must adopt a rule binding on all member states.

Section 491.004(5), F.S., requires the Board to adopt rules to implement and enforce the provisions of ch. 491, F.S. Section 1 of the bill creates the Professional Counseling Licensure Compact as s. 491.017, F.S., thereby requiring the Board to adopt rules to implement and enforce the compact, which may include the imposition of a fee for granting a privilege to practice in this state granting and a fee to cover the cost of the operations and activities of the commission, pursuant to the compact.

E. Other Constitutional Issues:

The compact authorizes the commission to "adopt reasonable rules to effectively and efficiently achieve the purposes of the compact," and these rules carry the force of law in member states, which is potentially an unlawful delegation of legislative authority. If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the commission.

The Legislature delegated similar rulemaking powers to the Nurse Licensure Compact when it adopted the compact language into statute. The rules adopted by the Nurse Licensure Compact are now applicable to Florida without the Legislature's subsequent approval, similar to what the state would encounter with the counseling compact adoption and included rulemaking provision. In the case of the counseling compact, should Florida find that rules adopted by the commission are not acceptable, the compact provides a mechanism for a majority of state legislatures to override commission rules. Furthermore, the state maintains the ability to withdraw from the compact.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Lines 734-742 of the bill authorize the commission to levy and collect an annual assessment *from each member state* or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount

must be allocated based on a formula to be determined by the commission, which must adopt a rule binding on all member states.

B. Private Sector Impact:

CS/SB 358 could lead to more licensed mental health counselors practicing in Florida. It could also lead to more Florida-licensed mental health counselors practicing through telehealth and providing care to patients in other member states. The fiscal result to the private sector is indeterminate.

C. Government Sector Impact:[34]

The DOH reports that its Division of Medical Quality Assurance (MQA) may experience an increase in revenues if the compact is enacted in Florida, as the bill authorizes member states to charge a fee for granting a privilege to practice under the compact. The number of applicants for compact licensure is indeterminate and a fiscal impact cannot be calculated.

MQA may experience a recurring increase in workload associated with processing applications and issuing initial and renewal licenses to participate in the compact. The DOH projects needing a minimum of one full-time equivalent (FTE), a Regulatory Specialist III (PG 19), with a projected cost of $71,147 ($48,963/Salary $21,878/Expense $306/HR).

MQA may experience a recurring increase in workload associated with the additional complaints and investigations due to the new compact license. At this time, the impact is indeterminate.

The bill authorizes the commission to levy and collect an annual assessment from each member state. The annual membership cost with the Licensed Professional Counselors Compact is unknown at this time, yet the DOH anticipates that existing budget authority is adequate to absorb this recurring cost.

If the bill is enacted if the compact becomes effective, MQA will experience a non-recurring increase in workload and costs associated with updating the Licensing and Enforcement Information Database System, Online Service Portal, Cognitive Virtual Agent, Continuing Education Tracking System, License Verification Search Site, and board website to support multistate licensing. Additionally, MQA will be required to establish a process for sharing information with the data system and update existing data exchange services with the Agency for Health Care Administration.

The total estimated cost for the first year is $71,147 in the following categories:

- Salary- $48963/Recurring
- Expense- $17,229/Recurring $4,649/Non-Recurring
- Human Resources - $306/Recurring

[34] *Supra* note 1.

Section 491.004(5), F.S., requires the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling to adopt rules to implement and enforce the provisions of ch. 491, F.S. Section 1 of the bill creates the Professional Counseling Licensure Compact as s. 491.017, F.S., thereby requiring the Board to adopt rules to implement and enforce the compact, once it becomes effective.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The counseling compact model compact legislation[35] defines a "licensed professional counselor" as a counselor licensed by a member state, regardless of the title used by that State, to independently assess, diagnose, and treat behavioral health conditions." Under Florida law, a mental health counselor, clinical social worker, and a marriage and family therapist may be interpreted to fit the definition of a licensed professional counselor. For this reason, the bill at lines 232-236 defines a "licensed professional counselor" as "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."

This means that in Florida, only a licensed mental health counselor may apply for and be granted a privilege to practice in another member state. In other member states, a professional who meets that member state's definition of a licensed professional counselor, regardless of what title the professional holds, may apply for and be granted a privilege to practice in another member state. To be granted a privilege to practice under the compact, a licensed professional counselor applicant must pass a nationally recognized exam approved by the compact commission, have 60 hours of graduate coursework in specified topic areas or have a master's degree in counseling; and have completed supervised postgraduate professional experience as defined by the commission.

The bill acknowledges that a person from another member state who is granted a privilege to practice in Florida may be licensed as a practitioner other than a mental health counselor. (See lines 1156-1158 and 1165-1166.) If it is the intent that a licensed professional counselor be granted a privilege to practice in this state only if he or she holds a license that is substantially similar to that of a Florida mental health counselor, then this bill should be amended.

Statutes Affected:

This bill creates section 491.017 of the Florida Statutes.

This bill substantially amends the following sections of the Florida Statutes: 456.073, 456.076, 491.004, 491.005, 491.006, 491.009, and 768.28.

[35] Counseling Compact, *Model Legislation* (Dec. 4, 2020) *available at* https://counselingcompact.org/wp-content/uploads/2021/06/Final_Counseling_Compact_With_Cover.pdf (last accessed Oct. 31, 2021).

VIII. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on November 3, 2021:
The CS changes the effective date of the underlying bill from July 1, 2022, to reflect that the bill's provisions become effective only after the compact is enacted into law by 10 states. The CS also requires the DOH to notify the Division of Law Revision when the compact has been enacted into law by 10 states.

B. Amendments:

None.

166930

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
11/03/2021	.	
	.	
	.	
	.	

The Committee on Health Policy (Rodriguez) recommended the following:

Senate Amendment (with title amendment)

Delete line 1334

and insert:

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.

166930

11
12 ================ T I T L E A M E N D M E N T ================
13 And the title is amended as follows:
14 Delete line 120
15 and insert:
16 judgments; requiring the department to notify the
17 Division of Law Revision upon enactment of the compact
18 into law by 10 states; providing a contingent
19 effective date.

By Senator Rodriguez

39-00389A-22 2022358__

A bill to be entitled

An act relating to the 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; authorizing member states to charge a fee for granting a privilege to practice under the compact; specifying that that 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

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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; providing an effective date.

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

Section 1. Section 491.017, Florida Statutes, is created 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) Member states may charge a fee for granting the privilege to practice.

(4) 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.

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

(6) 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) Pay any applicable fees, including any state fee, for the privilege to practice.

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

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

(i) 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, pay all applicable fees, 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) The licensed professional counselor must pay all applicable fees to the new home state in order to be issued a new home state license for purposes of the compact.

(7) 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.

(8) 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.

(9) 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; fees paid by compact member states; and any fees charged to licensees for the privilege to practice.

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 levy and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the commission and its staff. Such assessments and fees must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount must be allocated based on a formula to be determined by the commission, which shall adopt a rule binding on all member states.

(d) 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.

(e) 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. This act shall take effect July 1, 2022.

The Florida Senate

APPEARANCE RECORD

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

11/2/21
Meeting Date

Health
Committee

358
Bill Number or Topic

Amendment Barcode (if applicable)

Name Phillip Sudermon Phone

Address Email

Street

City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Americans for Prosperity

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

11/3/21
Meeting Date

Health Policy
Committee

358
Bill Number or Topic

Amendment Barcode (if applicable)

Name Michael Cusick

Phone 850-212-0626

Address 200 West College
Street

Email Mike@MichaelCusick.com

Tallahassee FL 32301
City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

November 1, 2021
Meeting Date

Health Policy
Committee

SB 358
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dr. Karla L. Sapp

Phone 9129806049

Address 501 S. Blairstone Rd. Apt. 623
Street

Email drkarlasapp@gmail.com

Tallahassee
City

Florida
State

32301
Zip

Reset Form

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

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

S-001 (08/10/2021)

2022 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Florida Department of Health

BILL INFORMATION	
BILL NUMBER:	358
BILL TITLE:	Professional Counselors Licensure Compact
BILL SPONSOR:	Rodriguez (A)
EFFECTIVE DATE:	7/1/2022

COMMITTEES OF REFERENCE
1) Health Policy
2) Appropriations Subcommittee on Health and Human Services
3) Appropriations
4)
5)

CURRENT COMMITTEE
Health Policy

SIMILAR BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	10/25/2021
LEAD AGENCY ANALYST:	Janet Hartman
ADDITIONAL ANALYST(S):	
LEGAL ANALYST:	Louise St. Laurent
FISCAL ANALYST:	Jonathan Sackett

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The bill enacts the Interstate Licensed Professional Counselors compact and adds Florida as a member state to include licensed Mental Health Counselors. It establishes specified procedures and requirements for professional counselors to obtain and maintain a privilege to practice in a member state; the composition, powers, and responsibilities of the Counseling Compact Commission; and requirements related to the oversight, dispute resolution, and enforcement of the compact. The bill implementation is contingent on enactment of similar legislation in ten states.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

The licensed Mental Health Counseling profession continues to expand in Florida and has reported an average growth in recent years of more than 1,000 new licensees per year; increasing the total licensed population to 15,518 practitioners (2020/2021 Annual Report). Florida law delineates between an application by examination for initial licensure and application by endorsement for Mental Health Counselors who have previously held an active, unencumbered, license in another state. Section 491.005(4), Florida Statutes, specifies the minimum qualifications for application by examination and section 491.006, Florida Statutes, provides the qualifications for applicants who are eligible for application by endorsement.

Application by Examination – Initial Licensure Requirements
Initial applicants must possess a minimum of a master's degree from a regionally accredited program in Mental Health Counseling or a closely related field that consists of at least 60 semester hours or 80 quarter hours and specific graduate coursework, including: Counseling Theories and Practice, Human Growth and Development, Diagnosis and Treatment of Psychopathology, Human Sexuality, Group Theories and Practice, Individual Evaluation and Assessment, Career and Lifestyle Assessment, Research and Program Evaluation, Social and Cultural Foundations, Substance Abuse, and Legal, Ethical, and Professional Standards Issues. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) which consists of at least 60 semester hours or 80 quarter hours to be licensed.

In addition to educational requirements, initial applicants must provide documentation to demonstrate completion of a 700-hour university-sponsored clinical practicum or internship with at least 280 hours of direct client services. After graduation, registered Mental Health Counselor Interns are required to complete post-graduate supervised experience conducted under the supervision of a board-approved qualified supervisor with at least 100 hours of supervision in no less than 100 weeks. Supervision experience hours are accrued on an hour-for-hour basis by providing face-to-face psychotherapy with clients. Registered interns are required to meet with their qualified supervisor every two weeks to review cases and to receive guidance. The final licensing requirement is successful completion of the National Clinical Mental Health Counseling Examination (NCMHCE) developed by the National Board for Certified Counselors (NBCC).

Application by Endorsement – Licensure Requirements
Applicants by endorsement who have practiced in another state for at least three out of the last five years are considered to have completed all minimum education, practicum, and supervision requirements and are required to provide limited documentation to become licensed. Applicants provide a license verification demonstrating an unencumbered license from the current state of licensure; proof of successful completion of the National Clinical Mental Health Counseling Examination (NCMHCE); and complete continuing education coursework in Florida laws and rules, HIV/AIDS, and domestic violence. As a method to streamline licensure for experienced Mental Health Counselors, Florida law does not require endorsement candidates to provide proof of education nor demonstrate completion of supervised experience.

Criminal History Disclosure Requirement
Licensure application forms are required to be submitted with license fees for processing. The application includes a mandatory disclosure of criminal history; however, applicants are not required to submit fingerprints to complete a criminal background check. Section 456.0135, Florida Statutes, provides the Department of Health authority to mandate criminal background checks for specified professions; however, mental health professions regulated by chapter 491, Florida Statutes, are not included.

Florida Telehealth Providers

Florida licensed Mental Health Counselors are identified as telehealth providers in accordance with section 456.47, Florida Statutes. The law further delineates the process for out-of-state licensed Mental Health Counselors to register as a telehealth provider in Florida. Florida telehealth providers may provide health care by telehealth methods to clients physically located in Florida. Telehealth providers may not provide health care services to clients located in other states without express authorization. This limits Florida telehealth providers from continuing clinical services while a client is temporarily located in another state and reduces business development opportunities to expand their practice to clients residing in other states. Licensure compacts include provisions for telehealth practice in member states without additional consideration or licensure.

Interstate Occupational License Compacts

According to the Council of State Governments (CSG), occupational licensure compacts create reciprocity between states while maintaining the quality and safety of services and protecting state sovereignty. Compacts have been adopted to provide the most effective means for achieving borderless practice for license practitioners and military spouses. Compacts relieve the burden of maintaining multiple state licenses for practitioners who serve clients in multiple states or are required to frequently relocate. Interstate compacts are formal, legislatively enacted agreements between two or more states that bind them to the compacts' provisions. According to the CSG, since January 2016, 170 separate pieces of licensure compact legislation have been passed in the United States. To date, 42 states and territories have enacted occupational licensure compacts for nurses, physicians, physical therapists, emergency medical technicians, psychologists, speech therapists/audiologists, occupational therapists, and counselors.

Existing Health Care Licensure Compacts in Florida
On January 19, 2018, applicants and currently licensed Florida nurses became eligible to apply for a multi-state license under the enhanced Nurse Licensure Compact, or eNLC. The eNLC allows registered nurses and licensed practical nurses who hold licensure in one Compact state to practice in any of the 27 Compact states without obtaining additional state licenses. This has effectively reduced regulatory requirements by eliminating the need for nurses to obtain a separate license to practice in different states. Florida joined the Nurse Licensure Compact upon the passage of HB 1061 during the 2016 regular Legislative Session.

Counseling Compact Adoption
Earlier this year, the Counseling Compact was successfully passed and signed into law in two states. On May 10, 2021, Georgia Governor Brian Kemp signed HB395 and subsequently on May 18, 2021, Maryland Gov. Larry Hogan signed SB 571/HB 736. The Compact has also been introduced this year in Tennessee (SB1027 HB0959), Nebraska (LB554), Ohio (SB204), and North Carolina (HB791). The threshold for Compact enactment requires a core group of ten-member states before the legislation can be fully enacted. According to the National Center for Interstate Compacts, Council of State Governments, the ten states required could be accomplished as early as the year 2022.

2. EFFECT OF THE BILL:

The bill implements the Interstate Licensed Professional Counselors compact and adds Florida as a member state. The only Florida licensed mental health profession affected by this compact is Mental Health Counselor, regulated by chapter 491, Florida Statutes, as defined in Compact Article II.

Section 1
Compact Article I: Purpose

The bill identifies the primary purpose of the compact is to increase public access to professional counseling services and provide opportunities for interstate practice by licensed professional counselors who meet uniform licensure requirements. The compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure while facilitating the exchange of information between member states regarding licensure, investigations, adverse actions, and disciplinary history of licensed professional counselors.

The bill reduces the regulatory burden for licensed professional counselors by eliminating the necessity to hold licenses in multiple states. The compact also includes specific provisions to support spouses of relocating active duty military personnel. The compact expands opportunities for interstate practice by individuals who meet the established and uniform licensure requirements. The uniform licensure requirements delineated in the compact are equivalent to a licensed Mental Health Counselor in Florida.

Compact Article II: Definitions

The bill establishes the definitions of key terms used through the compact to alleviate confusion on the part of practitioners and regulators. The definition of licensed professional counselor encompasses chapter 491, Florida Statues, and identifies the Florida recognized license, Licensed Mental Health Counselor.

Compact Article III: State Participation

The bill provides specific requirements for participation in the compact and establishes the duties of the compact member state. 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 the applicant to obtain or retain a license in the 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.

The bill specifies that a compact member state must 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. Florida law differs from the compact licensure requirements and provides separate minimum qualifications for mental health counselors who are licensed for the first time (initial) and those who are eligible for endorsement licensure based upon their prior experience in another state.

Initial Florida applicants must possess a master's degree from a regionally accredited program in mental health counseling or a closely related field that consists of at least 60 semester hours or 80 quarter hours and required graduate coursework. The bill specifies that compact applicants must possess a master's degree in mental health counseling or 60 semester hours, or 90 quarter hours of graduate coursework including specified topic areas. While both Florida and the compact have the same eight, core subjects for individuals who did not graduate from an accredited mental health counseling program, Florida also requires coursework in human sexuality, individual evaluation and assessment, and substance abuse. Beginning July 1, 2025, initial Florida applicants must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs which consists of at least 60 semester hours or 80 quarter hours to apply for licensure under this paragraph. Once implemented, the specified coursework will no longer be a factor in a licensing decision for a single-state, Florida license.

Initial Florida applicants must also demonstrate proof of two years of post-masters, supervised experience under the supervision of a Board approved qualified supervisor. The bill specifies that the compact commission will define the experience requirement but is not delineated by the bill at this time. The supervision requirement delineated in existing Florida law is consistent with the Council for Accreditation of Counseling and Related Educational Programs accreditation standard.

Applicants by endorsement who have practiced in another state for at least three out of the last five years are only required to provide a license verification from the state of licensure; proof of completion of the National clinical Mental Health Counseling Examination (NCMHCE); and complete continuing education coursework in Florida laws and rules, HIV/AIDS, and domestic violence. Florida law does not require endorsement candidates to provide proof of education nor demonstrate completion of supervised experience. The bill will require compact applicants to demonstrate compliance with the educational and experience requirements who may have otherwise qualified for an endorsement application without documented proof. The model compact is designed to establish mutual minimum qualifications for licensure to

ensure that each participating state is confident in the qualifications of the applicant. While the process may require additional documentation for an experienced counselor, the process will ensure consistency in minimum requirements across all compact states.

The implementation of this bill would not adversely affect applicants who choose to apply for single-state licensure in Florida. However, single-state licensure does not permit practitioners to practice in other compact member states. The bill specifies that a member state may charge a fee for granting the privilege to practice which is generally less than a single-state license fee. This provision will increase the types of licenses available to practice mental health counseling in Florida but may reduce revenue collected from out of state applicants who would typically apply for a license in Florida at the full fee rate. The additional license type will require the development and implementation of a new license application to offer the compact license as an alternative to the Florida license to practice.

The bill requires member states to implement procedures for reviewing criminal history records. This includes the provision for collection of fingerprints for the purpose of comparison with the Federal Bureau of Investigation and the agency responsible for retaining member state criminal records. In Florida, the Florida Department of Law Enforcement is identified for that purpose. Presently, applicants licensed under chapter 491, Florida Statutes, are not required to provide fingerprints for the purpose of a criminal history review. As such, this provision will be inconsistent with existing licensing minimum requirements within this chapter. If implemented, single-state applicants and registered interns would not be required to submit to a criminal history check, but compact, multi-state applicants would. The Department of Health has existing infrastructure to collect, review, and maintain information regarding criminal history based on other licensed professions with this requirement. Additionally, the department has an ORI number assigned by the Federal Bureau of Investigation dedicated to mental health professions. The implementation of background screening for compact applicants would require minimal, internal system modifications.

Compact Article IV: Privilege to Practice

The compact is an occupational licensure agreement based on the mutual recognition model, in which a practitioner's home state license is mutually recognized by other compact member states based on a set of criteria laid out within the language of the compact. This model will allow counselors to practice in compact member states, either in-person or via telehealth, through obtaining a "privilege to practice." The bill delineates the requirements for licensees to exercise the privilege to practice under the compact, a licensee must:

- Hold a license in the home state;
- Have a valid Social Security number or National Practitioner Identification number;
- Be eligible for a privilege to practice in any member state;
- Have not had any encumbrance on any state license within the previous two years;
- Notify the commission that the licensee is seeking the compact privilege within a remote state(s);
- Pay any applicable fees;
- Meet any continuing education requirements established by the home state;
- Meet any jurisprudence requirement established by the remote state(s) in which the licensee is seeking a privilege to practice; and
- Report to the commission any adverse action, encumbrance, or restriction taken by any nonmember state within 30 days from the date the action is taken.

