Health & Human Services Committee

Thursday, February 8, 2024
8:00 AM – 10:00 AM
Morris Hall (17 HOB)

Meeting Packet

Paul Renner
Speaker

Randy Fine
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time: Thursday, February 08, 2024 08:00 am

End Date and Time: Thursday, February 08, 2024 10:00 am

Location: Morris Hall (17 HOB)

Duration: 2.00 hrs

Consideration of the following bill(s):

HB 63 Protection from Surgical Smoke by Woodson
HB 73 Supported Decisionmaking Authority by Tant, Koster
CS/HB 89 Revive Awareness Day by Healthcare Regulation Subcommittee, Plakon
CS/HB 99 Social Work Licensure Interstate Compact by Healthcare Regulation Subcommittee, Hunschofsky
CS/HB 101 Pub. Rec. & Meetings/Social Work Licensure Interstate Compact by Healthcare Regulation Subcommittee, Hunschofsky
CS/HB 115 Progressive Supranuclear Palsy and Other Neurodegenerative Diseases Policy Workgroup by Healthcare Regulation Subcommittee, Bankson, Plakon
CS/CS/HB 197 Health Care Practitioners and Massage Therapy by Health Care Appropriations Subcommittee, Healthcare Regulation Subcommittee, Lopez, V.
CS/HB 309 Rural Emergency Hospitals by Select Committee on Health Innovation, Shoaf
CS/HB 415 Pregnancy and Parenting Resources Website by Health Care Appropriations Subcommittee, Jacques
CS/HB 505 Tax Collectors by Local Administration, Federal Affairs & Special Districts Subcommittee, Truenow
CS/HB 591 Hot Car Death Prevention by Children, Families & Seniors Subcommittee, Brannan, Smith
HB 725 Veterans' Long-term Care Facilities Admissions by Woodson, Snyder
CS/HB 827 Mental Health Professionals by Healthcare Regulation Subcommittee, Koster
HB 855 Dental Services by McClure, Berfield
CS/HB 935 Home Health Care Services by Select Committee on Health Innovation, Franklin
CS/HB 1269 Potency for Adult Personal Use of Marijuana by Healthcare Regulation Subcommittee, Massullo, Fine
CS/HB 1343 Health Care Patient Protection by Select Committee on Health Innovation, Altman

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m. Wednesday, February 7, 2024.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Wednesday, February 7, 2024.

To submit an electronic appearance form, and for information about attending or testifying at a committee meeting, please see the “Visiting the House” tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 02/06/2024 4:01PM by Arnold.Sabrina

HB 63

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 63 Protection from Surgical Smoke
SPONSOR(S): Woodson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 410

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	14 Y, 0 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee	14 Y, 0 N	Smith	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Surgical smoke is the gaseous by-product produced when tissue is dissected or cauterized by heat generating devices such as lasers, electrosurgical units, ultrasonic devices, and high-speed burrs, drills and saws. Surgical smoke contains chemicals, blood and tissue particles, bacteria, and viruses, and has been proven to exhibit potential risks for surgeons, nurses, anesthesiologists, and technicians in the operating room due to long term exposure.

The bill requires hospitals and ambulatory surgical centers to adopt and implement policies by January 1, 2025, that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke. Smoke evacuation systems must effectively capture, filter, and eliminate surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

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

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Surgical Smoke

Surgical smoke is the gaseous by-product produced when tissue is dissected or cauterized by heat generating devices such as lasers, electrosurgical units, ultrasonic devices, and high-speed burrs, drills and saws.[1] During a surgical procedure, the heat generated from one of these devices causes the target cell membranes to rupture, and subsequently generates and releases a plume of smoke into the operating room.[2] Surgical smoke contains chemicals, blood and tissue particles, bacteria, and viruses, and has been proven to exhibit potential risks for surgeons, nurses, anesthesiologists, and technicians in the operating room due to long term exposure.[3]

Potential known health effects from the exposure to surgical smoke include eye, nose, and throat irritation; headache; cough; nasal congestion; and asthma and asthma-like symptoms, but little is known about the health effects from chronic exposure to surgical smoke.[4] Other risks include the transmission of viruses through surgical smoke; for example, transmission of Human Papillomavirus (HPV) through surgical smoke from lasers has been documented,[5] and some researchers have suggested that surgical smoke may act as a vector for cancerous cells that may be inhaled.[6]

Surgical Smoke Evacuation Systems

Smoke evacuators are devices which contain a suction unit (i.e. a vacuum), filter, hose, and inlet nozzle. They are designed, as recommended by the Center for Disease Control, to capture air from where the nozzle is targeted and filter the air through a HEPA filter.[7] These systems may be stationary, with permanent construction requirements, or handheld portable systems with disposable filters, hand pieces, and hoses. While costs for these products range greatly, with installation of a stationary system costing as much as $120,000,[8] the more common handheld systems have recurring costs associated with disposable parts of roughly $19 per surgery, and total recurring costs including filter replacement between $8,000 and $10,000 annually depending on frequency of use.[9]

[1] Liu Y, Song Y, Hu X, Yan L, Zhu X. Awareness of surgical smoke hazards and enhancement of surgical smoke prevention among the gynecologists. Journal of Cancer (June 2, 2019) available at https://www.jcancer.org/v10p2788.htm (last visited January 21, 2024).
[2] *Id*.
[3] *Id*.
[4] Steege AL, Boiano JM, Sweeney MH. NIOSH health and safety practices survey of healthcare workers: training and awareness of employer safety procedures, American Journal of Industrial Medicine (February 18, 2014) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504242/ (last visited January 21, 2024).
[5] *Id.*
[6] United States Department of Labor, Occupational Safety and Health Administration, *Surgical Suite >> Smoke Plume*, available at https://www.osha.gov/etools/hospitals/surgical-suite/smoke-plume, (last visited January 21, 2024).
[7] Centers for Disease Control, *Control of Smoke from Laser/Electrical Surgical Procedures*, available at https://www.cdc.gov/niosh/docs/hazardcontrol/hc11.html (last visited January 21, 2024).
[8] Relias Media, *Consider Overall Cost, Ease when Choosing Evacuators,* available at https://www.reliasmedia.com/articles/61664-consider-overall-cost-ease-when-choosing-evacuators (last visited January 21, 2024).
[9] *See* Relias Media, *OR Teams Often Exposed to Toxic Chemicals in Surgical Smoke*, Mar. 1, 2021, available at https://www.reliasmedia.com/articles/147530-or-teams-often-exposed-to-toxic-chemicals-in-surgical-smoke#:~:text=The%20estimated%20cost%20of%20using,for%20the%20standard%20electrosurgical%20pencil. (last visited January 21, 2024), Ohio Legislative Service Commission, *SB 161 Fiscal Note & Local Impact Statement*, available at https://www.legislature.ohio.gov/download?key=17773&format=pdf (last visited January 21, 2024); Kreuger, Steven, et al., *The Effect of a Surgical Smoke Evacuation System on Surgical Site Infections of the Spine*, available at https://www.oatext.com/pdf/CMID-3-132.pdf (last visited January 21, 2024).