As indicated in the bill, the privilege to practice is valid until the expiration date indicated on the home license. A licensee providing mental health 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 specific period of time, impose fines, or take any other necessary actions to protect the health and safety of its citizens. This provision ensures that the board retains regulatory authority for the licensee regardless of whether they are issued a home license in Florida or are practicing in this state based on the authority of the compact.

The bill addresses disciplinary action taken on a licensee by addressing both discipline in a home state as well as if disciplinary action is taken while practicing in a remote state. If a home state license is encumbered by the board, the licensee loses the privilege to practice in any remote state until the home state license is no longer encumbered and two years have elapsed from the date of any encumbrance or restriction. However, if a licensee's privilege to practice in a remote state is removed, the individual may lose the privilege to practice in any remote state until the specific period of time for which the privilege to practice was removed has ended; all fines have been paid; and two years have elapsed from the date of any encumbrance or restriction. This language suggests that revocation of a privilege to practice in a remote state may not necessarily extend to other states in the compact.

Compact Article V: Obtaining a New Home State License Based on a Privilege to Practice

The bill limits home state licensure to one member state at a time and establishes a process by which a licensee can change their home state. The licensee will be required to complete a new FBI fingerprint based criminal background check, any required state-level background check, and any jurisprudence requirements of the new state. If a practitioner moves from a non-member state to a member state, or from a member state to a non-member state, the practitioner must apply for a single state license in the new state, under the requirements of that state.

Compact Article VI: Active Duty Military Personnel or Their Spouses

Active duty military personnel or their spouses must designate a home state where the individual has a current license in good standing. The individual may retain the home state designation regardless of the physical practice location while the service member is on active duty.

Compact Article VII: Privilege to Practice Telehealth

This section establishes that privilege to practice under the compact shall include the provision of telehealth services to patients in member states. While Florida has maintained a comprehensive telehealth law for nearly three years, licensed professional counselors may only practice telehealth to clients located in Florida unless authorization is granted to practice in other states. The bill expands the use of telehealth to facilitate increased delivery of services within all member states. This is particularly important for existing clients of Florida counselors who travel outside the state or move to another state and prefer to continue receiving services from their established mental health counselor. As it relates to the business operation of a mental health practice, the bill expands the ability for licensed professional counselors with a privilege to practice in any member state to develop a client base in other member states. Licensees providing telehealth services in a remote state must adhere to the laws and regulations, including scope of practice, of the remote state.

Compact Article VIII: Adverse Actions

The bill establishes processes for imposing disciplinary penalties, maintains a home state's exclusive power to take adverse action against a license issued by that home state and allows remote states to investigate and take adverse action against a privilege to practice granted by that remote state. Home states must take reported adverse action from any member state into account, in accordance with the home state's laws. Member states may initiate joint investigations of licensees and are required to share investigative materials in furtherance of any joint or single-state investigation of a licensee. Member states must report any adverse action to the compact data system, which then alerts the home state of the adverse action. Any member state may take adverse action based on the factual findings of a remote state. The bill maintains the right for the Board to require a licensee to participate in the Impaired Practitioner Program.

Compact Article IV: Establishment of Counseling Compact Commission

This section of the bill outlines the composition and the powers of the compact commission and executive committee. Each member state must have one delegate selected by that member state's licensing board. The delegate must be a current member of the licensing board (a licensed professional counselor, public member, or board administrator). The commission must meet at least once each calendar year, and must, among other duties establish bylaws; promulgate rules to effectively and efficiently achieve the purpose of the compact; and establish an executive committee. The commission may collect an annual assessment from each member state or impose fees on other parties to cover the cost of operations and activities.

Compact Article X: Data System

This section is drafted to require the sharing of licensure information by all compact states. The commission must provide for the development, maintenance, and utilization of a coordinated database and reporting system containing licensure, adverse action, and investigative information on all licensed individuals in member states. A member state must submit a

specified uniform data set to the data system on all individuals to whom the compact is applicable as required by the rules of the commission. The commission must 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 will be available to any other member state but is restricted from release to non-member states.

Compact Article XI: Rulemaking

The bill specifies that rules are applicable and carry the same weight as law in all member states. Rulemaking conducted by the commission includes a provision for 30-day notice of proposed rulemaking published on the website of the Board and noticed in the Florida Administrative Register, with an opportunity for public hearing if one is requested by 25 people, a government agency, or an association that has at least 25 members. If a public hearing is held, the commission will publish relevant information to encourage meeting access. The bill includes a provision that if the commission issues a rule that exceeds authority under the compact, it is considered void and ineffectual.

Compact Article XII: Oversight, Dispute Resolution, and Enforcement

The bill ensures compliance with the compact by member states. The Executive, Legislative, and Judicial branches of state government in each member state must enforce the compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the compact, the commission must provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, or any other action to be taken by the commission and provide remedial training and specific technical assistance regarding the default. 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.

Compact Article XIII: Date of Implementation of the Counseling Compact Commission and Associated Rules, Withdrawal, and Amendment.

The bill specifies that the compact will take effect on the date of enactment by the tenth state. The ten states will form the first commission and any state that joins after this date is subject to the rules of the commission as they exist on the date when the compact becomes law in that state. As one of the first ten states to file legislation, Florida is on course to serve on the initial commission who will establish the initial rules of the compact. If future legislation is enacted to repeal Florida's involvement in the compact, the bill requires a six-month period for withdrawal. The bill restricts a state from amending the compact by postponing the effective date until enacted into the laws of all member states.

Compact Article XIV: Binding Effect of Compact and Other Laws

The bill is drafted to include severability clauses. The first, if a provision of the compact is declared to be in conflict with the United States Constitution, all other provisions remain valid for all member states. The second, if a provision is held contrary to a member state's constitution, the compact retains its full force in all other states, and all other provisions remain valid in the affected state.

Section 2
The bill amends section 456.073, Florida Statutes, to include a provision requiring the reporting of significant investigatory information related to a health care practitioner practicing under the compact to the designated data system. Article X of the compact requires member states to submit significant investigative information to the coordinated database in accordance with the rules of the commission, once established.

Section 3
The bill amends section 456.076, Florida Statutes, to include a provision that the terms of an impaired practitioner contract must include the practitioner's withdrawal from practice under the compact.

Section 4
The bill amends section 491.004, Florida Statutes, to authorize 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 Counseling Compact Commission.

Section 5
The bill amends the minimum qualifications for licensure of mental health practitioners regulated under section 491.005, Florida Statutes, by exempting health care practitioners who practice under the Professional Counselors Licensure Compact from licensure requirements.

Section 6
The bill amends the minimum qualifications for licensure of mental health practitioners regulated under section 491.006, Florida Statutes, by exempting health care practitioners who practice under the Professional Counselors Licensure Compact from licensure requirements.

Section 7
The bill amends the grounds for denial of a license delineated in section 491.009, Florida Statutes, to include a reference of newly created section 491.017, Florida Statutes. Additionally, the bill authorizes the board to take adverse action against a mental health practitioner's license including affecting the privilege to practice under the compact as well as imposing disciplinary penalties.

Section 8
The bill extends the waiver of sovereign immunity in tort actions to include the state's delegate on the Counseling Compact commission, while serving in that capacity. It further delineates that commission administrators, officers, employees, representatives, or the executive director, while acting within the scope of employment or duties in Florida are considered an agent of the state.

Section 9
The bill specifies an effective date of July 1, 2022.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y☐ N☒

If yes, explain:	N/A
Is the change consistent with the agency's core mission?	Y☐ N☒
Rule(s) impacted (provide references to F.A.C., etc.):	N/A

***4.* WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?**

Proponents and summary of position:	Unknown
Opponents and summary of position:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y☐ N☒

If yes, provide a description:	N/A
Date Due:	N/A
Bill Section Number(s):	N/A

6. ARE THERE ANY NEW GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSIONS, ETC. REQUIRED BY THIS BILL? Y☐ N☒

Board:	N/A
Board Purpose:	N/A

Who Appoints:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y☐ N☒

Revenues:	N/A
Expenditures:	N/A
Does the legislation increase local taxes or fees? If yes, explain.	N/A
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y☒ N☐

Revenues:	DOH/MQA may experience an increase in revenues due to the provisions of this bill. This bill authorizes member states to charge a fee for granting a privilege to practice under the compact. The number of applicants for compact licensure is indeterminate; therefore, the fiscal impact cannot be calculated.
Expenditures:	1 full-time equivalent (FTE) position will be required to implement the provisions of this bill. Salary is calculated at base of the position plus 58% for fringe benefits. DOH/MQA will experience a recurring increase in workload associated with processing applications and issuing initial and renewal licenses. The impact is indeterminate; yet it is anticipated that a minimum of 1 FTE will be required to implement the provisions of this legislation. 1 Regulatory Specialist III (PG 19), no travel, is requested. Based on the LBR standards, the total FTE cost is $71,147 ($48,963/Salary $21,878/Expense $306/HR). DOH/MQA may experience a recurring increase in workload associated with the additional complaints and investigations due to the new compact license. The impact is indeterminate; therefore, the fiscal impact cannot be calculated at this time. DOH/MQA will experience a recurring increase in cost. The annual membership cost with the Interstate Licensed Professional Counselors Compact is unknown at this time, yet it is anticipated that current budget authority is adequate to absorb.

	DOH/MQA will experience a non-recurring increase in workload and costs associated with updating the Licensing and Enforcement Information Database System, Online Service Portal, Cognitive Virtual Agent, Continuing Education Tracking System, License Verification Search Site, and board website to support multistate licensing. Additionally, DOH/MQA will be required to establish a process for sharing information with the established Commission database and update existing data exchange services with the Agency for Health Care Administration. The impact is indeterminate; therefore, the fiscal impact cannot be calculated at this time. The total estimated cost for the first year is $71,147 in the following categories: Salary- $48963/Recurring Expense- $17,229/Recurring $4,649/Non-Recurring Human Resources - $306/Recurring
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y☒ N☐

Revenues:	None
Expenditures:	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.
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y☒ N☐

If yes, explain impact.	Applicants for the Florida Interstate Licensed Professional Counselors compact will be required to pay a fee to participate in the compact.
Bill Section Number:	N/A

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y☒ N☐

If yes, describe the anticipated impact to the agency including any fiscal impact.	DOH/MQA will experience a non-recurring increase in workload and costs associated with updating the Licensing and Enforcement Information Database System, Online Service Portal, Cognitive Virtual Agent, Continuing Education Tracking System, License Verification Search Site, and board website to support multistate licensing. Additionally, DOH/MQA will be required to establish a process for sharing information with the established Commission database and update existing data exchange services with the Agency for Health Care Administration.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y☐ N☒

If yes, describe the anticipated impact including any fiscal impact.	N/A

ADDITIONAL COMMENTS

None.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	Lines 441-444 of the proposed legislation require applicants for a mental health compact license to be fingerprinted for a criminal background check. Section 456.0135, Florida Statutes, specifies those health care practitioners required to be fingerprinted and background screened as a condition of licensure and sets forth the process for obtaining and retaining the fingerprints. Counselors licensed pursuant to chapter 491 are not included in the provisions of this section. Lines 609-637 of the proposed legislation allows the compact commission or committees of the compact to convene in a closed, nonpublic meeting to discuss issues specified in the proposed legislation. Such closed meetings may be deemed inconsistent with Florida's open meetings laws. Lines 832-833 of the proposed legislation sets forth authority to adopt rules to effectively and efficiently achieve the purposes of the compact. This language may be subject to challenge as an unauthorized delegation of legislative authority since the authority is not limited to the implementation and operation of the compact.

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Jr, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 13, 2021

I respectfully request that **Senate Bill #358**, relating to Professional Counselors Licensure Compact, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 39

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 296
INTRODUCER:	Senator Garcia
SUBJECT:	Health Care Expenses
DATE:	November 2, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 296 requires each Florida-licensed hospital and ambulatory surgical center (ASC) to, consistent with federal requirements on hospital price transparency in 45 C.F.R. part 180, establish, update, and make public a list of its standard charges for all items and services provided by the facility. The Agency for Health Care Administration (AHCA) is required to impose a fine of $500 per day, per instance of noncompliance on the facility if the facility is required to comply with 45 C.F.R. part 180 and violates the above requirement.

The bill creates s. 501.181, F.S., and amends s. 559.72, F.S., to provide requirements for consumer reporting agencies (CRA) related to medical debt. The bill prohibits a CRA from publishing a consumer report containing credit impairments resulting from medical debt under certain circumstances and requires a CRA to remove, without charging the patient a fee, any such credit impairment from the patient's credit report within 30 days after certain notification that the debt has been fully paid or settled or that the patient is in compliance with a payment plan.

To enforce these CRA-related provisions, the bill establishes a private right of action for an aggrieved patient. The bill provides that the patient may bring suit, within two years of the violation, to enjoin the prohibited action and to recover the greater of any actual damages or $1,500, as well as attorney fees and court costs. The Department of Agriculture and Consumer Services (DACS) is required to adopt rules to implement these requirements.

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

II. Present Situation:

Hospital and ASC Price Transparency

Florida Law

Section 395.301, F.S., requires hospitals and ASCs to provide information to current, former, and prospective patients regarding the pricing of services and procedures at that facility. The section requires each facility to post the following on its website:

- Information on payments made to that facility for defined bundles of services and procedures including, at a minimum, the estimated average payment received from all payors, excluding Medicaid and Medicare, for the descriptive service bundles available at that facility and the estimated payment range for such bundles.
- Information to prospective patients on the facility's financial assistance policy, including the application process, payment plans, and discounts, and the facility's charity care policy and collection procedures.
- A notification that services may be provided in the health care facility by the facility as well as by other health care providers who may separately bill the patient and that such health care providers may or may not participate with the same health insurers or health maintenance organizations (HMO) as the facility, if applicable.
- A notification that patients may request from the facility and other health care providers a more personalized estimate of charges and other information, and that patients should contact each health care practitioner who will provide services in the hospital to determine the health insurers and HMOs with which the health care practitioner participates as a network provider or preferred provider.
- The names, mailing addresses, and telephone numbers of the health care practitioners and medical practice groups with which it contracts to provide services in the facility and instructions on how to contact the practitioners and groups to determine the health insurers and HMOs with which they participate as network providers or preferred providers.
- A hyperlink to the health-related data, including quality measures and statistics that are disseminated by the AHCA pursuant to s. 408.05, F.S.

The section requires a hospital to post additional information to its website, including:

- The names and hyperlinks for direct access to the websites of all health insurers and HMOs for which the hospital contracts as a network provider or participating provider;
- A statement that:
  - Services may be provided in the hospital by the facility as well as by other health care practitioners who may separately bill the patient;
  - Health care practitioners who provide services in the hospital may or may not participate with the same health insurers or HMOs as the hospital; and
  - Prospective patients should contact the health care practitioner who will provide services in the hospital to determine the health insurers and HMOs with which the practitioner participates as a network provider or preferred provider; and
- As applicable, the names, mailing addresses, and telephone numbers of the health care practitioners and medical practice groups with which it contracts to provide services in the hospital, and instructions on how to contact the practitioners and groups to determine the

health insurers and HMOs with which they participate as network providers or preferred providers.

In addition, when requested and:

- Before providing any non-emergency medical services, each facility is required to provide a good faith estimate of reasonably anticipated charges by the facility for the treatment of the patient's or prospective patient's specific condition. The estimate:
  - Must include information on the facility's financial assistance policy, including the application process, payment plans, and discounts and the facility's charity care policy and collection procedures.
  - Must clearly identify any facility fees and, if applicable, include a statement notifying the patient or prospective patient that a facility fee is included in the estimate, the purpose of the fee, and that the patient may pay less for the procedure or service at another facility or in another health care setting.
  - Must notify the patient or prospective patient that services may be provided in the health care facility by the facility as well as by other health care providers that may separately bill the patient, if applicable.
- After the patient's discharge or release from a facility, the facility must provide to the patient or to the patient's survivor or legal guardian, as appropriate, an itemized statement or a bill detailing in plain language, comprehensible to an ordinary layperson, the specific nature of charges or expenses incurred by the patient. The statement:
  - Must include notice of hospital-based physicians and other health care providers who bill separately.
  - May not include any generalized category of expenses such as "other" or "miscellaneous" or similar categories.
  - Must list drugs by brand or generic name and not refer to drug code numbers when referring to drugs of any sort.
  - Must specifically identify physical, occupational, or speech therapy treatment by date, type, and length of treatment when such treatment is a part of the statement or bill.

Federal Law

In addition to the state requirements detailed above, 42 C.F.R. part 180 requires hospitals to make public:

- A machine-readable file containing a list of all standard charges for all items and services; and
- A consumer-friendly list of standard charges for a limited set of shoppable services.[1]

To make its list of standard charges and shoppable services public, a hospital must select a publicly available website to publish the standard charge information and the hospital must make the information available free of charge and without having to create a username and password or submit any personal identifying information.

The publication of a hospital's standard charges must include:

- A description of each item or service provided by the hospital.

[1] A shoppable service is defined as a service that can be scheduled by a healthcare consumer in advance.

- A gross charge that applies to each individual item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- A payer-specific negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting. Each payer-specific negotiated charge must be clearly associated with the name of the third party payer and plan.
- A de-identified minimum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- A de-identified maximum negotiated charge that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- Discounted cash price that applies to each item or service when provided in, as applicable, the hospital inpatient setting and outpatient department setting.
- Any code used by the hospital for purposes of accounting or billing for the item or service, including, but not limited to, the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the Diagnosis Related Group, the National Drug Code, or other common payer identifier.

The publication of a hospital's shoppable services must include:

- A plain-language description of each shoppable service.
- An indicator when one or more of the federal Centers for Medicare & Medicaid Services (CMS)-specified shoppable services are not offered by the hospital.
- The payer-specific negotiated charge that applies to each shoppable service (and to each ancillary service, as applicable). Each list of payer-specific negotiated charges must be clearly associated with the name of the third party payer and plan.
- The discounted cash price that applies to each shoppable service (and corresponding ancillary services, as applicable). If the hospital does not offer a discounted cash price for one or more shoppable services (or corresponding ancillary services), the hospital must list its undiscounted gross charge for the shoppable service (and corresponding ancillary services, as applicable).
- The de-identified minimum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).
- The de-identified maximum negotiated charge that applies to each shoppable service (and to each corresponding ancillary service, as applicable).
- The location at which the shoppable service is provided.
- Any primary code used by the hospital for purposes of accounting or billing for the shoppable service, including, as applicable, the Current Procedural Terminology code, the Healthcare Common Procedure Coding System code, the Diagnosis Related Group, or other common service billing code.

The CMS is charged with monitoring and enforcing hospital compliance with the above transparency provisions. If a hospital is found to be noncompliant, the CMS may take the following actions, in order:

- Provide a written warning notice to the hospital of the specific violation(s).
- Request a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements, according to 42 C.F.R. s. 180.80.

- Impose a civil monetary penalty on the hospital and publicize the penalty on a CMS website according to 42 C.F.R. s. 180.90 if the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan. The maximum daily amount of a penalty for violation is $300 even if the hospital is in violation of multiple discrete requirements of 42 C.F.R. part 180.

Compliance with Federal Requirements

A report published by Patient Rights Advocate.org[2] looked at a random sample of 500 of the 6,002 hospitals subject to the requirements above for compliance with the requirements.[3] The report estimated that only 5.6 percent (or 28) of the hospitals sampled were fully compliant with the rule.[4] The report found a hospital to be noncompliant with the rule "if it omitted any of the five standard charge criteria required by the rule, if it posted blanks or zeros in the data fields, if it did not post all negotiated payer rates associated with specific plans, or if the price estimator tool did not show both the negotiated rates and discounted cash prices to provide pricing for all healthcare consumers, including the uninsured and those desiring to pay cash directly."[5]

Of the hospitals surveyed, 49 were in Florida and only two of the 49 were found to be fully compliant with the transparency requirements.[6]

Credit Reports

A credit report is a record of a consumer's credit history and other information about the consumer, including his or her name, address, social security number, employment information, date of birth, and court judgments.[7] Three major credit bureaus—Equifax, Experian, and TransUnion—compile and sell consumer credit reports. Lenders, insurers, utility and cell phone companies, employers, and others may obtain a consumer's credit report for their use in determining (i.e., whether to extend credit), set insurance rates, or employ the consumer.[8] A consumer may also review his or her credit report at no charge once every 12 months from each of the credit bureaus.

Generally, the federal Fair Credit Reporting Act (FCRA)[9] regulates the activities of CRAs, the users of consumer reports, and those who furnish information to CRAs. In 2003, the FCRA was amended by the Fair and Accurate Credit Transactions Act (FACTA) to address identity theft,

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[2] Semi-Annual Hospital Price Transparency Compliance Report, July 2021, Patients Rights Advocate.org, available at https://static1.squarespace.com/static/60065b8fc8cd610112ab89a7/t/60f1c225e1a54c0e42272fbf/1626456614723/PatientRightsAdvocate.org+Semi-Annual+Hospital+Compliance+Report.pdf (last visited Oct. 26, 2021).
[3] *Id.* at p. 1
[4] *Id.* at p. 2
[5] *Id.*
[6] *Id.* at pp. 9-11
[7] 15 U.S. Code s. 1681 defines a "credit report" as any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, … general reputation, [or] personal characteristics… which is used…for the purpose of…establishing the consumer's eligibility for credit or employment purposes…. The Florida KIDS Act adopts this definition of a "credit report" in s. 501.0051(1)(a), F.S.
[8] Board of Governors of the Federal Reserve System, *Credit Reports and Credit Scores: Consumer's Guide*, *available at* https://www.federalreserve.gov/creditreports/pdf/credit_reports_scores_2.pdf (last visited Oct. 26, 2021).
[9] Fair Credit Reporting Act, Pub. L. No. 91-508, codified as amended at 15 U.S.C. s. 1681-1681x.

improve the accuracy of consumer records, and to increase consumer access to credit information.[10]

In general, the FCRA does not preempt state law with respect to consumer reports. However, the FCRA in section 625[11] lists several areas that are specifically preempted to federal law. Included in the list is section 605[12] of the FCRA, which establishes requirements relating to information contained in consumer reports, and section 611[13] of the FCRA, relating to the time by which a CRA must take any action in any procedure related to the disputed accuracy of information in a consumer's file.

III. Effect of Proposed Changes:

SB 296 amends s. 395.301, F.S., to require each licensed ASC and hospital to establish, update, and make public a list of the facility's standard charges for all items and services provided by the facility, consistent with federal requirements for price transparency in 45 C.F.R. part 180. The bill requires the AHCA to impose a fine of $500 per day, per instance of noncompliance, on a facility that is required to comply with 45 C.F.R. part 180 and that violates this provision.

The bill also creates s. 501.181, F.S., to establish requirements for patient credit protection. The bill defines the following terms:

- "Consumer report" has the same meaning as in 15 U.S.C. s. 1681a(d).
- "Consumer reporting agency" has the same meaning as in 15 U.S.C. s. 1681a(f).
- "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for health care services issued in this state by an authorized health care insurer, HMO, hospital medical service corporation, or self-insured plan in this state. The term does not include supplemental plans.
- "Health care provider" means a person or an entity that is licensed, certified, or otherwise authorized by the laws of this state to provide health care services.
- "Medical debt" means the outstanding balance a patient-consumer owes to a health care provider for health care services.
- "Patient-consumer" means an individual who receives health care services from a health care provider.

The bill prohibits a CRA from publishing a consumer report containing a credit impairment resulting from a patient-consumer's medical debt if the patient-consumer was covered by a health benefit plan when the health care services giving rise to the medical debt were provided and such services were covered by the health benefit plan and the patient-consumer's medical debt is an outstanding balance after the patient-consumer's copayments, deductibles, and coinsurance amounts owed for health care services were fully paid or settled or are being paid as part of a payment plan. The bill also prohibits a CRA from publishing a consumer report with a credit impairment resulting from a patient-consumer's medical debt without the express written

[10] Fair and Accurate Credit Transactions Act, Pub. L. No. 108-159 (2003).
[11] 15 U.S.C. s 1681t
[12] 15 U.S.C. s. 1681c
[13] 15 U.S.C. s. 1681b

consent of the patient consumer's health care provider. The bill amends s. 559.72, F.S., with a conforming prohibition.

The bill requires a CRA that receives a notification from a creditor indicating that a patient-consumer's medical debt has been fully paid or settled, or that the patient-consumer is in compliance with a payment plan, to remove any credit impairment resulting from the applicable medical debt within 30 days after receiving such notification. The bill specifies that such notification may include, but is not limited to, documentation showing the status of the patient-consumer's medical debt. The bill also prohibits a CRA from charging the patient-consumer any fee to remove the credit impairment.

The bill provides that a patient-consumer who is aggrieved by a violation of these provisions may bring an action to:

- Enjoin the violation.
- Recover actual damages or $1,500, whichever is greater.

In addition to any damages awarded under the bill, a patient-consumer will also be awarded reasonable attorney fees and court costs. The action must be commenced within two years after the violation occurs and all parties to the action may agree to arbitration to resolve the medical debt reporting dispute.

The bill requires the DACS to adopt rules to implement s. 501.181, F.S., as created by the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

Sections 2 and 3 of the bill create s. 501.181, F.S., and amend s. 559.72, F.S., respectively, to establish new prohibitions on CRAs publishing certain types of debt on credit reports as well as establish time frames for CRAs to address certain consumer disputes of inaccurate information on credit reports. Subsections 625(b)(1)(E) and

625(b)(1)(B) of the FCRA, respectively, state that no requirement or prohibition may be imposed under the laws of any state with the respect to:

- Section 605 of the FCRA relating to information contained in consumer reports; and
- Section 611 of the FCRA relating to the time by which a CRA must take any action in any procedure related to the disputed accuracy of information in a consumer's file.

As such, it is possible that the above provisions in sections 2 and 3 of SB 296 make changes in areas that are statutorily preempted to federal law and those sections of SB 296 may be found to violate the supremacy clause in Article VI, section 2, of the U.S. Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 296 may have an indeterminate negative fiscal impact on hospitals that are in violation of federal price transparency requirements in 45 C.F.R. part 180.

SB 296 may have an indeterminate negative fiscal impact on CRAs that are required to pay damages and attorney fees in suits brought under the provisions of the bill.

SB 296 may have an indeterminate positive fiscal impact on consumers who bring and win suits against CRAs under the provisions of the bill.

C. Government Sector Impact:

The AHCA may see an indeterminate positive fiscal impact from fees collected from hospitals that are in violation of federal price transparency requirements in 45 C.F.R. part 180.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 1 of the bill requires "each licensed facility" to publish certain information consistent with federal price transparency requirements in 45 C.F.R. part 180. Under ch. 395, F.S., "each licensed facility" would include ASCs. However, 45 C.F.R. part 180 only applies to hospitals. It is unclear whether the bill intends to require ASCs to publish the required information. Additionally, should ASCs be required to do so, it is likely that ASCs would not be subject to the fines imposed by the bill for noncompliance because a requirement of those fines being imposed is that the facility is required to comply with 45 C.F.R. part 180. It may be advisable to clarify whether this portion of the bill is meant to be applied to ASCs.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.301 and 559.72.

This bill creates section 501.181 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Garcia

37-00408A-22 2022296__

A bill to be entitled

An act relating to health care expenses; amending s. 395.301, F.S.; requiring a licensed facility to establish, update, and make public a list of the facility's charges for services which meets certain federal requirements; requiring the Agency for Health Care Administration to impose fines for violations of the public disclosure requirements; creating s. 501.181, F.S.; defining terms; prohibiting consumer reporting agencies from publishing a consumer report containing a medical debt credit impairment under certain circumstances; requiring the consumer reporting agency to remove the credit impairment, free of charge, under certain circumstances; requiring the agency to obtain express written consent from a patient-consumer's health care provider before publishing a consumer report containing a medical debt credit impairment; authorizing patient-consumers to initiate legal proceedings for violations; providing for damages and the award of attorney fees; requiring such actions to commence within a specified timeframe; authorizing the use of arbitration for disputes; requiring the Department of Agriculture and Consumer Services to adopt rules; amending s. 559.72, F.S.; prohibiting persons from reporting certain consumer debt to a consumer reporting agency without the express written consent of the creditor; providing an effective date.

37-00408A-22 2022296__

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

Section 1. Present paragraphs (b), (c), and (d) of subsection (1) of section 395.301, Florida Statutes, are redesignated as paragraphs (c), (d), and (e), respectively, and a new paragraph (b) is added to subsection (1) of that section, to read:

395.301 Price transparency; itemized patient statement or bill; patient admission status notification.—

(1) A facility licensed under this chapter shall provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility, or to patients' survivors or legal guardians, as appropriate. Such information shall be provided in accordance with this section and rules adopted by the agency pursuant to this chapter and s. 408.05. Licensed facilities operating exclusively as state facilities are exempt from this subsection.

(b) Each licensed facility shall establish, update, and make public a list of the facility's standard charges for all items and services provided by the facility, consistent with 45 C.F.R. part 180. The agency shall impose a fine of $500 per day per instance of noncompliance for a facility that is required to comply with 45 C.F.R. part 180 and that violates this paragraph.

Section 2. Section 501.181, Florida Statutes, is created to read:

501.181 Patient credit protection.—

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

(a) "Consumer report" has the same meaning as in 15 U.S.C. s. 1681a(d).

(b) "Consumer reporting agency" has the same meaning as in 15 U.S.C. s. 1681a(f).

(c) "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for health care services issued in this state by an authorized health care insurer, health maintenance organization, hospital medical service corporation, or self-insured plan in this state. The term does not include supplemental plans.

(d) "Health care provider" means a person or an entity that is licensed, certified, or otherwise authorized by the laws of this state to provide health care services.

(e) "Medical debt" means the outstanding balance a patient-consumer owes to a health care provider for health care services.

(f) "Patient-consumer" means an individual who receives health care services from a health care provider.

(2) CREDIT PROTECTION FOR PATIENT-CONSUMERS.—A consumer reporting agency may not publish a consumer report containing a credit impairment resulting from a patient-consumer's medical debt if all of the following conditions apply:

(a) The patient-consumer was covered by a health benefit plan when the health care services giving rise to the medical debt were provided and such services were covered by the health benefit plan.

(b) The patient-consumer's medical debt is an outstanding balance after the patient-consumer's copayments, deductibles, and coinsurance amounts owed for health care services were fully paid or settled or are being paid as part of a payment plan.

(3) REMOVAL OF CREDIT IMPAIRMENT.—

(a) If a consumer reporting agency receives notification from a creditor indicating that a patient-consumer's medical debt has been fully paid or settled or that the patient-consumer is in compliance with a payment plan, the consumer reporting agency must remove any credit impairment resulting from the applicable medical debt within 30 days after receiving such notification. Such notification may include, but is not limited to, documentation showing the status of the patient-consumer's medical debt.

(b) A consumer reporting agency may not charge the patient-consumer a fee to remove the credit impairment.

(4) EXPRESS CONSENT.—A consumer reporting agency may not publish a consumer report with a credit impairment resulting from a patient-consumer's medical debt without the express written consent of a patient-consumer's health care provider.

(5) PRIVATE RIGHT OF ACTION.—

(a) A patient-consumer who is aggrieved by a violation of this section may bring an action to:

1. Enjoin the violation.

2. Recover actual damages or $1,500, whichever is greater.

(b) In addition to any damages awarded, a patient-consumer shall also be awarded reasonable attorney fees and court costs.

(c) A civil action pursuant to this section must be commenced within 2 years after the violation occurs.

(d) All parties to the action may agree to arbitration to resolve the medical debt reporting dispute.

(6) RULEMAKING.—The Department of Agriculture and Consumer Services shall adopt rules to implement this section.

Section 3. Subsection (20) is added to section 559.72,

Florida Statutes, to read:

559.72 Prohibited practices generally.—In collecting consumer debts, no person shall:

(20) Report a credit impairment resulting from a patient-consumer's medical debt to a consumer reporting agency, as defined in 15 U.S.C. s. 1681a(f), without the express written consent of the creditor, if the creditor is a health care provider who provided the patient-consumer with health care services.

Section 4. This act shall take effect July 1, 2022.

DUPLICATE

The Florida Senate

APPEARANCE RECORD

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

Nov. 3. 2021
Meeting Date

Health Policy
Committee

SB 296
Bill Number or Topic

Amendment Barcode (if applicable)

Name Zayne Smith

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City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP

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

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

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

S-001 (08/10/2021)

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Jr., Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 18, 2021

I respectfully request that **296**, relating to Health Care Expenses, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ileana Garcia
Florida Senate, District 37

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 330
INTRODUCER:	Senator Brodeur
SUBJECT:	Medicaid Modernization
DATE:	November 2, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 330 authorizes the Agency for Health Care Administration (AHCA) to reimburse for remote patient monitoring and store-and-forward services as optional services in the Florida Medicaid program, subject to specific appropriations. If the services are rendered, the bill would have a minor operational and indeterminate fiscal impact on Florida Medicaid. *See* section V of this analysis.

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

II. Present Situation:

Telehealth

Relevant Terminology

Section 456.47, F.S., defines the term "telehealth" as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

"Synchronous" telehealth refers to the live, real-time, or interactive transmission of information between a patient and a health care provider during the same time period. The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

"Asynchronous" telehealth refers to the transfer of data between a patient and a health care provider over a period of time and typically in separate time frames. This is commonly referred to as "store-and-forward."

Store-and-forward allows for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos, through telecommunications technology to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service after the data have been collected.[1] The transfer of X-rays or MRI images from one health care provider to another health care provider for review in the future would be considered asynchronous telehealth through store-and-forward technology.

"Remote patient monitoring" refers to the collection, transmission, evaluation, and communication of individual health data to a health care provider from the patient's location through technology such as wireless devices, wearable sensors, implanted health monitors, smartphones, and mobile apps.[2] Remote monitoring is used to monitor physiologic parameters, including weight, blood pressure, blood glucose, pulse, temperature, oximetry, respiratory flow rate, and more. Remote monitoring can be useful for ongoing condition monitoring and chronic disease management. Depending upon the patient's needs, remote monitoring can be synchronous or asynchronous.

Florida Telehealth Providers

In 2019, the Legislature passed and the Governor approved CS/CS/HB 23, which created s. 456.47, F.S. The bill became effective on July 1, 2019.[3] It authorized Florida-licensed health care providers[4] to use telehealth to deliver health care services within their respective scopes of practice.

The bill also authorized out-of-state health care providers to use telehealth to deliver health care services to Florida patients if they register with the Department of Health (DOH) or the applicable board[5] and meet certain eligibility requirements.[6] A registered out-of-state telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

Telehealth providers who treat patients located in Florida must be one of the licensed health care practitioners listed below[7] and be either Florida-licensed, licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

- Behavioral Analyst

[1] Center for Connected Health Policy, National Telehealth Policy Resource Center, *Store-and-Forward (Asynchronous) available at* https://www.cchpca.org/about/about-telehealth/store-and-forward-asynchronous (last visited Oct. 21, 2021).
[2] American Board of Telehealth, *Telehealth: Defining 21st Century Care, available at* https://www.americantelemed.org/resource/why-telemedicine/ (last visited Oct. 21, 2021).
[3] Chapter 2019-137, s. 6, Laws of Fla.
[4] Section 456.47(1)(b), F.S.
[5] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH's Division of Medical Quality Assurance.
[6] Section 456.47(4), F.S.
[7] Section 456.47(1)(b), F.S. These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

- Acupuncturist
- Allopathic physician
- Osteopathic physician
- Chiropractor
- Podiatrist
- Optometrist
- Nurse
- Pharmacist
- Dentist
- Dental Hygienist
- Midwife
- Speech Therapist
- Occupational Therapist
- Radiology Technician
- Electrologist
- Orthotist
- Pedorthist
- Prosthetist
- Medical Physicist
- Emergency Medical Technician
- Paramedic
- Massage Therapist
- Optician
- Hearing Aid Specialist
- Clinical Laboratory Personnel
- Respiratory Therapist
- Psychologist
- Psychotherapist
- Dietician/Nutritionist
- Athletic Trainer
- Clinical Social Worker
- Marriage and Family Therapist
- Mental Health Counselor

The Legislature also passed HB 7067 in 2019 that would have required an out-of-state telehealth provider to pay an initial registration fee of $150 and a biennial registration renewal fee of $150, but the bill was vetoed by the Governor and did not become law.[8]

On March 16, 2020, Surgeon General Scott Rivkees executed DOH Emergency Order 20-002 authorizing certain out-of-state physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses to provide telehealth in Florida without the need to register

[8] Transmittal Letter from Governor Ron DeSantis to Secretary of State Laurel Lee (June 27, 2019) *available at* https://www.flgov.com/wp-content/uploads/2019/06/06.27.2019-Transmittal-Letter-3.pdf (last visited Oct. 21, 2021).

as a telehealth provider under s. 456.47(4), F.S.[9] Five days later, the Surgeon General executed DOH Emergency Order 20-003[10] to also authorize certain out-of-state clinical social workers, marriage and family therapists, mental health counselors, and psychologists to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S. These emergency orders were extended and expired on June 26, 2021.[11] Out-of-state health care practitioners are no longer authorized to perform telehealth services for patients in Florida unless they become licensed or registered in Florida.

Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults, and persons with disabilities.[12] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[13]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[14]

Florida Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of

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[9] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020) *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Oct. 21, 2021).
[10] Department of Health, State of Florida, *Emergency Order DOH No. 20-003* (Mar. 21, 2020) *available at* https://s33330.pcdn.co/wp-content/uploads/2020/03/DOH-EO-20-003-3.21.2020.pdf (last visited Oct. 21, 2021).
[11] Florida Board of Medicine, *Important Updates for Health Care Providers Regarding Expiration of Emergency Orders* (July 1, 2021) *available at* https://r.bulkmail.flhealthsource.gov/mk/mr/JV-U0AMitwBXlP7zcFx3Djqu1KfE1B57JaGN-nnNySmOjEY5xGSsIyII28XjOGeZ4yKv9rWQUryqAibmdrixNZdgE9Q61dmUoHRF1Rnyijg-ewyAl_rZBT8c (last visited Oct. 18, 2021).
[12] Medicaid.gov, *Medicaid*, *available at* https://www.medicaid.gov/medicaid/index.html (last visited Oct. 21, 2021).
[13] Section 20.42, F.S.
[14] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Oct. 21, 2021).

services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two components, the Managed Medical Assistance (MMA) program and the Long-term Care program. Florida's SMMC offers a health care package covering both acute and long-term care. The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014 and was re-procured for a period beginning December 2018 and ending in 2023.