Surgical Smoke Regulation

Hospitals and ambulatory surgical centers (ASCs) must comply with the 2021 National Fire Protection Association (NFPA) 101 Life Safety Code.[10] The 2021 version does not require the use of surgical smoke evacuation systems, but the 2024 version does. However, in Florida, the 2021 version will be enforceable until 2027, when the State Fire Marshal adopts the 2024 version.[11] The 2024 version requires facilities to capture surgical smoke using either a dedicated exhaust system (may share an established system for waste gas removal), a connection and return or exhaust duct after air cleaning through high efficiency particulate air (HEPA) and gas phase filtration, or a point of use smoke evacuator for air cleaning and return to the space. As a result, Florida will have no regulatory requirement to use surgical smoke evacuation systems in hospitals and ASCs until 2027.

The Occupational Safety and Health Administration (OSHA) recognizes potential risk factors and remedial measures, but it has not adopted regulations on protection from surgical smoke. OSHA's recognized controls and work practices for surgical smoke include:[12]

- Using portable local smoke evacuators and room suction systems with in-line filters.
- Keeping the smoke evacuator or room suction hose nozzle inlet within two inches of the surgical site to effectively capture airborne contaminants.
- Having a smoke evacuator available for every operating room where plume is generated.
- Evacuating all smoke, no matter how much is generated.
- Keeping the smoke evacuator "ON" (activated) at all times when airborne particles are produced during all surgical or other procedures.
- Considering all tubing, filters, and absorbers as infectious waste and dispose of them appropriately.
- Using new tubing before each procedure and replace the smoke evacuator filter as recommended by the manufacturer.
- Inspecting smoke evacuator systems regularly to ensure proper functioning.

Additionally, the Joint Commission, an accrediting organization for hospitals and ASCs, recommends the following actions to protect patients and staff from the dangers of surgical smoke:

- Implement standard procedures for the removal of surgical smoke and plume through the use of engineering controls, such as smoke evacuators and high filtration masks.
- Use specific insufflators for patients undergoing laparoscopic procedures.
- During laser procedures, use standard precautions to prevent exposure to the aerosolized blood, blood by-products and pathogens contained in surgical smoke plumes.
- Establish, review, and make available policies and procedures for surgical smoke safety and control.
- Provide surgical team members with initial and ongoing education and competency verification on surgical smoke safety, including the organization's policies and procedures.
- Conduct periodic training exercises to assess surgical smoke precautions and consistent evacuation for the surgical suite or procedural area."[13]

As of August 2023, 11 states have adopted legislation to require the use of surgical smoke evacuation systems in certain health care facilities. Of those 11 states, 8 states require surgical smoke evacuation systems to be used in hospitals and ASCs for procedures that generate surgical smoke, and 3 states require them to be used in all health care facilities for procedures that produce surgical smoke.[14]

[10] Rule 69A-3.012, F.A.C., and s. 633.206(1)(b), F.S.
[11] S. 633.202(1), F.S., requires the State Fire Marshal to adopt a new version of the fire prevention code every third year. The 2021 version becomes effective December 31, 2024, so the 2024 version will not become effective until December 31, 2027.
[12] *Id.*
[13] The Joint Commission, *Quick Safety Issue 56: Alleviating the Dangers of Surgical Smoke*, available at https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-56/quick-safety-issue-56/ (last visited January 21, 2024).
[14] Staff of the Select Committee on Health Innovation conducted a 50-state analysis on laws relating to surgical smoke evacuation.

Effect of the Bill

The bill requires hospitals and ASCs to adopt and implement policies by January 1, 2025, that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke. Smoke evacuation systems must effectively capture, filter, and eliminate surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Creates s. 395.1013, F.S., relating to smoke evacuation systems required.
Section 2: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will have a negative fiscal impact on hospitals and ASCs who do not currently use surgical smoke evacuation systems during procedures that generate surgical smoke. Such hospitals and ASCs could incur costs of up to $10,000 per surgical suite annually.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None. The bill does not appear to affect local or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not necessitate rule-making for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to protection from surgical smoke; creating s. 395.1013, F.S.; defining the terms "smoke evacuation system" and "surgical smoke"; requiring hospitals and ambulatory surgical centers to, by a specified date, adopt and implement policies requiring the use of smoke evacuation systems during certain surgical procedures; providing an effective date.

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

Section 1. Section 395.1013, Florida Statutes, is created to read:

395.1013 Smoke evacuation systems required.—

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

(a) "Smoke evacuation system" means equipment that effectively captures, filters, and eliminates surgical smoke at the site of origin before the smoke makes contact with the eyes or respiratory tract of occupants in the room.

(b) "Surgical smoke" means the gaseous byproduct produced by energy-generating devices such as lasers and electrosurgical devices. The term includes, but is not limited to, surgical plume, smoke plume, bio-aerosols, laser-generated airborne contaminants, and lung-damaging dust.

(2) By January 1, 2025, each licensed facility shall adopt

and implement policies that require the use of a smoke evacuation system during any surgical procedure that is likely to generate surgical smoke.

Section 2. This act shall take effect July 1, 2024.