Medical Necessity Requirements

Florida Medicaid covers services that are medically necessary, as defined in its Medicaid state plan pursuant to Rule 59G-1.010 of the Florida Administrative Code. Care, goods, and services fit the definition of "medically necessary" if they are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflective of the level of service that can be safely furnished, and *for which no equally effective and more conservative or less costly treatment is available statewide*; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

Telemedicine Coverage under the Florida Medicaid Program

Florida Medicaid covers telemedicine in both the managed care and fee-for-service delivery systems.

Medicaid health plans have broad flexibility in covering telemedicine services.[15] In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities at no cost to the state, including remote patient monitoring and store-and-forward services.[16] Services provided through these additional telemedicine modalities are not included in the capitation rates the AHCA pays to the plans.[17]

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[15] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Guidance for Medical and Behavioral Health Providers* (Mar. 18, 2020) *available at* https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf (last visited Oct. 21, 2021).

[16] Agency for Health Care Administration, *2021 Senate Bill 852 Fiscal Analysis* (Feb. 1, 2021) (on file with the Senate Committee on Health Policy).

[17] *Id.*

Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face.[18] For example, a health plan may not require the prior authorization of a service delivered via telemedicine if it does not require prior authorization of that service delivered face-to-face.[19]

Under the fee-for service delivery system and in times of non-emergency, Florida Medicaid generally reimburses only for synchronous telemedicine services provided through the use of audio-visual equipment.[20] On March 18, 2020, the AHCA issued a Florida Medicaid Health Care Alert to provide telemedicine guidance for all medical and behavioral health care providers during the COVID-19 state of emergency.[21] Throughout the duration of the state of emergency, the AHCA expanded telehealth to include and provide for the reimbursement of certain store-and-forward and remote patient monitoring modalities rendered by licensed physicians, APRNs, and PAs functioning within their scope of practice.[22] The AHCA also expanded services provided through telemedicine that may be reimbursed under the FFS delivery system to include certain therapies, medication management, behavioral health, and medication-assisted treatment services.[23] The state of emergency expired on June 26, 2021, as Executive Order 21-94 expired.

The Federal Health Insurance Portability and Accountability Act (HIPAA)[24]

HIPAA Privacy Rule[25]

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. The HIPAA Privacy Rule sets national standards for when protected health information (PHI) may be used and disclosed.

Only certain entities and their business associates are subject to HIPAA's provisions. These "covered entities" include: health plans, health care providers; and health care clearinghouses.

The Privacy Rule gives individuals privacy and confidentiality rights with respect to their protected PHI, including rights to examine and obtain a copy of their health records in the form and manner they request, and to ask for corrections to their information. Also, the Privacy Rule permits the use and disclosure of health information needed for patient care and other important purposes.

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[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Supra* note 15.
[22] *Id.*
[23] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Flexibilities for Behavioral Health Providers During the COVID-19 State of Emergency* (Apr. 16, 2020) *available at* http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderAlerts/tabId/48/Default.aspx (last visited Oct. 21, 2021).
[24] Centers for Medicare & Medicaid Services, *Medicare Learning Network Booklet, HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules* (May. 2021) *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf (last visited Oct. 29, 2021).
[25] 45 C.F.R. Part 160 and Subparts A and E of Part 164.

The Privacy Rule protects PHI held or transmitted by a covered entity or its business associate, in any form, whether electronic, paper, or verbal. PHI includes information that relates to any of the following:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual.

HIPAA Security Rule[26]

The HIPAA Security Rule specifies safeguards that covered entities and their business associates must implement to protect electronic PHI (ePHI) confidentiality, integrity, and availability.

Covered entities and business associates must develop and implement reasonable and appropriate security measures through policies and procedures to protect the security of ePHI they create, receive, maintain, or transmit. Each entity must analyze the risks to ePHI in its environment and create solutions appropriate for its own situation. What is reasonable and appropriate depends on the nature of the entity's business as well as its size, complexity, and resources.

Under the Security Rule, covered entities must:

- Ensure the confidentiality, integrity, and availability of all ePHI they create, receive, maintain, or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the ePHI;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance by their workforce.

When developing and implementing Security Rule compliant safeguards, covered entities and their business associates may consider all of the following:

- Size, complexity, and capabilities;
- Technical, hardware, and software infrastructure;
- The costs of security measures; and
- The likelihood and possible impact of risks to ePHI.

Covered entities must review and modify security measures to continue protecting ePHI in a changing environment.

HIPAA Breach Notification Rule[27]

The HIPAA Breach Notification Rule requires covered entities to notify affected individuals; the federal HHS; and, in some cases, the media of a breach of unsecured PHI. Generally, a breach is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.

[26] 45 C.F.R. Part 160 and Subparts A and C of Part 164.
[27] 45 C.F.R. Subpart D.

The impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity demonstrates a low probability that the PHI has been compromised based on a risk assessment of, at a minimum, the following factors:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

Most notifications must be provided without unreasonable delay and no later than 60 days following the breach discovery. Notifications of smaller breaches affecting fewer than 500 individuals may be submitted to HHS annually. The Breach Notification Rule also requires business associates of covered entities to notify the covered entity of breaches at or by the business associate.

Notification of Enforcement Discretion during Public Health Emergency

Covered health care providers acting in good faith will not be subject to penalties for violations of the HIPAA Privacy Rule, the HIPAA Security Rule, or the HIPAA Breach Notification Rule that occur in the good faith provision of telehealth during the public health emergency.[28]

On March 17, 2020, the federal Department of Health & Human Services (HHS) Office for Civil Rights (OCR) issued a Notification of Enforcement of Discretion, meaning that the OCR may exercise its enforcement discretion and not pursue penalties for HIPPA violations against health care providers that serve patients through everyday communication technologies during the public health emergency.[29] If a provider follows the terms of the Notification and any applicable OCR guidance, it will not face HIPAA penalties if it experiences a hack that exposes protected health information from a telehealth session.[30]

Jurisdiction and Venue for Telehealth-related Actions[31]

For purposes of s. 456.47, F.S., any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed or in the patient's county of residence. Venue for a civil or administrative action initiated by the DOH, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider, may be located in the patient's county of residence or in Leon County.

[28] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (last visited Oct. 29, 2021).
[29] Press Release, U.S. Department of Health and Human Services, *OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency* (Oct. 29, 2021) *available at* https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html (last visited Oct. 29, 2021).
[30] *Supra* note 28.
[31] Section 456.47(5), F.S.

III. Effect of Proposed Changes:

Section 1 amends s. 409.906, F.S., to authorize the AHCA to reimburse under the Florida Medicaid program for the following optional services:

- Remote patient monitoring services. This includes:
  - Remote monitoring of physiologic parameters;
  - The supply of devices with daily recording or programmed alert transmission; and
  - Remote physiologic monitoring treatment management services that require interactive communication between the recipient and provider.
- Remote evaluation of recorded video and images, including interpretation and follow-up with the recipient within 24 business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment. This text mirrors national billing codes. In practice, the AHCA would implement it according to those national billing codes and corresponding guidelines. This means that the AHCA would be authorized to reimburse for the remote evaluation of recorded video and images with the interpretation of the video and images and follow-up communicated to the patient within 24 business hours of the evaluation. Under the authority of this paragraph, the AHCA may not reimburse for the remote evaluation of recorded video and images if the remote evaluation:
  - Takes place during an in-person visit;
  - Takes place within seven days after an in-person visit; or
  - Triggers an in-person visit within 24 hours or at the soonest available appointment.

Like all Medicaid services, these remote patient monitoring and store-and-forward services may be provided only when medically necessary.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:[32]

If the optional Medicaid services authorized in the bill are rendered, then the bill would have a minor operational and indeterminate fiscal impact on the Florida Medicaid program. The bill could lead to an increase in the use of telemedicine for the provision of diagnostic, preventive, and treatment services. The number of additional telehealth services that would be provided is unknown. The bill poses an indeterminate fiscal impact on Medicaid managed care plan capitation rates.

Additionally, the AHCA would need to revise the telemedicine State Plan Amendment that is currently in effect, update its rules, update the Florida Medicaid Management Information System, and communicate changes to enrolled providers and managed care plans, all of which are part of the AHCA's routine business practices.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.906 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[32] Agency for Health Care Administration, *2022 Senate Bill 330 Fiscal Analysis* (Oct. 31, 2022) (on file with the Senate Committee on Health Policy).

By Senator Brodeur

9-00121-22 2022330__

A bill to be entitled

An act relating to Medicaid modernization; amending s. 409.906, F.S.; authorizing Medicaid to reimburse providers for certain remote evaluation and patient monitoring services; providing an effective date.

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

Section 1. Subsection (28) is added to section 409.906, Florida Statutes, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend

9-00121-22 2022330__

the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(28) REMOTE EVALUATION AND MONITORING SERVICES.—

(a) The agency may pay for remote evaluation of recorded video and images, including interpretation and followup with the recipient within 24 business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment.

(b) The agency may pay for remote patient monitoring services, including remote monitoring of physiologic parameters, supply of devices with daily recording or programmed alert transmission, and remote physiologic monitoring treatment management services requiring interactive communication with the recipient and provider.

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

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

The Florida Senate

APPEARANCE RECORD

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

11/3/2021
Meeting Date

Health Policy
Committee

SB 330
Bill Number or Topic

Amendment Barcode (if applicable)

Name David Mica, Jr. Phone

Address Email

Street

City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Hospital Association

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

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

Nov. 3. 2021
Meeting Date

Health Policy
Committee

SB 330
Bill Number or Topic

Amendment Barcode (if applicable)

Name Zayne Smith

Phone 850.228.4243

Address 215 S. Monroe St. Suite 603
Street

Email zsmith@aarp.org

Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP

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

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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

1/12/21	330
Meeting Date	Bill Number or Topic
Health	
Committee	Amendment Barcode (if applicable)

Name Phillip Suderman Phone

Address Email

Street

City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Americans for Prosperity

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

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

S-001 (08/10/2021)

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 330
BILL TITLE:	Medicaid Modernization
BILL SPONSOR:	Senator Brodeur
EFFECTIVE DATE:	July 1, 2022

COMMITTEES OF REFERENCE
1) Health Policy
2) Appropriations Subcommittee on Health and Human Services
3) Appropriations
4)
5)

CURRENT COMMITTEE
Health Policy

SIMILAR BILLS	
BILL NUMBER:	**N/A**
SPONSOR:	**N/A**

PREVIOUS LEGISLATION	
BILL NUMBER:	SB 852
SPONSOR:	Senator Brodeur
YEAR:	2021
LAST ACTION:	Died in Appropriations Subcommittee on Health and Human Services

IDENTICAL BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

Is this bill part of an agency package?
Y ___ N _X__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	October 31, 2021
LEAD AGENCY ANALYST:	For any questions, please contact Patrick Steele at (850) 412-3615
ADDITIONAL ANALYST(S):	Jesse Botcher
LEGAL ANALYST:	Kim Kellum
FISCAL ANALYST:	Ana Rivas

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

As drafted, the bill amends section 409.906, F.S., to allow the Florida Medicaid program to reimburse for remote evaluation of recorded video and images and remote patient monitoring beginning July 1, 2022.

The bill defines remote evaluation of recorded video and images as, "including interpretation and follow up with the recipient within 24 business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment".

The bill defines remote patient monitoring as, "including remote monitoring of physiologic parameters, supply of devices with daily recording or programmed alert transmission, and remote physiologic monitoring treatment management services requiring interactive communication with the recipient and provider".

The fiscal impact is currently under review and is indeterminate at this time.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Florida Medicaid Program

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. This authority includes establishing and maintaining a Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services (CMS).

Medicaid is supported through both state and federal financial resources. As of August 2021, over 4.8 million Floridians were enrolled in the Medicaid program.

Medicaid Telemedicine

Florida Medicaid services are delivered to Medicaid recipients through either the fee-for-service delivery system or a managed care delivery system, with the majority of recipients receiving their services through a Medicaid managed care plan.

Florida Medicaid defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. Currently, telemedicine is covered by both managed care and fee for service delivery system. .

Fee-For-Service (FFS) Telemedicine Coverage:

Within the FFS program, Florida Medicaid only reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum, audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner. Currently, within the FFS program, Florida Medicaid reimburses only for services delivered via synchronous telemedicine. To qualify for payment, practitioners must be in a location separate from their patients and be using appropriate audio-visual equipment. Florida Medicaid currently does not pay for telehealth services such as chart reviews, telephone conversations, and fax transmissions

Medicaid Managed Care Telemedicine Coverage:

In addition to the services covered under the FFS delivery system, health plans cover additional telemedicine modalities at no cost to the State. These modalities include asynchronous remote patient monitoring and store-and-forward services. Costs associated with these additional telemedicine services are not included in the capitation rates the Agency pays the plans. In addition, Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face. For

example, they cannot require prior authorization of a service delivered via telemedicine if they do not require prior authorization of that service when delivered face-to-face.

Flexibilities due to COVID-19:

The Agency allowed for an exception during the COVID-19 state of emergency to allow audio-only telemedicine for services such as behavioral health in both managed care and fee-for-service delivery systems.

2. EFFECT OF THE BILL:

The bill amends s. 409.906, F.S., allowing for remote evaluation and monitoring services. The bill states that the Agency may reimburse for remote evaluation of recorded video and images, interpretation and follow up with recipients. Additionally, the Agency may pay for remote patient monitoring as a covered benefit. To establish these services as covered benefits in the Medicaid program, the Agency would need to revise the telemedicine State Plan Amendment and rule, to clarify that reimbursement is available for these additional telemedicine services. These requirements do have an operational impact but can be accomplished with current Agency resources.

The fiscal impact is currently under review and is indeterminate at this time. While this legislation is unlikely to increase overall costs to the Medicaid program, it may lead to sustained additional utilization of telemedicine for diagnostic, preventive, and treatment service.

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

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y ___ N _X__

If yes, explain:	N/A
Is the change consistent with the agency's core mission?	Y __ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	N/A

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	Unknown
Opponents and summary of position:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N _X___

If yes, provide a description:	N/A
Date Due:	N/A
Bill Section Number(s):	N/A

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _X__

Board:	N/A
Board Purpose:	N/A
Who Appointments:	N/A
Appointee Term:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	N/A
Expenditures:	N/A
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	N/A
Expenditures:	Indeterminate fiscal impact on the Florida Medicaid Program. The number of recipients and additional telehealth services that would be received under this bill is currently unknown. Reasonable costs to comply with potential fiscal impacts must be forecasted and incorporated into the capitation rates paid to the SMMC plans, and therefore increase the cost to the State. SB 330 poses and indeterminate fiscal impact on the capitation rates.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y ___N _X__

Revenues:	N/A
Expenditures:	N/A
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	N/A
Bill Section Number:	N/A

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y __X_ N ___

If yes, describe the anticipated impact to the agency including any fiscal impact.	The Agency's Florida Medicaid Management Information System will require system updates that can be accomplished with current Agency financial resources.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y ___ N _X__

If yes, describe the anticipated impact including any fiscal impact.	N/A

ADDITIONAL COMMENTS

N/A

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	N/A

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 852
BILL TITLE:	Medicaid Modernization
BILL SPONSOR:	Senator Brodeur
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1)
2)
3)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
Y ___ N _X__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 1, 2021
LEAD AGENCY ANALYST:	Jesse Bottcher
ADDITIONAL ANALYST(S):	Erica Floyd Thomas
LEGAL ANALYST:	
FISCAL ANALYST:	Ana Rivas

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 852 amends section 409.906, Florida Statutes (F.S.) by adding subsection (28) allowing the Agency to pay, through Medicaid, for remote evaluation of recorded video and images and remote patient monitoring.

The bill describes remote evaluation of recorded video and images as including interpretation and follow up with the recipient within business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment.

The bill describes remote patient monitoring as including remote monitoring of physiologic parameters, supply of devices with daily recording or programmed alert transmission, and remote physiologic monitoring treatment management services requiring interactive communication with the recipient and provider.

SB 852 poses a minor operational and indeterminate fiscal impact on the Florida Medicaid program.

SB 852 has an effective date of July 1, 2021.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Florida Medicaid Program

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security. This authority includes establishing and maintaining a Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services (CMS).

Together, states and the federal government fund Medicaid. As of December 2020, over 4.5 million Floridians were enrolled in the Medicaid program.

Medicaid Telemedicine

The Agency covers telemedicine in both the managed care and fee-for-service delivery systems. Florida Medicaid defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. The Medicaid program only reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.

Florida Medicaid services are delivered to Medicaid recipients through either the fee-for-service delivery system or a managed care delivery system, with most Medicaid recipients receiving their services through a Medicaid managed care plan.

In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities at no cost to the State. These modalities include asynchronous remote patient monitoring and store-and-forward services. Health plans covering Medicaid services to plan enrollees via these additional telemedicine modalities are not included in the capitation rates the Agency pays the plans. In addition, Medicaid health plans are required to cover telemedicine services in “parity” with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face. For example, they cannot require prior authorization of a service delivered via telemedicine if they do not require prior authorization of that service when delivered face-to-face.

Currently, Florida Medicaid reimburses only for services delivered via synchronous telemedicine in in the fee-for-service delivery system. To qualify for payment, practitioners must be in a location separate from their patients and be using appropriate audio-visual equipment. Florida Medicaid currently does not pay for telehealth services such chart reviews, telephone conversations, and fax transmissions. The Agency allowed

for an exception during the Covid-19 state of emergency to allow audio-only telemedicine for services such as behavioral health in both managed care and fee-for-service delivery systems.

2. EFFECT OF THE BILL:

Senate Bill 852 amends s. 409.906, F.S., optional Medicaid services, to allow for remote evaluation and monitoring services. The bill states that the Agency may reimburse for recorded video and images, interpretation and follow up with recipients. Additionally, the proposed legislation states that the Agency may pay for remote patient monitoring as a covered benefit. To establish these services as covered benefits in the Medicaid program, the Agency would need to revise the telemedicine State Plan Amendment and rule. These requirements do have an operational impact but can be accomplished with current Agency resources.

SB 852 poses an indeterminate fiscal impact on the Florida Medicaid program if the Agency adds these services. While this legislation is unlikely to increase overall costs to the Medicaid program, it may lead to sustained additional utilization of telemedicine for diagnostic, preventive and treatment service.

SB 852 has an effective date of July 1, 2021.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y ___ N _X__

If yes, explain:	
Is the change consistent with the agency's core mission?	Y __ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	
Opponents and summary of position:	

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N _X___

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _X__

Board:	

Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	N/A
Expenditures:	N/A
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	N/A
Expenditures:	SB 852 poses an indeterminate fiscal impact on the Florida Medicaid Program. The number of recipients and additional telehealth services that would be received under this bill is unknown. Reasonable costs to comply with mandates must be built into the capitation rates paid to the plans, and therefore increase the cost to the State. SB 852 poses and indeterminate fiscal impact on the capitation rates.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y ___N _X__

Revenues:	N/A
Expenditures:	N/A
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	N/A
Bill Section Number:	N/A

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y __X_ N ___

If yes, describe the anticipated impact to the agency including any fiscal impact.	This bill requires minor system updates in FLMMIS that can be accomplished with current Agency resources.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y ___ N _X__

If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Jr., Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 13, 2021

I respectfully request that **Senate Bill 330**, relating to **Medicaid Modernization**, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Jason Brodeur

Senator Jason Brodeur
Florida Senate, District 9

File signed original with committee office

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 312
INTRODUCER:	Senator Diaz
SUBJECT:	Telehealth
DATE:	October 13, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Favorable**
2.			BI	
3.			RC	

I. Summary:

SB 312 removes a provision in the definition of "telehealth" that excludes audio-only telephone calls.

The bill also amends a provision that, in practice, will allow a telehealth provider to issue a renewal prescription for a controlled substance listed in Schedule III, IV, or V of s. 893.03, F.S., through telehealth, within the scope of his or her practice, and in accordance with other state and federal laws. Currently, telehealth providers are prohibited from prescribing controlled substances through telehealth unless the prescription is for: the treatment of a psychiatric disorder, inpatient treatment at a hospital, the treatment of a patient receiving hospice services, or the treatment of a resident in a nursing home facility.[1] The bill narrows this prohibition to prohibit the prescribing of only Schedule II controlled substances through telehealth except under those specific circumstances.

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

II. Present Situation:

Telehealth

Relevant Terminology

Section 456.47, F.S., defines the term "telehealth" as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health

[1] Section 456.47(2)(c), F.S.

services; and health administration. Section 456.47(1)(a), F.S., provides that the term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

"Synchronous" telehealth refers to the live, real-time, or interactive transmission of information between a patient and a health care provider during the same time period. The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

"Asynchronous" telehealth refers to the transfer of data between a patient and a health care provider over a period of time and typically in separate time frames. This is commonly referred to as "store-and-forward."

Florida Telehealth Providers

In 2019, the Legislature passed and the Governor approved CS/CS/HB 23, which created s. 456.47, F.S. The bill became effective on July 1, 2019.[2] It authorized Florida-licensed health care providers[3] to use telehealth to deliver health care services within their respective scopes of practice.

The bill also authorized out-of-state health care providers to use telehealth to deliver health care services to Florida patients if they register with the Department of Health (DOH) or the applicable board[4] and meet certain eligibility requirements.[5] A registered out-of-state telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

Telehealth providers who treat patients located in Florida must be one of the licensed health care practitioners listed below[6] and be either Florida-licensed, licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

- Behavioral Analyst
- Acupuncturist
- Allopathic physician
- Osteopathic physician
- Chiropractor
- Podiatrist
- Optometrist
- Nurse
- Pharmacist

[2] Chapter 2019-137, s. 6, Laws of Fla.
[3] Section 456.47(1)(b), F.S.
[4] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH's Division of Medical Quality Assurance.
[5] Section 456.47(4), F.S.
[6] Section 456.47(1)(b), F.S. These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

- Dentist
- Dental Hygienist
- Midwife
- Speech Therapist
- Occupational Therapist
- Radiology Technician
- Electrologist
- Orthotist
- Pedorthist
- Prosthetist
- Medical Physicist
- Emergency Medical Technician
- Paramedic
- Massage Therapist
- Optician
- Hearing Aid Specialist
- Clinical Laboratory Personnel
- Respiratory Therapist
- Psychologist
- Psychotherapist
- Dietician/Nutritionist
- Athletic Trainer
- Clinical Social Worker
- Marriage and Family Therapist
- Mental Health Counselor

The Legislature also passed HB 7067 in 2019 that would have required an out-of-state telehealth provider to pay an initial registration fee of $150 and a biennial registration renewal fee of $150, but the bill was vetoed by the Governor and did not become law.[7]

On March 16, 2020, Surgeon General Scott Rivkees executed DOH Emergency Order 20-002 authorizing certain out-of-state physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S.[8] Five days later, the Surgeon General executed DOH Emergency Order 20-003[9] to also authorize certain out-of-state clinical social workers, marriage and family therapists, mental health counselors, and psychologists to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S. These

[7] Transmittal Letter from Governor Ron DeSantis to Secretary of State Laurel Lee (June 27, 2019) *available at* https://www.flgov.com/wp-content/uploads/2019/06/06.27.2019-Transmittal-Letter-3.pdf (last visited Oct 21, 2021).
[8] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020) *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Oct. 21, 2021).
[9] Department of Health, State of Florida, *Emergency Order DOH No. 20-003* (Mar. 21, 2020) *available at* https://s33330.pcdn.co/wp-content/uploads/2020/03/DOH-EO-20-003-3.21.2020.pdf (last visited Oct. 21, 2021).

emergency orders were extended and expired on June 26, 2021.[10] Out-of-state health care practitioners are no longer authorized to perform telehealth services for patients in Florida unless they become licensed or registered in Florida.

Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[11] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[12]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[13]

Telemedicine Coverage under the Florida Medicaid Program

Florida Medicaid covers telemedicine in both the managed care and fee-for-service delivery systems.

Medicaid health plans have broad flexibility in covering telemedicine services.[14] Beginning on April 3, 2020, and throughout the COVID-19 state of emergency, the AHCA provided for the reimbursement of audio-only telehealth services in the managed care and fee-for-service delivery systems when rendered by licensed physicians (including psychiatrists), advanced practice

[10] Florida Board of Medicine, *Important Updates for Health Care Providers Regarding Expiration of Emergency Orders* (July 1, 2021) *available at* https://r.bulkmail.flhealthsource.gov/mk/mr/JV-U0AMitwBXlP7zcFx3Djqu1KfE1B57JaGN-nnNySmOjEY5xGSsIyII28XjOGeZ4yKv9rWQUryqAibmdrixNZdgE9Q61dmUoHRF1Rnyijg-ewyAl_rZBT8c (last visited Oct. 18, 2021).
[11] Medicaid.gov, *Medicaid*, *available at* https://www.medicaid.gov/medicaid/index.html (last visited Oct. 21, 2021).
[12] Section 20.42, F.S.
[13] *Id.*
[14] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Guidance for Medical and Behavioral Health Providers* (Mar. 18, 2020) *available at* https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf (last visited Nov. 1, 2021).

registered nurses, and physician assistants.[15,16] During the state of emergency, Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face.[17]

Under the fee-for service delivery system and in times of non-emergency, Florida Medicaid generally reimburses only for synchronous telemedicine services provided through the use of audio-visual equipment.[18] Beginning on April 16, 2020, and throughout the state of emergency, the AHCA provided for the reimbursement of audio-only behavioral health services for Medicaid reimbursement under the fee-for service and managed care delivery systems when video capability was not available.[19] To be reimbursed, a behavioral health provider must have documented that the enrollee did not have access to audio and video technology necessary for the service to be fully provided via telemedicine.[20]

The Federal Health Insurance Portability and Accountability Act (HIPAA)[21]

HIPAA Privacy Rule[22]

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. The HIPAA Privacy Rule sets national standards for when protected health information (PHI) may be used and disclosed.

Only certain entities and their business associates are subject to HIPAA's provisions. These "covered entities" include: health plans, health care providers; and health care clearinghouses.

The Privacy Rule gives individuals privacy and confidentiality rights with respect to their protected PHI, including rights to examine and obtain a copy of their health records in the form and manner they request, and to ask for corrections to their information. Also, the Privacy Rule permits the use and disclosure of health information needed for patient care and other important purposes.

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[15] Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-20* (Apr. 3, 2020) *available at* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/2018-23_plan_comm/PT_2020-20_COVID-19_State-of-Emergency_Telemedicine_Services.pdf (last visited Nov. 1, 2021).

[16] 2021 Senate Bill 700 also amended the definition of telehealth in s. 456.47, F.S., to include audio-only telephone calls. Agency for Health Care Administration, *Senate Bill 700 Fiscal Analysis* (Feb. 15, 2021) (on file with the Senate Committee on Health Policy).

[17] *Id.*

[18] Agency for Health Care Administration, *Senate Bill 852 Analysis* (Feb. 1, 2021) (on file with the Senate Committee on health Policy).

[19] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Flexibilities for Behavioral Health Providers During the COVID-19 State of Emergency* (Apr. 16, 2020) *available at* https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf (last visited Nov. 1, 2021).

[20] *Id.*

[21] Centers for Medicare & Medicaid Services, *Medicare Learning Network Booklet, HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules* (May. 2021) *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurity.pdf (last visited Oct. 29, 2021).

[22] 45 C.F.R. Part 160 and Subparts A and E of Part 164.

The Privacy Rule protects PHI held or transmitted by a covered entity or its business associate, in any form, whether electronic, paper, or verbal. PHI includes information that relates to any of the following:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual.

HIPAA Security Rule[23]

The HIPAA Security Rule specifies safeguards that covered entities and their business associates must implement to protect electronic PHI (ePHI) confidentiality, integrity, and availability.

Covered entities and business associates must develop and implement reasonable and appropriate security measures through policies and procedures to protect the security of ePHI they create, receive, maintain, or transmit. Each entity must analyze the risks to ePHI in its environment and create solutions appropriate for its own situation. What is reasonable and appropriate depends on the nature of the entity's business as well as its size, complexity, and resources.

Under the Security Rule, covered entities must:

- Ensure the confidentiality, integrity, and availability of all ePHI they create, receive, maintain, or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the ePHI;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance by their workforce.

When developing and implementing Security Rule compliant safeguards, covered entities and their business associates may consider all of the following:

- Size, complexity, and capabilities;
- Technical, hardware, and software infrastructure;
- The costs of security measures; and
- The likelihood and possible impact of risks to ePHI.

Covered entities must review and modify security measures to continue protecting ePHI in a changing environment.

HIPAA Breach Notification Rule[24]

The HIPAA Breach Notification Rule requires covered entities to notify affected individuals; the federal HHS; and, in some cases, the media of a breach of unsecured PHI. Generally, a breach is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.

[23] 45 C.F.R. Part 160 and Subparts A and C of Part 164.
[24] 45 C.F.R. Subpart D.

The impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity demonstrates a low probability that the PHI has been compromised based on a risk assessment of, at a minimum, the following factors:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

Most notifications must be provided without unreasonable delay and no later than 60 days following the breach discovery. Notifications of smaller breaches affecting fewer than 500 individuals may be submitted to HHS annually. The Breach Notification Rule also requires business associates of covered entities to notify the covered entity of breaches at or by the business associate.

Notification of Enforcement Discretion during Public Health Emergency

Covered health care providers acting in good faith will not be subject to penalties for violations of the HIPAA Privacy Rule, the HIPAA Security Rule, or the HIPAA Breach Notification Rule that occur in the good faith provision of telehealth during the public health emergency.[25]

On March 17, 2020, the federal Department of Health & Human Services (HHS) Office for Civil Rights (OCR) issued a Notification of Enforcement of Discretion, meaning that the OCR may exercise its enforcement discretion and not pursue penalties for HIPPA violations against health care providers that serve patients through everyday communication technologies during the public health emergency.[26] If a provider follows the terms of the Notification and any applicable OCR guidance, it will not face HIPAA penalties if it experiences a hack that exposes protected health information from a telehealth session.[27]

Jurisdiction and Venue for Telehealth-related Actions[28]

For purposes of s. 456.47, F.S., any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed or in the patient's county of residence. Venue for a civil or administrative action initiated by the DOH, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider, may be located in the patient's county of residence or in Leon County.

[25] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (last visited Nov. 1, 2021).
[26] Press Release, U.S. Department of Health and Human Services, *OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency* (Mar. 17, 2021) *available at* https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html (last visited Oct. 31, 2021).
[27] *Supra* note 25.
[28] Section 456.47(5), F.S.

Controlled Substance Prescribing through Telehealth

Controlled Substances Generally

Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act. This chapter classifies controlled substances into five schedules in order to regulate the manufacture, distribution, preparation, and dispensing of the substances. The scheduling of substances in Florida law is generally consistent with the federal scheduling of substances under 21 U.S.C. s. 812:

- A Schedule I substance has a high potential for abuse and no currently accepted medical use in treatment in the United States and its use under medical supervision does not meet accepted safety standards. Examples include heroin and lysergic acid diethylamide (LSD).
- A Schedule II substance has a high potential for abuse, a currently accepted but severely restricted medical use in treatment in the United States, and abuse may lead to severe psychological or physical dependence. Examples include cocaine and morphine.
- A Schedule III substance has a potential for abuse less than the substances contained in Schedules I and II, a currently accepted medical use in treatment in the United States, and abuse may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. Examples include lysergic acid; ketamine; and some anabolic steroids.
- A Schedule IV substance has a low potential for abuse relative to the substances in Schedule III, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule III. Examples include alprazolam, diazepam, and phenobarbital.
- A Schedule V substance has a low potential for abuse relative to the substances in Schedule IV, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule IV. Examples include low dosage levels of codeine, certain stimulants, and certain narcotic compounds.

Federal Law[29]

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008[30] amended the federal Controlled Substances Act, to prohibit a practitioner from issuing a "valid prescription" for a controlled substance through the Internet without having first conducted at least one in-person medical evaluation, except in certain circumstances. Thereafter, the prescriber may prescribe controlled substances to that patient via Internet or a phone call. The Act offers seven exceptions to the in-person exam. One such exception occurs when the Secretary of the federal Department of Health and Human Services (HHS) has declared a public health emergency.

[29] 21 U.S.C. s. 829.
[30] Public Law No. 110-425 (2008).

Federal Guidance During the COVID-19 Public Health Emergency

On January 31, 2020, the Secretary of HHS issued a public health emergency.[31] On March 16, 2020, the federal Drug Enforcement Agency (DEA) published a COVID-19 Information page on the Diversion Control Division website, authorizing DEA-registered practitioners, authorized designated DEA-registered practitioners to issue prescriptions for all Schedule II-V controlled substances to patients without first conducting an in-person medical evaluation during the public health emergency, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.
- The evaluation is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable federal and state law.[32]

Florida Law

Under Florida law, controlled substance providers are required to conduct an in-person physical examination prior to issuing a prescription for a controlled substance.[33]

Section 456.44, F.S., as amended during the 2018 legislative session by CS/CS/HB 21,[34] authorizes prescribers to prescribe a three-day supply of a Schedule II opioid[35] or up to a seven-day supply if medically necessary. The prescribing limits on Schedule II opioids do not apply to prescriptions for acute pains related to: cancer, a terminal condition, pain treated with palliative care, or a traumatic injury with an Injury Severity Score of 9 or higher.[36]

That section also requires a prescriber and dispenser to report to and review the Prescription Drug Monitoring Program database known as E-FORCSE (Electronic-Florida Online Reporting Controlled Substance Evaluation) to review a patient's controlled substance dispensing history prior to prescribing or dispensing a Schedule II-IV controlled substance for patients 16 years older.[37] These limitations and requirements apply to practitioners providing services in-person and through telehealth.

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[31] Determination that a Public Health Emergency Exists, Alex M. Azar II, Secretary of U.S. Department of Health and Human Services (January 31, 2020) *available at* https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx (last visited Oct. 31, 2021).

[32] Diversion Control Division, U.S. Department of Justice Drug Enforcement Administration, *COVID-19 Information Page*, *available at* https://www.deadiversion.usdoj.gov/coronavirus.html (last visited Nov. 1, 2021). Letter from Thomas Prevoznik, Deputy Assistant Administrator, Diversion Control Division, U.S. Department of Justice Drug Enforcement Administration, to DEA Qualifying Practitioners and Other Practitioners, (Mar. 31, 2020) *available at* https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf last visited Nov. 1, 2021).

[33] Section 456.44, F.S.

[34] Chapter 2018-13, Laws of Fla.

[35] All opioids are controlled substances. Opioids range in classification between Schedule I and Schedule V.

[36] Section 456.44(1)(a), F.S.

[37] Section 893.055, F.S.

Section 456.47(2)(c), F.S., as created by 2019 CS/CS/HB 23,[38] prohibits telehealth providers from prescribing any controlled substance unless the controlled substance is prescribed for:

- The treatment of a psychiatric disorder;
- Inpatient treatment at a licensed hospital;
- The treatment of a patient receiving hospice services; or
- The treatment of a resident of a nursing home facility.

Florida DOH Emergency Order No. 20-002

The same day that the HHS Secretary authorized qualified prescribers to prescribe Schedule II-V controlled substances, Surgeon General Rivkees issued DOH Emergency Order No. 20-002,[39] which suspended s. 456.47(2)(c), F.S., and authorized specified Florida-licensed prescribers[40] to issue a renewal prescription for a Schedule II-IV controlled substance only for an existing patient for the purpose of treating chronic nonmalignant pain without conducting another physical examination of the patient. This emergency order was extended[41] and expired on June 26, 2021.[42]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 456.47(1)(a), F.S., to remove a provision in the definition of "telehealth" that excludes audio-only telephone calls. This change does not post a direct impact on Florida Medicaid but would allow Medicaid to elect to reimburse for audio-only telephone calls.

Section 1 of the bill also amends s. 456.47(2)(c), F.S. Currently, telehealth providers are prohibited from prescribing controlled substances through telehealth unless the prescription is for: the treatment of a psychiatric disorder, inpatient treatment at a hospital, the treatment of a patient receiving hospice services, or the treatment of a resident in a nursing home facility. The bill narrows this prohibition to prohibit the prescribing of only Schedule II controlled substances through telehealth except under those specific circumstances. In practice, this change will authorize a telehealth provider to issue a renewal prescription for a controlled substance listed in Schedule III, IV, or V of s. 893.03, F.S., through telehealth, within the scope of his or her practice, and in accordance with other state and federal laws.

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[38] Chapter 2019-137, Laws of Fla.
[39] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020) *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Nov. 1, 2021).
[40] Physicians, osteopathic physicians, physician assistants, or advanced practice registered nurses that have designated themselves as a controlled substance prescribing practitioner on their practitioner profiles pursuant to s. 456.44, F.S.
[41] Department of Health, State of Florida, *Emergency Order DOH No. 20-011* (June 30, 2020) *available at* https://floridahealthcovid19.gov/wp-content/uploads/2020/06/DOH-Emergency-Order-DOH-No.-20-011.pdf (last visited Nov. 1, 2021).
[42] Florida Board of Medicine, *Important Updates for Health Care Providers Regarding Expiration of Emergency Orders* (July 1, 2021) *available at* https://r.bulkmail.flhealthsource.gov/mk/mr/JV-U0AMitwBXlP7zcFx3Djqu1KfE1B57JaGN-nnNySmOjEY5xGSsIyII28XjOGeZ4yKv9rWQUryqAibmdrixNZdgE9Q61dmUoHRF1Rnyijg-ewyAl_rZBT8c (last visited Oct. 18, 2021).

Under current law, no provider may prescribe a Schedule I drug under any circumstances. Florida law requires a prescriber to perform an in-person physical examination prior to prescribing a controlled substance for the treatment of chronic nonmalignant pain. All prescribers and dispensers of controlled substances must comply with ch. 893, F.S., by consulting and reporting to the Prescription Drug Monitoring Program database.

The applicable board, or the DOH if there is no board, may adopt rules to administer this section of statute.[43]

Section 2 of the bill provides an effective date of July 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill does not pose a direct impact on Florida Medicaid but would allow the AHCA to elect to reimburse for audio-only telephone calls. If the AHCA decides to authorize the

[43] Section 456.47(7), F.S.

reimbursement of audio-only telemedicine services, it will need to update Rule 59G-1.057, F.A.C., and communicate the changes to enrolled providers and health plans, both of which are part of the AHCA's routine business practices.[44] The vast majority of Medicaid recipients are already covered for audio-only telehealth services through the Medicaid health plans, so the bill is unlikely to increase overall costs to the Florida Medicaid program.[45]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 456.47 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[44] Agency for Health Care Administration, Senate Bill 864 Bill Analysis & Economic Impact Statement (Mar. 11, 2021) (on file with the Senate Committee on Health Policy).
[45] *Supra* note 16.

By Senator Diaz

36-00376-22 2022312__

A bill to be entitled

An act relating to telehealth; amending s. 456.47, F.S.; revising the definition of the term "telehealth"; narrowing the prohibition on prescribing controlled substances through telehealth to include only specified controlled substances; providing an effective date.

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

Section 1. Paragraph (a) of subsection (1) and paragraph (c) of subsection (2) of section 456.47, Florida Statutes, are amended to read:

456.47 Use of telehealth to provide services.—

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

(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include ~~audio-only telephone calls,~~ e-mail messages~~,~~ or facsimile transmissions.