HB 73

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 73 Supported Decisionmaking Authority
SPONSOR(S): Tant and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 446

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N	Lloyd	Brazzell
2) Civil Justice Subcommittee	17 Y, 0 N	Mathews	Jones
3) Health & Human Services Committee		Lloyd	Calamas

SUMMARY ANALYSIS

Supported decisionmaking authority (SDM) is a person-driven decisionmaking model that empowers a person with a disability (the decisionmaker) to make life choices with help from a supporter, while the values, priorities, and wishes of the decisionmaker drive the process. The supporter identified in the SDM agreement helps the person with a disability understand and explore options, to know risks and benefits associated with the options, to receive recommendations, and to independently exercise his or her rights with appropriate assistance based on his or her unique needs and abilities. The SDM agreement model does not provide the designated agent, advisor, or supporter the authority to bind or act on behalf of the adult with a disability on any subject matter.

HB 73 creates an SDM agreement under Florida's Power of Attorney chapter, chapter 709. The bill permits an adult with disabilities to seek an SDM agreement. Such an agreement authorizes an agent, advisor, or supporter to:

- Assist the decisionmaker in understanding the options, responsibilities, and consequences of life decisions.
- Assist the decisionmaker in accessing, collecting, and obtaining information and records relevant to a life decision including, but not limited to, medical, psychological, financial, educational, or treatment records, to which the decisionmaker is entitled, from any person or entity.
- Assist the decisionmaker in exercising his or her rights.
- Assist the decisionmaker in communicating his or her decisions.
- Access the decisionmaker's personal information, to the extent authorized by the SDM agreement.

HB 73 also requires the circuit court to consider the specific needs and abilities of a person with developmental disabilities when determining whether to approve a request for a guardian advocate. When a guardian advocate court order is issued, the order must address what other alternatives to the guardian advocate were considered and why such alternatives were not sufficient.

For petitions to determine incapacity, the bill adds a requirement to address whether the alleged incapacitated person needs assistance to exercise his or her rights, including through SDM, and whether or not this level of assistance is appropriate or insufficient for the situation. HB 73 also permits the examining committee, which determines incapacity, to allow another individual to assist in communications with the individual with a disability, when requested by the court-appointed counsel for the alleged incapacitated person.

HB 73 does not appear to have a fiscal impact on state or local governments.

The bill has an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Developmental Disabilities

A developmental disability is statutorily defined as a disorder or syndrome that is attributable to an intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.[1]

Guardianship

When a court deems an individual legally incompetent,[2] a third party or a guardian may be appointed to make decisions on that individual's behalf.[3] Current state law defines a "guardian" as a person who has been appointed by the court to act on behalf of a ward's person, property, or both.[4] The process to determine an individual's incapacity and the possible appointment of a guardian begins with a verified petition. The petition must provide detailed, factual information supporting the reasons the petitioner believes the individual to be incapacitated, including the specific rights or activities the alleged incapacitated person is incapable of managing on their own behalf.[5] Once a person has been found to be incapacitated, a specific guardianship order is issued with details on specific restrictions, the role of the guardian, and the name of the guardian.[6] The order must:

- Be consistent with the ward's welfare and safety;
- Clearly state the rights removed from the ward and delegated to the guardian;
- Be the least restrictive and appropriate alternative; and
- Reserve to the ward the right to make decisions in all matters commensurate with his or her ability to do so.[7]

Any resident of the state who is 18 years old and of sound mind is qualified to act as a guardian.[8] A nonresident of this state may act as a guardian of state resident if they are related to the person by blood, adoption, or law.[9] Individuals who are disqualified include those who have been convicted of felonies, those who are incapacitated by illness, or are otherwise unable to assist another with the execution of their duties.[10]

A guardian coordinates and monitors his or her ward's services and needs, including his or her funds, as directed by the guardianship court order.[11] The ward's funds and property belong to the ward and do not become the property of the guardian. These funds must be kept separate from and accounted for independently from any of the guardian's funds.

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[1] S. 393.063(9), F.S.
[2] Current state law defines an "incapacitated person" to mean a person who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of the person. *See* s. 744.102(12), F.S.
[3] Martinis, J., *Supported decisionmaking: Protecting rights, ensuring choices*, BIFOCAL: A Journal of the ABA Commission on Law and Aging, 36(5), pgs. 107-110 (2015), available at Supported Decision-Making: Protecting Rights, Ensuring Choices (americanbar.org) (last visited December 2, 2023).
[4] S. 744.102(9), F.S.
[5] S. 744.3201, F.S.
[6] SS. 744.3371-.345, F.S.
[7] S. 744.2005, F.S.
[8] S. 744.309(1), F.S.
[9] S. 744.309(2), F.S.
[10] S. 744.309,(3), F.S.
[11] National Guardianship Association, *What is Guardianship?,* What Is Guardianship? | National Guardianship Association (last visited December 2, 2023).

Guardianships can be grouped into different types based on the level of authority granted to the guardian:

- *Limited or partial guardianship*[12] occurs when an individual has been deemed incapable of making decisions in only specific areas of life, and a guardian has the authority to decide for the individual in those specific areas only. The grants of legal authority granted or not granted to a guardian are specially noted in the court order.
- *Full or plenary guardianship*[13] occurs when the court has found that an individual lacks capacity to make all legal decisions, and the guardian is authorized to make all decisions for the ward.[14]

Once awarded guardianship, a guardian may be further categorized based on how he or she reaches decisions for his or her ward. A guardian may substitute his or her own understanding of the ward's wishes. These substitute decisionmakers generally follow one of two standards:

- *A substituted judgement standard* means the guardian makes decisions he or she believes the ward would have wanted, if capable.
- *A best interest judgement* standard means the guardian makes decisions based on what the guardian determines to be in the ward's best interest.[15]

In 1987, then-United States Congressman Claude Pepper likened the rights a ward has to that of a felon and posited that:

> *The typical ward has fewer rights than the typical convicted felon . . . . By appointing a guardian, the court entrusts to someone else the power to choose where they will live, what medical treatment they will get and, in rare cases, when they will die. It is, in one short sentence, the most punitive civil penalty that can be levied against an American citizen, with the exception . . . of the death penalty.*[16]

The guardian, as fiduciary, must:

- Act within the scope of the authority granted by the court and as provided by law;
- Act in good faith;
- Act in a manner in the ward's best interests under the circumstances; and
- Use any special skills or expertise the guardian possesses when acting on behalf of the ward.[17]

Additionally, the fiduciary relationship between the guardian and the ward may not be used for the guardian's private gain, other than the remuneration for fees and expenses provided by law.[18] Should a guardian breach his or her fiduciary duty to the ward, the court is authorized to intervene.[19]

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[12] *See* S. 744.102(9)(a), F.S.: A "Limited guardian" means a guardian who has been appointed by the court to exercise the legal rights and powers specifically designated by court order entered after the court has found that the ward lacks the capacity to do some, but not all, of the tasks necessary to care for his or her person or property, or after the person has voluntarily petitioned for appointment of a limited guardian.