(2) PRACTICE STANDARDS.—

(c) A telehealth provider may not use telehealth to prescribe a controlled substance listed in Schedule II of s. 893.03 unless the controlled substance is prescribed for the following:

1. The treatment of a psychiatric disorder;

36-00376-22 2022312__

2. Inpatient treatment at a hospital licensed under chapter 395;

3. The treatment of a patient receiving hospice services as defined in s. 400.601; or

4. The treatment of a resident of a nursing home facility as defined in s. 400.021.

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

The Florida Senate

APPEARANCE RECORD

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Meeting Date	Bill Number or Topic
11/3/21	SB 310
Committee	**Amendment Barcode (if applicable)**
Health Policy	

Name Eric Stevens Phone 3059030606

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City Miami State FL Zip 33141

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

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

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

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

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The Florida Senate

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11/2/21
Meeting Date

Health
Committee

312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Phillip Swaterman

Phone

Address
Street

Email

City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Americans for Prosperity

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

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S-001 (08/10/2021)

The Florida Senate

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11/3/2021
Meeting Date

Health Policy
Committee

312
Bill Number or Topic

Amendment Barcode (if applicable)

Name David Mica, Sr.

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City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Florida Hospital Association

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

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S-001 (08/10/2021)

The Florida Senate

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11-3-2021
Meeting Date

Health Policy
Committee

SB 312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Steve Winn

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Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

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

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S-001 (08/10/2021)

The Florida Senate

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11/3/21
Meeting Date

Health Policy
Committee

312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Chris Nuland

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Chapter, American College of Physicians

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

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S-001 (08/10/2021)

DUPLICATE

The Florida Senate

APPEARANCE RECORD

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Nov. 3. 2021
Meeting Date

Health Policy
Committee

SB 312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Zayne Smith

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Tallahassee FL 32301
City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AARP

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

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

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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NOV 3
Meeting Date

Health Policy
Committee

312
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jarod Fowler

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Street

Tallahassee FL 32308

City State Zip

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Medical Association

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

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

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S-001 (08/10/2021)

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 700
BILL TITLE:	Telehealth
BILL SPONSOR:	Senator Rodriguez
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1) Health Policy (HP)
2) Appropriations Subcommittee on Health and Human Services (AHS)
3) Appropriations (AP)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
Y ___ N _X__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 15, 2021
LEAD AGENCY ANALYST:	Tim Buehner, Matt Brackett
ADDITIONAL ANALYST(S):	DD Pickle
LEGAL ANALYST:	
FISCAL ANALYST:	Maureen Castaño

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 700 (Telehealth) amends sections 409.908 and 456.47, Florida Statutes (F.S.). These changes revise the state's definition of telehealth and add requirements for Florida Medicaid's reimbursement of telemedicine services. In addition, the bill makes changes to chapter 465, F.S., permitting telehealth providers acting within their scope of practice to prescribe certain controlled substances via telehealth and allowing physician supervisory arrangements of non-physician practitioners to take place via telehealth. Federal statutes do not allow the prescribing of controlled substances via telehealth. The bill also creates the term "remote-site pharmacy" and provides direction related to remote site pharmacy permits, operation, and oversight. SB 700's other changes align chapters 458, 459 and 893, F.S. with the amended language in section 409.908 and 456.47, F.S.

This bill poses operational impacts that are part of the agency's routine business practices and do not require an appropriation. This legislation is unlikely to increase overall costs to the Medicaid program, as the vast majority of Medicaid recipients are already covered for these services through the Medicaid health plans. This bill takes effect on July 1, 2021.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Florida Medicaid Program

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. This authority includes establishing and maintaining a Medicaid state plan, approved by the Centers for Medicare and Medicaid Services (CMS).

Telemedicine under Florida Medicaid

By allowing patients to consult their practitioners remotely, telemedicine has the ability to improve health care access both nationally and at the state level. Telemedicine or telehealth has two primary categories, synchronous and asynchronous. The former involves the use of two-way, interactive audio-visual equipment to allow for real-time communication between a practitioner and patient, and the latter consists of practices such as store-and-forward that allows for the transmission of records or data for evaluation at a later time.

Florida Medicaid services are delivered to Medicaid recipients through either the fee-for-service delivery system or a managed care delivery system, with most Medicaid recipients receiving their services through a Medicaid managed care plan.

In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities. These modalities include asynchronous remote patient monitoring and store-and-forward services. In addition, Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan must cover services via telemedicine, where appropriate, in a manner no more restrictive than the health plan would cover the service face-to-face.

Currently, Florida Medicaid reimburses for services delivered via asynchronous telemedicine in the managed care delivery system, but not in the fee-for-service delivery system. To qualify for payment, practitioners must be in a location other than their patients and be using appropriate audio-visual equipment. Florida Medicaid currently does not reimburse for telehealth services such as chart reviews, telephone conversations, and email or fax transmissions. In response to the COVID-19 state of emergency, the Agency took multiple steps to expand telemedicine to prevent recipients from having lapses in treatment due to access issues. One of those changes was to allow audio-only telehealth services in both managed care and fee-for-service delivery systems.

Federal Telemedicine Requirements

CMS does not impose any significant requirements on how state Medicaid programs implement telemedicine, granting a high degree of flexibility provided that such service delivery is compliant with their state plan authorities. However, the U.S. Drug Enforcement Agency prohibits the prescription of controlled substances (e.g., opioids) via telemedicine consults, although it has made an exception to this policy during the COVID-19 pandemic.

2. EFFECT OF THE BILL:

Senate Bill (SB) 700 (Telehealth) amends sections 409.908 and 456.47, Florida Statutes (F.S.). These changes revise the state's definition of telehealth and add requirements for Florida Medicaid's telemedicine services.

SB 700 amends the definition of telehealth in s. 456.47 to include audio-only telephone calls, personal email messages, facsimile transmission, and any other non-public facing telecommunications technology. SB 700 amends section 409.908, F.S. to require Florida Medicaid to reimburse telemedicine as defined in 456.47, including store-and-forward and remote patient monitoring. While Medicaid health plans cover remote patient monitoring and store and forward, this bill would mandate coverage for all Medicaid recipients, including those in the fee-for-service delivery system. The bill also permits out-of-state physicians who are registered with the Florida Department of Health as a telehealth provider to enroll in Florida Medicaid as an out-of-state provider for the purpose of providing telehealth services.

These changes pose operational impacts to update Medicaid Florida Administrative Code rules, seek federal approval for an amendment to the state plan, enroll new providers, and program the claims payment and enrollment systems. These actions are part of the Agency's routine business practices and do not require an appropriation. This legislation is unlikely to increase overall costs to the Medicaid program, as the vast majority of Medicaid recipients are already covered for these services through the Medicaid health plans. It has the potential increase utilization of telemedicine instead of face-to-face visits for diagnostic, preventive and treatment services.

SB 700 make additional changes that do not directly affect the Agency:

- Permits telehealth providers acting within their scope of practice to prescribe certain controlled substances via telehealth visit. This conflicts with federal regulations as stated above.
- Allows physician supervisory arrangements of non-physician practitioners (e.g., physician assistants and advanced practice registered nurses) to take place via telehealth
- Creates the term "remote site pharmacy" and provides direction related to remote site pharmacy permits, operation, and oversight.

This bill takes effect on July 1, 2021.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y ___ N _X__

If yes, explain:	
Is the change consistent with the agency's core mission?	Y ___ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	NA
Opponents and summary of position:	NA

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N __x__

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _x__

Board:	
Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	N/A	
Expenditures:	N/A	
Does the legislation increase local taxes or fees? If yes, explain.	No	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A	

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	N/A	
Expenditures:	This legislation is unlikely to increase overall costs to the Medicaid program, as the vast majority of Medicaid recipients are already covered for these services through the Medicaid health plans.	

Does the legislation contain a State Government appropriation?	No	
If yes, was this appropriated last year?	N/A	

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y ___N _X__

Revenues:	N/A	
Expenditures:	N/A	
Other:	N/A	

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	N/A	
Bill Section Number:	N/A	

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y _x__ N ___

If yes, describe the anticipated impact to the agency including any fiscal impact.	Additional billing codes will need to be programmed. This is part of routine operations of the Agency.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y ___ N ___

If yes, describe the anticipated impact including any fiscal impact.	See comment on conflict with DEA prohibitions on prescribing controlled substances via telemedicine.

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 852
BILL TITLE:	Medicaid Modernization
BILL SPONSOR:	Senator Brodeur
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1)
2)
3)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
Y ___ N _X__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 1, 2021
LEAD AGENCY ANALYST:	Jesse Bottcher
ADDITIONAL ANALYST(S):	Erica Floyd Thomas
LEGAL ANALYST:	
FISCAL ANALYST:	Ana Rivas

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 852 amends section 409.906, Florida Statutes (F.S.) by adding subsection (28) allowing the Agency to pay, through Medicaid, for remote evaluation of recorded video and images and remote patient monitoring.

The bill describes remote evaluation of recorded video and images as including interpretation and follow up with the recipient within business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment.

The bill describes remote patient monitoring as including remote monitoring of physiologic parameters, supply of devices with daily recording or programmed alert transmission, and remote physiologic monitoring treatment management services requiring interactive communication with the recipient and provider.

SB 852 poses a minor operational and indeterminate fiscal impact on the Florida Medicaid program.

SB 852 has an effective date of July 1, 2021.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Florida Medicaid Program

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security. This authority includes establishing and maintaining a Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services (CMS).

Together, states and the federal government fund Medicaid. As of December 2020, over 4.5 million Floridians were enrolled in the Medicaid program.

Medicaid Telemedicine

The Agency covers telemedicine in both the managed care and fee-for-service delivery systems. Florida Medicaid defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. The Medicaid program only reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.

Florida Medicaid services are delivered to Medicaid recipients through either the fee-for-service delivery system or a managed care delivery system, with most Medicaid recipients receiving their services through a Medicaid managed care plan.

In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities at no cost to the State. These modalities include asynchronous remote patient monitoring and store-and-forward services. Health plans covering Medicaid services to plan enrollees via these additional telemedicine modalities are not included in the capitation rates the Agency pays the plans. In addition, Medicaid health plans are required to cover telemedicine services in “parity” with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face. For example, they cannot require prior authorization of a service delivered via telemedicine if they do not require prior authorization of that service when delivered face-to-face.

Currently, Florida Medicaid reimburses only for services delivered via synchronous telemedicine in in the fee-for-service delivery system. To qualify for payment, practitioners must be in a location separate from their patients and be using appropriate audio-visual equipment. Florida Medicaid currently does not pay for telehealth services such chart reviews, telephone conversations, and fax transmissions. The Agency allowed

for an exception during the Covid-19 state of emergency to allow audio-only telemedicine for services such as behavioral health in both managed care and fee-for-service delivery systems.

2. EFFECT OF THE BILL:

Senate Bill 852 amends s. 409.906, F.S., optional Medicaid services, to allow for remote evaluation and monitoring services. The bill states that the Agency may reimburse for recorded video and images, interpretation and follow up with recipients. Additionally, the proposed legislation states that the Agency may pay for remote patient monitoring as a covered benefit. To establish these services as covered benefits in the Medicaid program, the Agency would need to revise the telemedicine State Plan Amendment and rule. These requirements do have an operational impact but can be accomplished with current Agency resources.

SB 852 poses an indeterminate fiscal impact on the Florida Medicaid program if the Agency adds these services. While this legislation is unlikely to increase overall costs to the Medicaid program, it may lead to sustained additional utilization of telemedicine for diagnostic, preventive and treatment service.

SB 852 has an effective date of July 1, 2021.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y ___ N _X__

If yes, explain:	
Is the change consistent with the agency's core mission?	Y __ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	
Opponents and summary of position:	

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N _X___

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _X__

Board:	

Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	N/A
Expenditures:	N/A
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	N/A
Expenditures:	SB 852 poses an indeterminate fiscal impact on the Florida Medicaid Program. The number of recipients and additional telehealth services that would be received under this bill is unknown. Reasonable costs to comply with mandates must be built into the capitation rates paid to the plans, and therefore increase the cost to the State. SB 852 poses and indeterminate fiscal impact on the capitation rates.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y ___N _X__

Revenues:	N/A
Expenditures:	N/A
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	N/A
Bill Section Number:	N/A

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y __X_ N ___

If yes, describe the anticipated impact to the agency including any fiscal impact.	This bill requires minor system updates in FLMMIS that can be accomplished with current Agency resources.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y ___ N _X__

If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

2021 AGENCY SUMMARY BILL ANALYSIS & ECONOMIC IMPACT STATEMENT

AGENCY: Agency for Health Care Administration

BILL#:	**SB 864**
RELATING TO:	**Telehealth**
SPONSOR(S):	**Senator Brodeur**
COMPANION BILLS:	**SB 660**

ANALYST/REVIEWER NAME:	**Matt Brackett**
DIVISION/UNIT:	**Bureau of Medicaid Policy**
CONTACT NUMBER:	**850-412-4151**

COORDINATED WITH:	
DIVISION/UNIT:	
CONTACT NUMBER:	

I. SUMMARY:

Senate Bill (SB) 864 amends section 456.47, Florida Statutes (F.S.) removing language from the definition of "telehealth" that prohibits audio-only telephone calls. Although this change does not require any actions by Florida Medicaid, it does allow for the Agency to continue allowing audio-only telemedicine in Medicaid, which was enacted during the COVID-19 state of emergency. If the Agency decides to allow audio-only telemedicine after the end of the public health emergency, it will need to update its Medicaid telemedicine policy (Rule 59G-1.057, F.A.C.) and communicate the change to enrolled providers and the health plans participating in the Statewide Medicaid Managed Care program, both of which are part of its routine business practices.

The bill also amends a telehealth exemption for licensed health care practitioners that are not licensed in Florida that allows them to not have to register with the State. The bill grants and exception to telehealth registration through the Department of Health if they provide the services in consultation with a health care professional licensed in the state. Without the change in this bill, the exemption required that the service be provided in consultation with a Florida-licensed provider that has "ultimate authority over the diagnosis and care of the patient." This change does not pose an impact to Florida Medicaid. It could expand the number of out of state providers that have the option of using telemedicine to deliver services without having to register.

This bill takes effect on July 1, 2021.

II. Does this bill impact the Agency? If yes, please provide a brief explanation of the impact:

SB 864 does not pose a direct impact on Florida Medicaid but would allow Medicaid elect to reimburse for audio-only telephone calls after the COVID public health emergency ends.

III. FISCAL COMMENTS:

N/A

IV. SUGGESTED AMENDMENTS:

N/A

Suggested amendment language:

Justification:

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SPB 7000
INTRODUCER:	Health Policy Committee
SUBJECT:	OGSR/Nonviable Birth Certificates
DATE:	November 3, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown		**Submitted as Comm. Bill/Fav**

I. Summary:

SPB 7000 amends s. 382.008(8), F.S., to save from repeal the public record exemption for certain information that may be collected by the Department of Health when issuing a nonviable birth certificate. Specifically, the cause of death and parentage of the fetus, marital status of the parents, and any medical information included in nonviable birth records are confidential and exempt from public disclosure.

The public records exemption stands repealed on October 2, 2022, unless reviewed and reenacted by the Legislature under the Open Government Sunset Review Act. This proposed bill removes the scheduled repeal of the exemption to continue the confidential and exempt status of the information.

The proposed bill provides an effective date of October 1, 2022.

II. Present Situation:

Access to Public Records – Generally

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] The right to inspect or copy applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

Additional requirements and exemptions related to public records are found in various statutes and rules, depending on the branch of government involved. For instance, s. 11.0431, F.S., provides public access requirements for legislative records. Relevant exemptions are codified in s. 11.0431(2)-(3), F.S., and the statutory provisions are adopted in the rules of each house of the

[1] FLA. CONST. art. I, s. 24(a).
[2] *Id*.

Legislature.[3] Florida Rule of Judicial Administration 2.420 governs public access to judicial branch records.[4] Lastly, ch. 119, F.S., provides requirements for public records held by executive agencies.

Executive Agency Records – The Public Records Act

Chapter 119, F.S., known as the Public Records Act, provides that all state, county, and municipal records are open for personal inspection and copying by any person and that providing access to public records is a duty of each agency.[5]

A public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[6] The Florida Supreme Court has interpreted the statutory definition of "public record" to include "material prepared in connection with official agency business which is intended to perpetuate, communicate, or formalize knowledge of some type."[7]

The Florida Statutes specify conditions under which public access to public records must be provided. The Public Records Act guarantees every person's right to inspect and copy any public record at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.[8] A violation of the Public Records Act may result in civil or criminal liability.[9]

The Legislature may exempt public records from public access requirements by passing a general law by a two-thirds vote of both the House and the Senate.[10] The exemption must state with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish the stated purpose of the exemption.[11]

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[3] *See* Rule 1.48, *Rules and Manual of the Florida Senate*, (2010-2022) and Rule 14.1, *Rules of the Florida House of Representatives*, Edition 1, (2020-2022).
[4] *State v. Wooten*, 260 So.3d 1060 (Fla. 4th DCA 2018).
[5] Section 119.01(1), F.S. Section 119.011(2), F.S., defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[6] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency."
[7] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc*., 379 So.2d 633, 640 (Fla. 1980).
[8] Section 119.07(1)(a), F.S.
[9] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[10] FLA. CONST. art. I, s. 24(c).
[11] *Id*. *See, e.g., Halifax Hosp. Medical Center v. News-Journal Corp.*, 724 So.2d 567 (Fla. 1999) (holding that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption); *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So.2d 189 (Fla. 1st DCA 2004) (holding that a statutory provision written to bring another party within an existing public records exemption is unconstitutional without a public necessity statement).

General exemptions from the public records requirements are contained in the Public Records Act.[12] Specific exemptions often are placed in the substantive statutes relating to a particular agency or program.[13]

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." Custodians of records designated as "exempt" are not prohibited from disclosing the record; rather, the exemption means that the custodian cannot be compelled to disclose the record.[14] Custodians of records designated as "confidential and exempt" may not disclose the record except under circumstances specifically defined by the Legislature.[15]

Open Government Sunset Review Act

The Open Government Sunset Review Act[16] (the Act) prescribes a legislative review process for newly created or substantially amended[17] public records or open meetings exemptions, with specified exceptions.[18] It requires the automatic repeal of such exemption on October 2nd of the fifth year after creation or substantial amendment unless the Legislature reenacts the exemption.[19]

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[20] An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- The exemption allows the state or its political subdivisions to effectively and efficiently administer a governmental program and such administration would be significantly impaired without the exemption;[21]
- The exemption protects sensitive, personal information, the release of which would be defamatory, cause unwarranted damage to the good name or reputation of the individual, or would jeopardize the individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[22] or
- It protects information of a confidential nature concerning entities, such as trade or business secrets.[23]

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[12] *See, e.g.*, s. 119.071(1)(a), F.S. (exempting from public disclosure examination questions and answer sheets of examinations administered by a governmental agency for the purpose of licensure).
[13] *See, e.g.*, s. 213.053(2)(a), F.S. (exempting from public disclosure information contained in tax returns received by the Department of Revenue).
[14] *See Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA 1991).
[15] *WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004).
[16] Section 119.15, F.S.
[17] An exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings as well as records. Section 119.15(4)(b), F.S.
[18] Section 119.15(2)(a) and (b), F.S., provide that exemptions that are required by federal law or are applicable solely to the Legislature or the State Courts System are not subject to the Open Government Sunset Review Act.
[19] Section 119.15(3), F.S.
[20] Section 119.15(6)(b), F.S.
[21] Section 119.15(6)(b)1., F.S.
[22] Section 119.15(6)(b)2., F.S.
[23] Section 119.15(6)(b)3., F.S.

The Act also requires specified questions to be considered during the review process.[24] In examining an exemption, the Act directs the Legislature to question carefully the purpose and necessity of reenacting the exemption.

If the exemption is continued and expanded, then a public necessity statement and a two-thirds vote for passage are required.[25] If the exemption is continued without substantive changes or if the exemption is continued and narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to sunset, then records created before the sunset date may not be made public unless otherwise provided by law.[26]

Vital Statistics

The Office of Vital Statistics,[27] housed within the Department of Health (DOH), is responsible for compiling, storing, and preserving the vital records of the state.[28] Vital records are the official certificates or reports of birth, death, fetal death, marriage, dissolution of marriage, certain name changes, and data related to these records.[29]

Florida officially began collecting birth and death records in 1917. Two years later, in 1919, the state became a nationally recognized death registration jurisdiction. In 1924, the state became a nationally recognized birth registration jurisdiction. Since 1927, marriage and dissolution records have been filed with the Office of Vital Statistics.[30] In addition to the state office, which operates under the direction of the state registrar, district offices operate under the direction of local registrars.

Birth Registration

A certificate for each live birth that occurs in this state must be filed within five days after the birth. The certificate may be filed with the local registrar of the district where the birth occurred or submitted electronically to the state registrar. Responsibility for filing the certificate is assigned to various persons depending upon where the birth occurs. For example, if the birth

[24] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[25] *See generally* s. 119.15, F.S.
[26] Section 119.15(7), F.S.
[27] The statutes consistently refer to the "Office" of Vital Statistics and not the "Bureau" of Vital Statistics. For example, see s. 382.003, F.S. While the statutes refer to an Office of Vital Statistics, the DOH has established this responsibility at the bureau level. *See* the DOH's organizational chart available at: http://www.floridahealth.gov/about/_documents/orgchart.pdf (last visited Oct. 26, 2021).
[28] Section 382.003, F.S.
[29] Section 382.002(18), F.S.
[30] Department of Health, Florida Vital Statistics Annual Report, August 2016, Page *vii*, http://www.flpublichealth.com/VSBOOK/pdf/2015/Intro.pdf (last visited Oct. 21, 2021).

occurs in a hospital, birth center, or other health care facility, or in route thereto, the person in charge of the facility is responsible for filing the certificate. The health care practitioner in attendance is responsible for providing the facility with the information required by the birth certificate. If the birth occurs outside a facility and a physician, certified nurse midwife, midwife, or a public health nurse was in attendance, then that person must file the certificate.[31]

Death and Fetal Death Registration

A certificate for each death or fetal death[32] that occurs in this state must be filed within five days after the death. The certificate may be filed with the local registrar of the district in which the death or fetal death occurred or submitted electronically to the state registrar.[33]

Katherine's Law - Certificate of Birth Resulting in Stillbirth

In 2006, Governor Jeb Bush signed into law legislation that allows for the creation and issuance of a certificate of birth resulting in stillbirth.[34] This law is known as Katherine's Law.[35]

The certificate of birth resulting in stillbirth is not proof of live birth[36] and may not be used to establish identity.[37] Gestation must be 20 weeks or more,[38] and there must be a fetal death certificate on file with the Office of Vital Statistics in order for a certificate to be prepared. The information included on the certificate comes from the fetal death certificate.

Miscarriage

Miscarriage is often described as the spontaneous loss of a pregnancy that occurs before the 20th week of gestation. Approximately 10 to 20 percent of all known pregnancies end in miscarriage. The number of miscarriages might actually be higher because some occur before a woman is aware that she is pregnant.[39]

Stephanie Saboor Grieving Parents Act

In 2003, the Legislature enacted the Stephanie Saboor Grieving Parents Act.[40] This law applies to a physician, physician assistant, nurse, or midwife[41] or a hospital, ambulatory surgical center,

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[31] Section 382.013, F.S.
[32] Section 382.002(8), F.S., defines "fetal death" as death prior to the complete expulsion or extraction of a product of human conception from its mother if the 20th week of gestation has been reached and the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.
[33] Section 382.008(1), F.S.
[34] Section 382.002(17), F.S., defines "stillbirth" as an unintended, intrauterine fetal death after a gestational age of not less than 20 completed weeks.
[35] Chapter 2006-118, L.O.F.
[36] Section 382.0085(4)(e), F.S.
[37] *See* http://www.floridahealth.gov/certificates/certificates/birth/Stillbirth/index.html (last visited March 16, 2017).
[38] Section 382.002(17), F.S.
[39] *See for example,* The Mayo Clinic, Miscarriage website at: http://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/home/ovc-20213664, (last visited on Oct. 25, 2021).
[40] Chapter 2003-52, L.O.F., codified at s. 383.33625, F.S.
[41] *See* s. 383.33625(2), F.S., which requires a health care practitioner licensed pursuant to chapter 458, 459, 464, or 467, F.S., to provide the notification.

or birth center[42] with custody of fetal remains following a spontaneous fetal demise that occurs after a gestation period of less than 20 completed weeks. Those persons or facilities are required to notify the mother of her option to arrange for the burial or cremation of the fetal remains, as well as the procedures provided by general law.[43,44]

Grieving Families Act

In 2017, the Legislature enacted the Grieving Families Act, which enables a parent to obtain, in certain situations, a certificate of nonviable birth following a miscarriage.[45] The Grieving Families Act defines "nonviable birth" as "an unintentional, spontaneous fetal demise occurring after the completion of the 9th week of gestation but prior to the 20th week of gestation of a pregnancy that has been verified by a health care practitioner."[46]

A health care practitioner who attends or diagnoses a nonviable birth, or a facility at which the nonviable birth occurs, must advise a parent of a nonviable birth that they may request the preparation of a certificate of nonviable birth.[47] Upon the request of a parent of a nonviable birth, such practitioner or facility, must electronically file a registration of nonviable birth on the DOH's electronic death registration system or on a certain form with the DOH or the local registrar within 30 days after receiving the parent's request.[48] The practitioner or facility must also advise a parent how to contact the Office of Vital Statistics to request a certificate of nonviable birth.[49] After the health care practitioner has filed the nonviable birth registration, the parents may request the Office to issue a certificate of nonviable birth. The Office must issue a certificate of nonviable birth within 60 days after receiving a parent's request.[50]

A certificate of nonviable birth must contain:

- The date of the nonviable birth.
- The county in which the nonviable birth occurred.
- The name of the fetus, as provided on the registration of nonviable birth. If a name does not appear on the original or amended registration of nonviable birth and the requesting parent does not wish to provide a name, the Office of Vital Statistics must fill in the certificate of nonviable birth with the name "baby boy" or "baby girl" and the last name of the parent. If the sex of the child is unknown, the Office must fill in the certificate of nonviable birth with the name "baby" and the last name of the parent.
- The statement: "This certificate is not proof of a live birth."[51]

[42] Section 383.33625(4), F.S., requires a facility licensed pursuant to chapter 383 or chapter 395, F.S., to provide the notification.
[43] Section 383.33625(4), F.S.
[44] Fetal remains of less than 20 completed weeks of gestation would be considered biomedical waste, which is governed by s. 381.0098, F.S.
[45] Chapter 2017-38, L.O.F.
[46] Section 382.002(14), F.S.
[47] Section 382.0086(2)(a), F.S.
[48] Section 382.008(7), F.S.
[49] Section 382.0086(2), F.S.
[50] Section 382.0086(1), F.S.
[51] Section 382.0086(4)-(5), F.S.

The Office of Vital Statistics may not use a certificate of nonviable birth to calculate live birth statistics.[52] Because not all parents of nonviable births would seek to obtain a certificate, there would be limited value in collecting or analyzing nonviable birth certificate data for research purposes.

Nonviable Birth Registrations Filed by Year[53]	
2017	93
2018	156
2019	145
2020	121
2021 (Jan. 1 - Sept. 21)	86 to date

Exemption under Review

According to the statement of public necessity included in the original public records exemption,[54] medical information, including the cause of death of a nonviable fetus, and any medical information pertaining thereto, is sensitive and personal in nature and disclosure of such information may lead to an invasion of privacy of a parent experiencing a nonviable birth. Disclosure of information regarding the parentage of a nonviable fetus and the marital status of such fetus' parent may discourage an individual who would otherwise request a nonviable birth certificate from doing so due to real or perceived stigma regarding the nonviability of the fetus, the fetus' parentage, or the marital status of the fetus' parent.

All information relating to the cause of death and parentage of a nonviable fetus, the marital status of such fetus' parent, and any medical information included in nonviable birth records held by a state agency is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution, but may be released for health research purposes as approved by the DOH.[55] There have been no such health research requests and no request has been denied by the DOH.[56]

The DOH may issue a certified copy of an original nonviable birth certificate which includes the confidential and exempt information: to the fetus' parent; to any local, state, or federal agency for official purposes upon approval by the DOH; or upon the order of any court of competent jurisdiction.[57] Parents who do not provide identification may be issued a nonviable birth certificate as a public document, with confidential and exempt information redacted. To date, no entity other than a parent has requested a certified copy of a nonviable birth registration.[58]

[52] Section 382.0086(8), F.S.
[53] Email from Legislative Affairs Director, Department of Health, to Government Operations Subcommittee, Florida House of Representatives (Sept. 21, 2021) (on file with the Senate Committee on Health Policy).
[54] Chapter 2017-39, L.O.F.
[55] Section 382.008(8)(b), F.S.
[56] *Id.* at 53.
[57] Section 382.008(8)(a), F.S.
[58] *Id.* at 53.

The public records exemption stands repealed on October 2, 2022, unless reviewed and reenacted by the Legislature under the Open Government Sunset Review Act. The DOH recommends retaining the exemption in its current form.[59]

III. Effect of Proposed Changes:

The PCB saves from repeal a public record exemption in s. 382.008(8), F.S., for certain information that may be collected when issuing a nonviable birth certificate. Specifically, the cause of death and parentage of the fetus, marital status of the parents, and any medical information included in nonviable birth records will continue to be confidential and exempt from public disclosure beyond October 2, 2022.

The proposed bill provides an effective date of October 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Voting Requirement

Article I, s. 24(c), of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record exemption. The proposed bill continues the current public records exemption under sunset review; it does not expand this exemption or create a new one. Therefore, a two-thirds vote of the members present and voting for final passage of the bill is not required.

Public Necessity Statement

Article I, s. 24(c), of the State Constitution requires a bill that creates or expands an exemption to the public records requirements to state with specificity the public necessity justifying the exemption. The proposed bill continues the current public records exemption under sunset review; it does not expand this exemption or create a new one. Thus, the proposed bill does not require a public necessity statement.

Breadth of Exemption

Article I, s. 24(c) of the State Constitution requires a newly created public record or public meeting exemption to be no broader than necessary to accomplish the stated purpose of the law. The proposed bill continues the current public records exemption under sunset review; it does not expand this exemption or create a new one. It does not appear to be in conflict with the constitutional requirement that the exemption be no broader than necessary to accomplish its purpose.

[59] Conversation with Ken Jones, State Registrar and Bureau Chief, Bureau of Vital Statistics, Department of Health (Aug. 31, 2021).

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 382.008 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

FOR CONSIDERATION By the Committee on Health Policy

588-00708-22 20227000pb

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act; amending s. 382.008, F.S., which provides an exemption from public records requirements for certain information included in nonviable birth certificates; removing the scheduled repeal of the exemption; providing an effective date.

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

Section 1. Subsection (8) of section 382.008, Florida Statutes, is amended to read:

382.008 Death, fetal death, and nonviable birth registration.—

(8)(a) The original nonviable birth certificate shall contain all of the information required by the department for legal, social, and health research purposes. The department may issue a certified copy of an original nonviable birth certificate which includes the confidential and exempt information:

1. To the fetus' parent;

2. To any local, state, or federal agency for official purposes upon approval by the department; or

3. Upon the order of any court of competent jurisdiction.

(b) All information relating to the cause of death and parentage of a nonviable fetus, the marital status of such fetus' parent, and any medical information included in nonviable birth records held by a state agency is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State

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Constitution, but may be released for health research purposes as approved by the department.

(c) The department shall authorize the issuance of a certified copy of all or part of an original nonviable birth certificate, excluding any information that is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution, to any person requesting such copy, pursuant to paragraph (b), upon receipt of a request and payment of the fee prescribed in s. 382.0255.

~~(d) This subsection is subject to the Open Government Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.~~

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

OPEN GOVERNMENT SUNSET REVIEW OF SECTION 382.987, FLORIDA STATUTES
Response to Questions Relating to Nonviable Birth Registrations

1. WHAT IS THE EFFECT OF HIPAA ON THESE REGISTRATIONS?

The Florida Department of Health (DOH) is a hybrid entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As such, DOH as a whole is considered a covered entity whose business activities include both covered and non-covered functions. In compliance with 45 CFR § 164.105(a)(2), DOH has designated specific programs as covered health care components within the hybrid entity. The Bureau of Vital Statistics, which manages nonviable birth registrations, is not a designated program but it is required to maintain data and information secure and confidential in accordance with applicable state and federal laws.

The HIPAA Privacy Rule was not intended to interfere with public health laws and activities and it allows a covered entity such as a hospital to disclose PHI to a public health authority or to an agent of a public health authority when the public health authority is authorized by law to collect or receive such information.

2. WHAT ENTITIES HAVE REQUESTED NONVIABLE BIRTH REGISTRATIONS?

To date no entity other than a parent has requested a certified copy of a nonviable birth registration. There have been no health research requests and no request has been denied. If the parent did not provide appropriate identification the confidential information was redacted before the document was released as a public record. The following is a breakdown of requests by year.

2020 All requests made were from a parent who provided identification and the release was approved. There were 42 applications and 62 certified documents provided.

2019 All requests were from a parent who provided identification and the released of the document was approved. There were 62 applications and 99 certified documents provided.

2018 All requests were from a parent but 5 certificates were issued as a public document with confidential information redacted because identification was not provided. There were 47 applications and 70 certified documents provided.

2017 All requests were from a parent but 4 certificates were issued as a public document with confidential information redacted because identification was not provided. There were 47 applications for documents.

3. NONVIABLE BIRTH REGISTRATIONS FILED BY YEAR

YEAR	COUNT
2007	1
2012	1
2014	4
2015	2
2016	3
2017	93
2018	156
2019	145
2020	121
2021	86 to date

Denson, Tori

From: Roth, Danielle <Danielle.Roth@myfloridahouse.gov>
Sent: Wednesday, October 6, 2021 4:54 PM
To: Smith, Kelly
Subject: FW: Open Government Sunset Reviews of ss. 381.987 and 382.008(8), F.S.
Attachments: OPEN GOVERNMENT SUNSET REVIEW RESPONSE 9.21.21.docx

Hope this helps.

From: Love, Andrew <Andrew.Love@flhealth.gov>
Sent: Tuesday, September 21, 2021 12:45 PM
To: Roth, Danielle <Danielle.Roth@myfloridahouse.gov>
Subject: FW: Open Government Sunset Reviews of ss. 381.987 and 382.008(8), F.S.

See attached

From: McMullen, Linda N <Linda.McMullen@flhealth.gov>
Sent: Tuesday, September 21, 2021 12:39 PM
To: Love, Andrew <Andrew.Love@flhealth.gov>
Cc: Lamia, Christine E <Christine.Lamia@flhealth.gov>; Bradley, Alysson <Alysson.Bradley@flhealth.gov>
Subject: RE: Open Government Sunset Reviews of ss. 381.987 and 382.008(8), F.S.

Good afternoon, Drew.

Attached is the response to questions posed by legislative staff regarding section 381.987, Fla. Stat. Let me know if you have questions or need additional information. It is in WORD so you can reformat if necessary.

Linda

Linda McMullen
Assistant General Counsel | Office of General Counsel
Phone: (850) 245-4025 | Fax: (850) 245-4790

From: Roth, Danielle <Danielle.Roth@myfloridahouse.gov>
Sent: Wednesday, September 15, 2021 3:51 PM
To: Love, Andrew <Andrew.Love@flhealth.gov>
Cc: Toliver, Lance <Lance.Toliver@myfloridahouse.gov>
Subject: Open Government Sunset Reviews of ss. 381.987 and 382.008(8), F.S.

Good Afternoon Drew:

Thanks again for setting up the OGSR meeting on August 31. I wanted to follow-up with you regarding the supplemental information you are going to send over to me and Lance. I know this is a busy time of the year for you, but we'd appreciate any additional information you can send us at your earliest convenience. Thanks so much.

Danielle M. Roth | Attorney
Government Operations Subcommittee
Florida House of Representatives
209 House Office Building
402 S. Monroe Street
Tallahassee, FL 32399
(850) 717-4890

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SPB 7002
INTRODUCER:	Health Policy Committee
SUBJECT:	OGSR/Information Relating to Medical Marijuana Held by the Department of Health
DATE:	November 3, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown		**Submitted as Comm. Bill/Fav**

I. Summary:

SPB 7002 amends s. 381.987, F.S., to save from repeal the public records exemption for certain personal identifying information of patients, caregivers, and physicians held by the Department of Health (DOH) and relating to Florida's medical marijuana program. Specifically, the section makes confidential and exempt from public records requirements of s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution:

- A patient's or caregiver's personal identifying information held in the DOH's medical marijuana use registry (MMUR);
- All personal identifying information collected for the purpose of issuing MMUR identification cards;
- All personal identifying information pertaining to a physician certification for medical marijuana; and
- A qualified physician's Drug Enforcement Administration (DEA) number, residential address, and government-issued identification card.

The section requires the DOH to allow access to confidential and exempt information under specified circumstances and specifies that any information released by the DOH remains confidential and exempt and that the person who receives the information must maintain the information's confidential and exempt status.

The public records exemption stands repealed on October 2, 2022, unless reviewed and reenacted by the Legislature under the Open Government Sunset Review Act. This proposed bill removes the scheduled repeal of the exemption to continue the confidential and exempt status of the information.

The proposed bill provides an effective date of October 1, 2022.

II. Present Situation:

Access to Public Records – Generally

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] The right to inspect or copy applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

Additional requirements and exemptions related to public records are found in various statutes and rules, depending on the branch of government involved. For instance, s. 11.0431, F.S., provides public access requirements for legislative records. Relevant exemptions are codified in s. 11.0431(2)-(3), F.S., and the statutory provisions are adopted in the rules of each house of the Legislature.[3] Florida Rule of Judicial Administration 2.420 governs public access to judicial branch records.[4] Lastly, ch. 119, F.S., provides requirements for public records held by executive agencies.