[13] *See* S. 744.102(9)(b), F.S.; "Plenary guardian" means a person who has been appointed by the court to exercise all delegable legal rights and powers of the ward after the court has found that the ward lacks the capacity to perform all of the tasks necessary to care for his or her person or property.

[14] Blanck, P, and Martinis, J, *"The right to make choices": The National Resource Center for Supported Decisionmaking*, Inclusion, 3, pgs. 24-33 (2015), available at; The Right to Make Choices: The National Resource Center for Supported Decision-Making | National Resource Center (supporteddecisionmaking.org) (last visited December 2, 2023).

[15] Shalowitz, DI, et al., *The accuracy of surrogate decision makers: A systematic review*, Archives of Internal Medicine, 166(5), pgs. 493-497 (2006), available at The Accuracy of Surrogate Decision Makers: A Systematic Review | End of Life | JAMA Internal Medicine | JAMA Network (last visited December 2, 2023).

[16] *Id.*; Original citation of quote from H.R.Rep.No.100-641, at 1 (1987).

[17] S. 744.361(1), F.S.

[18] S.744.446, F.S.

[19] S. 744.446(4), F.S.

The following chart details some of the guardian's powers, either with or without court approval:

Examples of Powers That May Be Exercised by a Guardian	
Upon Court Approval[20]	**Without Court Approval[21]**
• Enter into contracts that are appropriate for, and in the best interest of, the ward. • Perform, compromise, or refuse performance of a ward's existing contracts. • Alter the ward's property ownership interests, including selling, mortgaging, or leasing any real property (including the homestead), personal property, or any interest therein. • Borrow money to be repaid from the property of the ward or the ward's estate. • Renegotiate, extend, renew, or modify the terms of any obligation owing to the ward. • Prosecute or defend claims or proceedings in any jurisdiction for the protection of the ward's estate. • Exercise any option contained in any policy of insurance payable to the ward. • Make gifts of the ward's property to members of the ward's family in estate and income tax planning. • Pay reasonable funeral, interment, and grave marker expenses for the ward.	• Retain assets owned by the ward. • Receive assets from fiduciaries or other sources. • Insure the assets of the ward's estate against damage, loss, and liability. • Pay taxes and assessments on the ward's property. • Pay reasonable living expenses for the ward, taking into consideration the ward's current finances. • Pay incidental expenses in the administration of the ward's estate. • Prudently invest liquid assets belonging to the ward. • Sell or exercise stock subscription or conversion rights belonging to the ward. • Consent to the reorganization, consolidation, merger, dissolution, or liquidation of a corporation or other business enterprise of the ward. • Employ, pay, or reimburse persons, including attorneys, auditors, investment advisers, care managers, or agents, even if they are associated with the guardian, to advise or assist the guardian in the performance of his or her duties. • Consent on behalf of the ward to a sterilization or abortion procedure on the ward.[22]

The best estimate of the total number of American adults living under a guardianship or conservatorship comes from a 2011 report which utilized limited data from participating states with centralized or computer-based accounting mechanisms for counting such documents. In this widely cited report, the authors claim that at least 1.3 million adults were living under either a guardianship or conservatorship, and courts controlled over $50 billion in assets of those under these same guardianships or conservatorships. Other researchers have estimated that approximately 1.5 million people in the United States are subject to guardianship at any one time.[23]

Alternatives to Guardianship

Historically, it has been the general intent in Florida to apply the least restrictive forms of guardianship to assist those who may be partially or fully incapacitated. In October 2016, Chief Justice Jorge Labarga of the Florida Supreme Court established a Guardianship Workgroup to better protect vulnerable people who are subject to guardianship and guardian advocacy. The workgroup was charged with examining "judicial procedures and best practices pertaining to guardianship," focusing on topics including, but not limited to, the use of least restrictive alternatives that address specific functional limitations.[24]

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[20] S. 744.441, F.S.
[21] S. 744.444, F.S.
[22] S. 744.3215, F.S.
[23] Van Duizend, R., *The Implications of an Aging Population on the State Courts, "NCSC, Future Trends in State Courts, p. 76 (Williamsburg, VA: NCSC, 2008* (2011), available at: http://www.guardianship.org/reports/Uekert_Van_Duizend_Adult_Guardianships.pdf, (last visited December 2, 2023).
[24] Judicial Management Council, Guardianship Workgroup Final Report, pg. 7 (June 2018) (on file with Health and Human Services Committee staff).

The workgroup recommended requiring the petition form for the appointment of a guardian include the description of these alternatives to guardianship and an explanation as to why one of these alternatives were insufficient options to this guardianship request as it pertained to the specific individual. The workgroup further recommended expanding the types of alternatives that must be addressed during a guardianship petition. The report offered alternatives to guardianship, including SDM, durable powers of attorney, trusts, banking services, advance directives, medical proxies, and representative payees.[25]

Additionally, the workgroup recommended the petitioner acknowledge the existence of a designation of a preneed guardian, if one exists, and to identify his or her efforts in determining whether a designation exists in the petition for appointment of a guardian.[26]

Current Florida law recognizes several types of guardianships which cover all areas of decisionmaking for both adults and minors.[27] For individuals with capacity,[28] an *Advance Directive* document can be written ahead of an expected need and express an individual's desires or provide decisionmaking authority to a trusted individual.[29] In either event, the individual making the advance directive must have the mental capacity to understand what he or she is doing at the time the directive is signed.

Durable Power of Attorney

Similar to an Advance Directive, a Durable Power of Attorney (POA) is a special type of written advance directive. An individual or grantor must demonstrate the capacity to understand the transfer of his or her decisionmaking rights to another individual or agent at the time of the document's execution. The rights granted can be as broad or as limited as the law allows and can include health care decisions. A POA is called "durable" when it is intended to continue even if the grantor becomes incapacitated.