Executive Agency Records – The Public Records Act

Chapter 119, F.S., known as the Public Records Act, provides that all state, county, and municipal records are open for personal inspection and copying by any person and that providing access to public records is a duty of each agency.[5]

A public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[6] The Florida Supreme Court has interpreted the statutory definition of "public record" to include "material prepared in connection with official agency business which is intended to perpetuate, communicate, or formalize knowledge of some type."[7]

The Florida Statutes specify conditions under which public access to public records must be provided. The Public Records Act guarantees every person's right to inspect and copy any public record at any reasonable time, under reasonable conditions, and under supervision by the

[1] FLA. CONST. art. I, s. 24(a).
[2] *Id*.
[3] *See* Rule 1.48, *Rules and Manual of the Florida Senate*, (2010-2022) and Rule 14.1, *Rules of the Florida House of Representatives*, Edition 1, (2020-2022).
[4] *State v. Wooten*, 260 So.3d 1060 (Fla. 4th DCA 2018).
[5] Section 119.01(1), F.S. Section 119.011(2), F.S., defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[6] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency."
[7] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc*., 379 So.2d 633, 640 (Fla. 1980).

custodian of the public record.[8] A violation of the Public Records Act may result in civil or criminal liability.[9]

The Legislature may exempt public records from public access requirements by passing a general law by a two-thirds vote of both the House and the Senate.[10] The exemption must state with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish the stated purpose of the exemption.[11]

General exemptions from the public records requirements are contained in the Public Records Act.[12] Specific exemptions often are placed in the substantive statutes relating to a particular agency or program.[13]

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." Custodians of records designated as "exempt" are not prohibited from disclosing the record; rather, the exemption means that the custodian cannot be compelled to disclose the record.[14] Custodians of records designated as "confidential and exempt" may not disclose the record except under circumstances specifically defined by the Legislature.[15]

Open Government Sunset Review Act

The Open Government Sunset Review Act[16] (the Act) prescribes a legislative review process for newly created or substantially amended[17] public records or open meetings exemptions, with specified exceptions.[18] It requires the automatic repeal of such exemption on October 2nd of the fifth year after creation or substantial amendment unless the Legislature reenacts the exemption.[19]

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[20]

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[8] Section 119.07(1)(a), F.S.
[9] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[10] FLA. CONST. art. I, s. 24(c).
[11] *Id*. *See, e.g., Halifax Hosp. Medical Center v. News-Journal Corp.*, 724 So.2d 567 (Fla. 1999) (holding that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption); *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So.2d 189 (Fla. 1st DCA 2004) (holding that a statutory provision written to bring another party within an existing public records exemption is unconstitutional without a public necessity statement).
[12] *See, e.g.*, s. 119.071(1)(a), F.S. (exempting from public disclosure examination questions and answer sheets of examinations administered by a governmental agency for the purpose of licensure).
[13] *See, e.g.*, s. 213.053(2)(a), F.S. (exempting from public disclosure information contained in tax returns received by the Department of Revenue).
[14] *See Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA 1991).
[15] *WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004).
[16] Section 119.15, F.S.
[17] An exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings as well as records. Section 119.15(4)(b), F.S.
[18] Section 119.15(2)(a) and (b), F.S., provide that exemptions that are required by federal law or are applicable solely to the Legislature or the State Courts System are not subject to the Open Government Sunset Review Act.
[19] Section 119.15(3), F.S.
[20] Section 119.15(6)(b), F.S.

An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- The exemption allows the state or its political subdivisions to effectively and efficiently administer a governmental program and such administration would be significantly impaired without the exemption;[21]
- The exemption protects sensitive, personal information, the release of which would be defamatory, cause unwarranted damage to the good name or reputation of the individual, or would jeopardize the individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[22] or
- It protects information of a confidential nature concerning entities, such as trade or business secrets.[23]

The Act also requires specified questions to be considered during the review process.[24] In examining an exemption, the Act directs the Legislature to question carefully the purpose and necessity of reenacting the exemption.

If the exemption is continued and expanded, then a public necessity statement and a two-thirds vote for passage are required.[25] If the exemption is continued without substantive changes or if the exemption is continued and narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to sunset, then records created before the sunset date may not be made public unless otherwise provided by law.[26]

Public Records Exemption for Personal Identifying Information Relating to Medical Marijuana Held by the DOH

Section 381.987, F.S., establishes that the following information is confidential and exempt from public records:

- A patient's or caregiver's personal identifying information held by the DOH in the MMUR established under s. 381.986, F.S., including, but not limited to, the patient's or caregiver's name, address, date of birth, photograph, and telephone number.
- All personal identifying information collected for the purpose of issuing a patient's or caregiver's MMUR identification card described in s. 381.986, F.S.

[21] Section 119.15(6)(b)1., F.S.
[22] Section 119.15(6)(b)2., F.S.
[23] Section 119.15(6)(b)3., F.S.
[24] Section 119.15(6)(a), F.S. The specified questions are:
- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[25] *See generally* s. 119.15, F.S.
[26] Section 119.15(7), F.S.

- All personal identifying information pertaining to the physician certification for marijuana and the dispensing thereof held by the DOH, including, but not limited to, information related to the patient's diagnosis, exception requests to the daily dose amount limit, and the qualified patient's experience related to the medical use of marijuana.
- A qualified physician's DEA number, residential address, and government-issued identification card.

The section allows the release of confidential and exempt information to specified persons or entities and also specifies that all information released remains confidential and exempt and that the person who receives the information must maintain such status. Any person who willfully and knowingly violates this provision, or any other provision in the section, commits a felony of the third degree. The section requires the DOH to allow access to the confidential and exempt information the following persons or entities:

- A law enforcement agency that is investigating a violation of law regarding marijuana in which the subject of the investigation claims an exception established under s. 381.986, F.S., except for information related to the patient's diagnosis.
- A medical marijuana treatment center approved by the DOH pursuant to s. 381.986, F.S., which is attempting to verify the authenticity of a physician certification for marijuana, including whether the certification had been previously filled and whether the certification was issued for the person attempting to have it filled, except for information related to the patient's diagnosis.
- A physician who has issued a certification for marijuana for the purpose of monitoring the patient's use of such marijuana or for the purpose of determining, before issuing a certification for marijuana, whether another physician has issued a certification for the patient's use of marijuana. The physician may access the confidential and exempt information only for the patient for whom he or she has issued a certification or is determining whether to issue a certification for the use of marijuana pursuant to s. 381.986, F.S.
- A practitioner licensed to prescribe prescription medications to ensure proper care of a patient before prescribing medication to that patient which may interact with marijuana.
- An employee of the DOH for the purposes of maintaining the MMUR and periodic reporting or disclosure of information that has been redacted to exclude personal identifying information.
- An employee of the DOH for the purposes of reviewing physician registration and the issuance of physician certifications to monitor practices that could facilitate unlawful diversion or the misuse of marijuana or a marijuana delivery device.
- The DOH's relevant health care regulatory boards responsible for the licensure, regulation, or discipline of a physician if he or she is involved in a specific investigation of a violation of s. 381.986, F.S. If a health care regulatory board's investigation reveals potential criminal activity, the board may provide any relevant information to the appropriate law enforcement agency.
- The Consortium for Medical Marijuana Clinical Outcomes Research established in s. 1004.4351(4), F.S.
- A person engaged in bona fide research if the person agrees:
    - To submit a research plan to the DOH which specifies the exact nature of the information requested and the intended use of the information;

- To maintain the confidentiality of the records or information if personal identifying information is made available to the researcher;
- To destroy any confidential and exempt records or information obtained after the research is concluded; and
- Not to contact, directly or indirectly, for any purpose, a patient or physician whose information is in the MMUR.

According to the statement of public necessity included in SB 6-A (2017), which established the public records exemption, the Legislature found that it was necessary to protect the personal identifying information of patients, caregivers, and physicians as such information could make the public aware of the patient's medical conditions, as well as be used to embarrass, humiliate, harass, or discriminate against the patient, caregiver, or physician over his or her decision to use, assist with the use of, or certify a patient for medical marijuana. As of October 22, 2021, there were 628,277 active, qualified patients in the MMUR and 2,765 physicians who qualify to issue certifications for medical marijuana.[27]

The public records exemption stands repealed on October 2, 2022, unless reviewed and reenacted by the Legislature under the Open Government Sunset Review Act. In a phone interview that Senate Health Policy Committee staff conducted with the DOH on August 31, 2021, the DOH recommended that the public records exemption be reenacted as is.[28]

III. Effect of Proposed Changes:

SPB 7002 amends s. 381.987, F.S., to save from repeal the public records exemption for certain personal identifying information of patients, caregivers, and physicians held by the DOH and relating to Florida's medical marijuana program. For specific information on the public records exemption please see Section II of this analysis.

The proposed bill provides an effective date of October 1, 2022.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[27] See Office of Medical Marijuana Use (OMMU) information sheet, October 22, 2021, available at https://knowthefactsmmj.com/wp-content/uploads/ommu_updates/2021/102221-OMMU-Update.pdf, (last visited Nov. 28, 2021). Note: the number of caregivers is not listed on the OMMUs webpage, nor is it specified on OMMU's annual report for 2020, which can be found at https://knowthefactsmmj.com/wp-content/uploads/2020/02/2020-Annual-Report.pdf (last visited Nov. 28, 2021.

[28] Conversation with Ken Jones, State Registrar and Bureau Chief, Bureau of Vital Statistics, Department of Health (Aug. 31, 2021).

B. Public Records/Open Meetings Issues:

Voting Requirement

Article I, s. 24(c), of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record exemption. The proposed bill continues the current public records exemption under sunset review; it does not expand this exemption or create a new one. Therefore, a two-thirds vote of the members present and voting for final passage of the bill is not required.

Public Necessity Statement

Article I, s. 24(c), of the State Constitution requires a bill that creates or expands an exemption to the public records requirements to state with specificity the public necessity justifying the exemption. The proposed bill continues the current public records exemption under sunset review; it does not expand this exemption or create a new one. Thus, the proposed bill does not require a public necessity statement.

Breadth of Exemption

Article I, s. 24(c) of the State Constitution requires a newly created public record or public meeting exemption to be no broader than necessary to accomplish the stated purpose of the law. The proposed bill continues the current public records exemption under sunset review; it does not expand this exemption or create a new one. It does not appear to be in conflict with the constitutional requirement that the exemption be no broader than necessary to accomplish its purpose.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 381.987 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

FOR CONSIDERATION By the Committee on Health Policy

588-00713-22 20227002pb

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act; amending s. 381.987, F.S., which provides an exemption from public records requirements for personal identifying information relating to medical marijuana held by the Department of Health; removing the scheduled repeal of the exemption; providing an effective date.

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

Section 1. Section 381.987, Florida Statutes, is amended to read:

381.987 Public records exemption for personal identifying information relating to medical marijuana held by the department.—

(1) The following information is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) A patient's or caregiver's personal identifying information held by the department in the medical marijuana use registry established under s. 381.986, including, but not limited to, the patient's or caregiver's name, address, date of birth, photograph, and telephone number.

(b) All personal identifying information collected for the purpose of issuing a patient's or caregiver's medical marijuana use registry identification card described in s. 381.986.

(c) All personal identifying information pertaining to the physician certification for marijuana and the dispensing thereof

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

588-00713-22 20227002pb

held by the department, including, but not limited to, information related to the patient's diagnosis, exception requests to the daily dose amount limit, and the qualified patient's experience related to the medical use of marijuana.

(d) A qualified physician's Drug Enforcement Administration number, residential address, and government-issued identification card.

(2) The department shall allow access to the confidential and exempt information in the medical marijuana use registry to:

(a) A law enforcement agency that is investigating a violation of law regarding marijuana in which the subject of the investigation claims an exception established under s. 381.986, except for information related to the patient's diagnosis.

(b) A medical marijuana treatment center approved by the department pursuant to s. 381.986 which is attempting to verify the authenticity of a physician certification for marijuana, including whether the certification had been previously filled and whether the certification was issued for the person attempting to have it filled, except for information related to the patient's diagnosis.

(c) A physician who has issued a certification for marijuana for the purpose of monitoring the patient's use of such marijuana or for the purpose of determining, before issuing a certification for marijuana, whether another physician has issued a certification for the patient's use of marijuana. The physician may access the confidential and exempt information only for the patient for whom he or she has issued a certification or is determining whether to issue a certification for the use of marijuana pursuant to s. 381.986.

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

(d) A practitioner licensed to prescribe prescription medications to ensure proper care of a patient before prescribing medication to that patient which may interact with marijuana.

(e) An employee of the department for the purposes of maintaining the registry and periodic reporting or disclosure of information that has been redacted to exclude personal identifying information.

(f) An employee of the department for the purposes of reviewing physician registration and the issuance of physician certifications to monitor practices that could facilitate unlawful diversion or the misuse of marijuana or a marijuana delivery device.

(g) The department's relevant health care regulatory boards responsible for the licensure, regulation, or discipline of a physician if he or she is involved in a specific investigation of a violation of s. 381.986. If a health care regulatory board's investigation reveals potential criminal activity, the board may provide any relevant information to the appropriate law enforcement agency.

(h) The Consortium for Medical Marijuana Clinical Outcomes Research established in s. 1004.4351(4).

(i) A person engaged in bona fide research if the person agrees:

1. To submit a research plan to the department which specifies the exact nature of the information requested and the intended use of the information;

2. To maintain the confidentiality of the records or information if personal identifying information is made

available to the researcher;

3. To destroy any confidential and exempt records or information obtained after the research is concluded; and

4. Not to contact, directly or indirectly, for any purpose, a patient or physician whose information is in the registry.

(3) The department shall allow access to the confidential and exempt information pertaining to the physician certification for marijuana and the dispensing thereof, whether in the registry or otherwise held by the department, to:

(a) An employee of the department for the purpose of approving or disapproving a request for an exception to the daily dose amount limit for a qualified patient; and

(b) The Consortium for Medical Marijuana Clinical Outcomes Research pursuant to s. 381.986 for the purpose of conducting research regarding the medical use of marijuana.

(4) All information released by the department under subsections (2) and (3) remains confidential and exempt, and a person who receives access to such information must maintain the confidential and exempt status of the information received.

(5) A person who willfully and knowingly violates this section commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.083.

~~(6) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.~~

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

The Florida Senate

APPEARANCE RECORD

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

11/3/2021
Meeting Date

Health Policy
Committee

7002
Bill Number or Topic

Amendment Barcode (if applicable)

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City *State* *Zip*

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

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: NORML Tallahassee

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

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

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

S-001 (08/10/2021)

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Committee on Health Policy **Judge:**

Started: 11/3/2021 11:30:25 AM
Ends: 11/3/2021 1:05:06 PM Length: 01:34:42

11:30:23 AM Meeting called to order By Chair Diaz
11:30:36 AM Roll call; a quorum is present
11:31:12 AM Comments by Chair Diaz; SB 296 by Senator Garcia will be temporarily postponed
11:31:34 AM Tab 3: SB 358 by Senator Rodriguez
11:31:55 AM Senator Rodriguez introduces the bill
11:32:21 AM Take up amendment bar code 166930 by Senator Rodriguez
11:32:40 AM questions on the amendment; none
11:32:52 AM amendment bar code 166930 is adopted
11:33:00 AM Questions on the bill? Yes
11:33:10 AM Question by Senator Jones
11:33:17 AM Response by Senator Rodriguez
11:33:29 AM Question by Senator Cruz
11:33:42 AM Response by Senator Rodriguez
11:34:17 AM Follow-up question by Senator Cruz
11:34:43 AM Response by Senator Rodriguez
11:35:05 AM Question by Senator Powell
11:35:13 AM Response by Senator Rodriguez
11:35:56 AM Follow-up question by Senator Powell
11:36:08 AM Response by Senator Rodriguez
11:36:30 AM No further questions
11:36:34 AM Michael Cusrecle waives in support
11:37:05 AM Phillip Suderman waives in support
11:37:13 AM Public testimony by Dr. Karla L. Sapp
11:40:33 AM Debate on the bill? Yes
11:40:46 AM Debate by Senator Powell
11:41:42 AM Debate by Senator Jones
11:42:24 AM Debate by Senator Garcia
11:42:30 AM Senator Rodriguez Closes on the bill
11:42:42 AM Roll call on SB 358
11:42:55 AM The bill is reported favorably
11:43:34 AM Tab 1: Appearance and presentation by the Agency for Health Care Administration Secretary Simone Marstiller
12:04:55 PM Questions on the presentation; yes
12:05:08 PM Question by Senator Jones
12:05:45 PM Response by Secretary Marstiller
12:06:54 PM Follow-up question by Senator Jones
12:07:26 PM Response by Secretary Marstiller
12:08:26 PM Follow-up question by Senator Jones
12:08:41 PM Response by Secretary Marstiller
12:08:51 PM Question by Senator Bean
12:09:18 PM Response by Secretary Marstiller
12:09:40 PM question by Senator Bean
12:10:25 PM Response by secretary Marstiller
12:10:32 PM Series of questions and responses between Senator Bean and Secretary Marstiller
12:12:26 PM Follow-up response by Secretary Marstiller
12:12:41 PM Question by Senator Bean
12:12:49 PM Response by Secretary Marstiller
12:13:00 PM Follow-up question by Senator Bean
12:13:19 PM Response by secretary Marstiller
12:13:25 PM Question by Senator Cruz
12:14:05 PM Response by Secretary Marstiller
12:14:14 PM Series of questions and responses between Senator Cruz and Secretary Marstiller

12:20:37 PM Question by Senator Powell
12:20:50 PM Response by Secretary Marstiller
12:21:30 PM Follow-up question by Senator Powell
12:22:24 PM Series of questions and responses between Senator Powell and Secretary Marstiller
12:30:11 PM Question by Senator Baxley
12:30:26 PM Response by Secretary Marstiller
12:31:33 PM Comments by Senator Baxley
12:31:54 PM Comments by Chair Diaz
12:32:15 PM Tab 2: SB 292 by Senator Polsky
12:32:51 PM Senator Book presents the bill
12:34:12 PM Questions; none. Public testimony; Yes.
12:34:13 PM Terri Fisk speaks in support
12:34:14 PM waives in support; Alisa Damico, Norssis Mejio, Amonola Sonlos, Debbie Gainsk, Lynn Miskiel, Theressa Bolger, Kathleen Vergara and David Cullen
12:34:22 PM Megan Harvey Speak in support
12:37:25 PM Debate; none
12:37:34 PM Senator Book wavies close
12:37:41 PM Roll call; SB 292 is reported fav
12:38:01 PM Tab 5: SB 330 by Senator Brodeur. Senator Brodeur presents the bill
12:39:45 PM Question by Senator Albritton
12:40:13 PM Response by Senator Brodeur
12:41:19 PM Question by Senator Albritton
12:41:36 PM Response by Senator Brodeur
12:42:30 PM Question by Senator Powell
12:42:58 PM Response by Senator Brodeur
12:43:38 PM Follow-up question by Senator Powell
12:44:20 PM Response by Senator Brodeur
12:44:33 PM No Further Questions
12:44:44 PM Philip Suderman speaks in support
12:44:45 PM Waives in support; David Mica Jr. and Zayne Smith
12:45:19 PM Debate; none
12:45:25 PM roll call; bill is reported favorably
12:46:08 PM Tab 6: SB 312 by Chair Diaz; Chair Diaz presents the bill
12:47:12 PM Questions on the bill; yes
12:47:21 PM Question by Senator Jones
12:47:34 PM Response by Senator Diaz
12:48:29 PM Question by Senator Cruz
12:48:46 PM Response by Senator diaz
12:50:09 PM Question by Senator Cruz
12:50:22 PM Comments by Chair Brodeur
12:50:50 PM Response by Senator Diaz
12:51:42 PM Public testimony; yes. Waives in support Jarrod Fuller, David Mica, Steven Winn, Chris Nuland and Zayne Smith.
12:52:25 PM Philip Suderman speaks in support
12:54:10 PM Eric Stevens speaks in support
12:55:26 PM Debate by Senator Albritton
12:56:40 PM Debate by Senator Garcia
12:57:03 PM Debate by Senator Baxley
12:57:36 PM Senator Diaz closes on the bill
12:58:19 PM Roll call; the bill is reported favorably
12:58:40 PM Tab 7: SPB 7000
12:59:12 PM
12:59:42 PM questions; none
12:59:51 PM debate none
1:00:00 PM Roll call; SPB 7000 the bill is reported favorably
1:00:21 PM Tab 8: SPB 7002
1:01:28 PM questions none
1:02:03 PM Melissa Villor speakes in support of the bill
1:03:59 PM debate; none
1:04:08 PM Roll call; SPB 7002 the bill will be reported favorably
1:04:47 PM Senator Jones moves to adjourn.