Health Care Surrogate and Living Will

A health care surrogate arrangement identifies through a written document specifically one or more persons who represent another person in health care decisions if he or she becomes unable to make those decisions in the future. A living will is a document that specifies the maker's wishes for the withholding or withdrawal of life prolonging procedures in the event of a terminal condition and should be updated as an individual's health status changes.

Less Restrictive Alternatives to Guardianship

Medical Proxy

A medical proxy can make health care decisions for an incapacitated or developmentally disabled patient if there is no advance directive or, if there is an advanced directive, no surrogate is available to make health care decisions.[30] The statute does not require any legal action or documentation for appointment as proxy. Instead, there is a statutory priority, starting with a guardian, then moving to spouse, adult child, parent, adult sibling, adult relative "who has exhibited special care and concern," close friend, and finally a social worker selected by a bioethics committee.

Client Advocate

[25] Id. at Appendix B.
[26] Id.
[27] *See* Part III, Ch. 744, F.S.; other guardian relationships include natural guardians, guardians of minors, emergency temporary guardians, standby guardians, pre-need guardian for a minor; and foreign guardian.
[28] "Capacity" is defined for these purposes as the mental ability to make and understand important legal and other decisions.
[29] "Advanced Directives for health care decisions" is described and defined in s. 744.3115, F.S. An "advance directive" document, in general, is defined to mean a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of this chapter.
[30] S. 765.401, F.S.

If a parent is unavailable, a family member or friend may be appointed as the client advocate for a person with developmental disabilities receiving services through the Agency for Persons with Disabilities.[31] This does not result in any legal authority, but allows the client advocate to participate in decisions related to services and provide an individual needed assistance as if he or she were the family member.

Co-signer of Bank Accounts

Requiring a second signature on an individual with disabilities' bank account, is a mechanism that may be used to help an individual who is still learning financial and banking skills. The designation of a co-signer lends a second set of eyes to help monitor how funds are flow in and out of an account and may also protect the individual with disabilities from unscrupulous actors.

Representative Payee

The Social Security Administration may appoint a representative payee to receive and manage benefits on behalf of an individual with disabilities. The designated "rep payee" must account to the federal Social Security Administration for any benefits received and managed on behalf of others annually.

Parent Representative

Ordinarily, when a minor student in the public school system turns 18, parental rights for the management of the student's education are also automatically transferred to the now-adult student, including all of the rights which the student is entitled to as a disabled individual. . If the adult student does not have a named guardian and also does not have the ability to provide informed consent on his or her educational program, the parent can be appointed to represent the educational interests of the adult student.

Guardian Advocate

Guardian advocacy is a process for family members, caregivers, or friends of individuals with a developmental disability to obtain the legal authority to act on their behalf if the person lacks the decisionmaking ability to do some, but not all, of the decisionmaking tasks necessary to care for his or her person or property.[32] This status change can be accomplished without having to declare the person with a developmental disability incapacitated.

A petition to appoint a guardian advocate for a person with a developmental disability may be executed by an adult person who is a resident of this state, called "petitioner."[33] The petition must be verified by the petitioner and must state:

- The name, age, and present address of the petitioner and the petitioner's relationship to the person with a developmental disability;
- The name, age, county of residence, and present address of the person with a developmental disability;
- That the petitioner believes that the person needs a guardian advocate and the factual information on which such belief is based;
- The exact areas in which the person lacks the ability to make informed decisions about his or her care and treatment services or to meet the essential requirements for his or her physical health or safety;
- The legal disabilities to which he or she is subject;
- If authority is sought over any property of the person, a description of that property and the reason why management or control of that property should be placed with a guardian advocate;
- The name of the proposed guardian advocate, the relationship of the proposed guardian advocate to the person with a developmental disability, the relationship of the proposed

[31] S. 393.0651, F.S.
[32] S. 393.12(2)(a), F.S.
[33] S. 393.12 (3), F.S.

guardian advocate with the providers of health care services, residential services, or other services to the person with developmental disabilities, and the reason why the proposed guardian advocate should be appointed. If a willing and qualified guardian advocate cannot be located, the petition must so state; and
- Whether the petitioner has knowledge, information, or belief that the person with a developmental disability has executed an advance directive or a durable power of attorney.[34]

Notice of the filing of the petition must be given to the person with a developmental disability, both verbally and in writing, in the language of the person and in English.[35] Notice must also be given to the person with a developmental disability's next of kin, any designated health care surrogate, an attorney-in-fact designated in a durable power of attorney, and such other persons as the court may direct.[36] A copy of the petition to appoint a guardian advocate must be served with the notice. The notice must state that a hearing will be held to inquire into the capacity of the person with a developmental disability to exercise the rights enumerated in the petition.[37] The notice must also state the date of the hearing on the petition.[38] The notice must state that the person with a developmental disability has the right to be represented by counsel of the person's own choice and the court must initially appoint counsel.[39]

Within three days after a petition has been filed, the court must appoint an attorney to represent a person with a developmental disability who is the subject of a petition to appoint a guardian advocate.[40] The person with a developmental disability may substitute his or her own attorney for the attorney appointed by the court.[41]

If the court finds the person with a developmental disability requires the appointment of a guardian advocate,[42] the order appointing the guardian advocate must contain findings of facts and conclusions of law:
- The nature and scope of the person's inability to make decisions;
- The exact areas in which the person lacks ability to make informed decisions about care and treatment services or to meet the essential requirements for the individual's physical health and safety;
- If any property of the person is to be placed under the management or control of the guardian advocate, a description of that property, any limitations as to the extent of such management or control, and the reason why management or control by the guardian advocate of that property is in the best interest of the person;
- If the person has executed an advanced directive or durable power of attorney, a determination as to whether the documents sufficiently address the needs of the person and a finding that the advanced directive or durable power of attorney does not provide an alternative to the appointment of a guardian advocate that sufficiently addresses the needs of the person with a developmental disability;
- If a durable power of attorney exists, the powers of the attorney-in-fact, if any, that are suspended and granted to the guardian advocate;
- If an advanced directive exists and the court determines that the appointment of a guardian advocate is necessary, the authority, if any, the guardian advocate shall exercise over the health care surrogate;
- The specific legal disabilities to which the person with a developmental disability is subject;
- The name of the person selected as guardian advocate; and

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[34] S. 393.12(3)(a)-(f), F.S.
[35] S. 393.12(4)(a), F.S.
[36] Id.
[37] S. 393.12(4)(b), F.S.
[38] Id.
[39] S. 393.12(4)(c), F.S.
[40] S. 393.12(5), F.S.
[41] Id.
[42] A "Guardian advocate" means a person appointed by a written order of the court to represent a person with developmental disabilities under s. 393.12, F.S. The term does not apply to a guardian advocate appointed for a person determined incompetent to consent to treatment under s. 394.4598, F.S.

- The powers, duties, and responsibilities of the guardian advocate, including bonding of the guardian advocate as provided by law.[43]

Generally, the difference between guardian advocacy and guardianship in Florida is the process to gain the authority. For guardian advocacy, the process does not include an adjudication of incapacity, while guardianship requires a finding of incapacity, at least in part. However, the duties and responsibilities are identical for guardian advocates and guardians.

Supported Decisionmaking

The integration mandate of Title II of the American with Disabilities Act[44] and subsequent federal court cases, such as *Olmstead v. L.C.,*[45] on how States' have delivered services to those individuals with disabilities are two sources used to support other decisionmaking policy models that are less restrictive than those currently available.[46] Supported decisionmaking (SDM) is another example of a person-driven decisionmaking model that empowers persons with disabilities to make life choices with help from a supporter or advisor.

The SDM process and procedure also requires the assistance of a supporter, advisor, or agent to carry out each choice. Through an SDM agreement, the individual is empowered to ask for support from their supporter where, in what format, and when he or she needs help. The supporter, under this role, has an equal obligation to ensure that the client has the necessary support to be successful, at the level the client has requested, to make recommendations and suggestions as needed, and generally advise but not act on behalf of the client.

The SDM model assumes all persons:

- Seek advice and guidance with making decisions;
- As long as they have the ability to communicate, have the ability and right to make choices; and
- That the choices of the individual should be honored.[47]

While SDM relationships can be of more or less formality and intensity ranging from informal support by people who speak with, rather than for, the individual with a disability[48] to more formalized micro boards and circles of support,[49] they share three common elements:

- Based on a set of guiding principles that emphasize the person with disability's autonomy, presumption of capacity, and right to make decisions on an equal basis with others;
- Recognize that a person's intent can form the basis of a decisionmaking process that does not entail removal of the individual's decisionmaking rights; and
- Acknowledge that individuals with disabilities will often need assistance in decisionmaking through such means as interpreter assistance, facilitated communication, assistive technologies and plain language.

Through these relationships, an individual with limitations in decisionmaking abilities can receive support to understand relevant information, issues, and available choices, to focus attention in making decisions, to help weigh options, to ensure that decisions are based on her own preferences, and, if

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[43] S. 393.12(8), F.S.

[44] 42 U.S.C. s.s. 12101 – 12213 (2006). Congress enacted the American with Disabilities Act in 1990 to address the continuing exclusion and isolation of individual with disabilities, and thus created a comprehensive mandate to end disability-based discrimination in employment, public accommodations, public services, benefits, and programs. *Quoting FN 2 from:* Salzman, L., *Rethinking Guardianship (Again): Substituted Decision Making as a Violation of the Integration Mandate of Title II of the Americans with Disabilities Act, Working Paper 282 (November 2009), available at* Microsoft Word - Salzman FINAL TPE (supporteddecisionmaking.org) *(last visited December 2, 2023).*

[45] Olmstead v. L.C. *ex rel. Zimring*, 527 U.S. 581, 597–99 (1999).

[46] Martinis, J., *Making it happen: Strategies for supported decisionmaking*, Impact, 32(1), 45 (2019)..

[47] Blanck, P., and Martinis, J., *The Right to Make Choices: The National Resource Center for Supported Decisionmaking*, 3 Inclusion 24 (2015), available at www.bbi.syr.edu/publications/2015/SDM_Overview.pdf.

[48] Dinerstein, R, *Implementing legal capacity under article 12 of the UN Convention on the Rights of Persons with Disabilities: The difficult road from guardianship to supported decision making*, Human Rights Brief, 30, pgs. 8-12, 10 (2012).

[49] Id. at pgs. 10-11.

necessary, to interpret and/or communicate her decisions to other parties.[50]

Growth in Interest in SDM

Initial promotion of SDM occurred in the early 1990s in British Columbia as a part of that country's disability rights' movement. This initial advocacy resulted in the first legislative recognition of the SDM agreement and option in the 1996 Representation Agreement Act in British Columbia. This act established a set of decisions regarding how individuals with cognitive disabilities may seek support, criteria for appointment of a supporter, and a mechanism by which decisions reached through SDM agreements would be legally recognized.[51] SDM achieved a significant breakthrough with the 2006 United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). In a landmark statement, the UNCRPD declared that member states must assist individuals with disabilities so that they can exercise their right to legal capacity. Furthermore, UNCRPD identified SDM as a crucial legal mechanism toward achieving this basic human right. Spurred by this development, several countries—including Canada, Ireland, Israel, the United Kingdom, Germany, Australia, and the United States—have begun to promote integration of SDM into their respective legal systems.[52]

In 2009, the Texas legislature created a pilot program to "promote the provision of SDM services to persons with intellectual and developmental disabilities and persons with other cognitive disabilities who live in the community".[53] After that program ended, Texas passed new laws recognizing the availability and effectiveness of SDM and required courts to find that a person cannot make decisions using SDM before appointing a guardian.[54]

In 2016, a similar law was passed and signed in Delaware. The Delaware law allows people with disabilities to designate a person as a supporter. The supporter is given legal status and authorization to assist the person in making life choices, including health, safety, and educational decisions, but is not allowed to make decisions on the individual's behalf.

Two private organizations have also endorsed the SDM option. .In 2012, the American Bar Association (ABA) convened stakeholders "to explore concrete ways to move from a model of substituted decisionmaking, like guardianship, to one of supported decision making, consistent with the human right of legal capacity".[55] In 2015, the ABA published an article calling for the use of SDM as an alternative to guardianship, stating, "In contrast to overbroad or undue guardianship, SDM can increase self-determination by ensuring that the person retains life control to the maximum extent possible".[56] In 2015, the ABA published an article calling for the use of SDM as an alternative to guardianship, stating, "In contrast to overbroad or undue guardianship, SDM can increase self-determination by ensuring that the person retains life control to the maximum extent possible."[57]

In 2015, the National Guardianship Association (NGA), which represents over 1,000 guardians, conservators and fiduciaries from across the United States, also published a position paper on SDM. It states that "modern day respect for individual rights dictates that we must allow each individual to make or participate to the extent possible in personal decisions." The NGA concluded "supported decisionmaking should be considered for the person before guardianship, and the SDM process should

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[50] Infra, FN 58, at pg. 306.
[51] Browning, M, et al., *Supported Decision Making: Understanding How its Conceptual Link to Legal Capacity is Influencing the Development of Practice*, Research and Practice in Intellectual and Developmental Disabilities, 1(1), pgs. 34-45 (2014).
[52] Supra, FN 33.
[53] Tex. Government Code Ann. § 531.02446 (2009), expired on Sept. 1, 2013.
[54] Tex. Est. Code s. 1101.101(a)(D) and (E).
[55] American Bar Association, *Beyond Guardianship: Supported Decisionmaking by Individuals with Intellectual Disabilities: A Short Summary from the 2012 National Roundtable*, available at http://www.americanbar.org/content/dam/aba/administrative/mental_physical_disability/SDMRRoundtable_Summary.authcheckdam.pdf.
[56] Supra, FN 1.
[57] Supra, FN 1.

be incorporated as a part of the guardianship if guardianship is necessary".[58] The NGA's position is consistent with most state laws, which require that less restrictive alternatives be considered or attempted prior to placing a person under guardianship.

Supported Decisionmaking Agreement

An SDM agreement is a written document evidencing an agreement between a person with disabilities and at least one supporter that describes, in detail, the type of help the person needs. The agreement outlines the terms and conditions of both parties and asks that third parties, including courts, recognize and respect the agreement. In an SDM agreement, those who can help in making decisions are called supporters; supporters agree to help explain information; answer questions; weigh options; and let others know about the decisions that are made. The supporter does not make the decisions.[59]

In general, all SDM relationships share three common features after varying for formality, types of support provided, or who provides the type of support. These commonalties are:

- The recognition that the person has the right to make his or her own decisions.
- The acknowledgement that the person can enter into a decision-making process or relationship without surrendering his or her right to make decisions; and
- The understanding that the person may need assistance in making or communicating decisions.[60]

Educational Transitions

Section 1003.5716, F.S., governs the transition process for individuals with disabilities from public school. During the student's seventh grade year, or when the student attains the age of 12, whichever occurs first, an individual education plan (IEP) team must begin the process of, and develop an IEP for, the identification of the need for transition services. The plan must be in place toto allow for implementation on the first day of the student's first year in high school.

As part of this process, when the student reaches age 17, the IEP team must provide information and instruction to the student and his or her parent on self-determination and the legal rights and responsibilities regarding the educational decisions that transfer to the student upon turning 18 years old. The information must address the ways in which the student may provide informed consent to allow the student's parent, legal guardian, or selected trusted adult to continue to participate in educational decisions, including:

- Provide Informed consent to grant permission to access confidential records protected under the federal Family Educational Rights and Privacy Act (FERPA) as provided in s. 1002.22, F.S.
- Pursue a Powers of attorney as provided in chapter 709, F.S.
- Seek a Guardian advocacy as provided in s. 393.12, F.S.
- Attain a Guardianship as provided in chapter 744, F.S.

Effect of the Bill

HB 73 creates a new legal instrument for individuals, including those with disabilities, who may need some assistance with decisionmaking and other activities of daily life, but do not require more restrictive instruments such as guardianship or guardian advocacy.

A supported decisionmaking agreement,(SDM agreement), a new power of attorney form, provides information, recommendations, and assistance to the eligible individual through a "supporter". The

[58] National Guardianship Association, *"Position Statement on Guardianship, Surrogate Decision Making, and Supported Decision Making*," (2015), available at http://www.guardianship.org/documents/NGA_Policy_Statement_052016.pdf.
[59] Martinis, J., *Making it happen: Strategies for supported decisionmaking*, Impact, 32(1), 45 (2019).
[60] Martinis, J., *Supported Decision-Making: Protecting Rights, Ensuring Choices, available at* Supported Decision-Making: Protecting Rights, Ensuring Choices (americanbar.org), Impact, (Commission on Law and Aging, Vol. 36, No. 5, May-June 2015)(December 2, 2023).

"supporter" would assist the individual in making decisions and exercising his or her rights, but that supporter does not have any authority to make any binding decisions for or on behalf of the individual.

The SDM agreement limits the supporter's authority and only permits the supporter to:

- Obtain information on behalf of the principal, and
- Assist the principal in communicating with third parties, including conveying the principal's communications, decisions, and directions to third parties on behalf of the principal.

To determine incapacity under ch. 744, F.S., the bill would require an inquiry whether the alleged incapacitated person uses assistance to exercise his or her own rights, including an SDM agreement, and as to whether this level of assistance is sufficient or too restrictive. HB 73 also permits the examining committee, which determines incapacity, to allow a supporter to assist with communication with the individual with a disability when requested by the court-appointed counsel for the alleged incapacitated person.

The bill further requires the circuit courts to consider the specific needs and abilities of a person with developmental disabilities when assigning a guardian or a guardian advocate, or when determining competency of the individual. The final order addressing the level of guardianship or decisionmaking selected must address why a particular, especially a less restrictive, level of care was not selected instead of a more-restrictive choice when less restrictive options were available..

The bill adds an SDM agreement to the list of alternative methods for parental involvement in the educational decisionmaking under s. 1003.5716, F.S., adds information what an IEP team must share with a parent during the transition development process plan for a student with a disability.

B. SECTION DIRECTORY:

Section 1: Amends s. 393.12, F.S., relating to capacity; appointment of guardian advocate.
Section 2: Amends s. 709.2201, F.S.; relating to authority of agent.
Section 3: Creates s. 702.2209, F.S.; relating to supported decisionmaking agreements.
Section 4: Amends s. 744.3201, F.S.; relating to petition to determine incapacity.
Section 5: Amends s. 744.331, F.S.; relating to procedures to determine incapacity.
Section 6: Amends s. 744.464, F.S.; relating to suggestion of capacity.
Section 7: Amends s. 1003.5716, F.S.; relating to transition to postsecondary education and career opportunities
Section 8: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not require rulemaking to implement its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to supported decisionmaking authority; amending s. 393.12, F.S.; requiring a circuit court to consider certain needs and abilities of a person with a developmental disability when determining whether to appoint a guardian advocate; providing requirements for a petition to appoint a guardian advocate for a person with a developmental disability and for a court order if the court finds that such person requires such appointment; amending s. 709.2201, F.S.; authorizing an agent acting for a principal to grant a supported decisionmaking agreement; creating s. 709.2209, F.S.; defining the term "supported decisionmaking agreement"; prohibiting such agreement from acting as a durable power of attorney; authorizing specified authority to a supported decisionmaking agreement; providing that certain communications shall be recognized as a communication of the principal under certain circumstances; amending s. 744.3201, F.S.; requiring a petition to determine incapacity of a person to include specified information relating to the alleged incapacitated person's use of assistance; amending s. 744.331, F.S.; providing requirements for an examining committee member when determining the alleged incapacitated

person's ability to exercise his or her rights; amending s. 744.464, F.S.; authorizing a suggestion of capacity to include certain capabilities of the ward; amending s. 1003.5716, F.S.; revising the requirements for a specified process relating to individual education plans for certain students to include supported decisionmaking agreements; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2), paragraph (a) of subsection (3), and subsection (8) of section 393.12, Florida Statutes, are amended to read:

393.12 Capacity; appointment of guardian advocate.—

(2) APPOINTMENT OF A GUARDIAN ADVOCATE.—

(a) A circuit court may appoint a guardian advocate, without an adjudication of incapacity, for a person with developmental disabilities, if the person lacks the decisionmaking ability to do some, but not all, of the decisionmaking tasks necessary to care for his or her person or property or if the person has voluntarily petitioned for the appointment of a guardian advocate. In determining whether to appoint a guardian advocate, the court shall consider the person's unique needs and abilities, including, but not limited

to, the person's ability to independently exercise his or her rights with appropriate assistance, and may only delegate decisionmaking tasks that the person lacks the decisionmaking ability to exercise. Except as otherwise specified, the proceeding shall be governed by the Florida Rules of Probate Procedure.

(3) PETITION.—

(a) A petition to appoint a guardian advocate for a person with a developmental disability may be executed by an adult person who is a resident of this state. The petition must be verified and must:

1. State the name, age, and present address of the petitioner and his or her relationship to the person with a developmental disability;

2. State the name, age, county of residence, and present address of the person with a developmental disability;

3. Allege that the petitioner believes that the person needs a guardian advocate and specify the factual information on which such belief is based;

4. Specify the exact areas in which the person lacks the decisionmaking ability to make informed decisions about his or her care and treatment services or to meet the essential requirements for his or her physical health or safety;

5. Specify the legal disabilities to which the person is subject; ~~and~~

6. Identify any other type of guardian advocacy or alternatives to guardian advocacy that the person has designated, is in currently, or has been in previously and the reasons why alternatives to guardian advocacy are insufficient to meet the needs of the person;

7. State whether the person uses assistance to exercise his or her rights, including, but not limited to, supported decisionmaking, and if so, why the assistance is inappropriate or insufficient to allow the person to independently exercise the person's rights; and

8.~~6.~~ State the name of the proposed guardian advocate, the relationship of that person to the person with a developmental disability; the relationship that the proposed guardian advocate had or has with a provider of health care services, residential services, or other services to the person with a developmental disability; and the reason why this person should be appointed. The petition must also state if a willing and qualified guardian advocate cannot be located.

(8) COURT ORDER.—If the court finds the person with a developmental disability requires the appointment of a guardian advocate, the court shall enter a written order appointing the guardian advocate and containing the findings of facts and conclusions of law on which the court made its decision, including:

(a) The nature and scope of the person's lack of

decisionmaking ability;

(b) The exact areas in which the individual lacks decisionmaking ability to make informed decisions about care and treatment services or to meet the essential requirements for his or her physical health and safety;

(c) The specific legal disabilities to which the person with a developmental disability is subject;

(d) The identity of existing alternatives and a finding as to the validity or sufficiency of such alternative to alleviate the need for the appointment of a guardian advocate;

(e)~~(d)~~ The name of the person selected as guardian advocate and the reasons for the court's selection; and

(f)~~(e)~~ The powers, duties, and responsibilities of the guardian advocate, including bonding of the guardian advocate, as provided in s. 744.351.

Section 2. Paragraph (d) is added to subsection (2) of section 709.2201, Florida Statutes, to read:

709.2201 Authority of agent.—

(2) As a confirmation of the law in effect in this state when this part became effective, such authorization may include, without limitation, authority to:

(d) If such authority is specifically limited, grant a supported decisionmaking agreement as defined in s. 709.2209(1).

Section 3. Section 709.2209, Florida Statutes, is created to read:

709.2209 Supported decisionmaking agreements.—

(1) For purposes of this section, "supported decisionmaking agreement" means an agreement in which the power of attorney grants an agent the authority to receive information and to communicate on behalf of the principal without granting the agent the authority to bind or act on behalf of the principal on any subject matter.

(2) A supported decisionmaking agreement is not a durable power of attorney under s. 709.2104. Any language of durability in a supported decisionmaking agreement is of no effect.

(3) A supported decisionmaking agreement may only include the authority to:

(a) Obtain information on behalf of the principal, including, but not limited to, protected health information under the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. s. 1320d, as amended; educational records under the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. s. 1232g; or information protected under 42 U.S.C. s. 290dd-2 or 42 C.F.R. part 2.

(b) Assist the principal in communicating with third parties, including conveying the principal's communications, decisions, and directions to third parties on behalf of the principal.

(4) A communication made by the principal with the assistance of or through an agent under a supported

decisionmaking agreement that is within the authority granted to the agent may be recognized for as a communication of the principal.

Section 4. Subsection (2) of section 744.3201, Florida Statutes, is amended to read:

744.3201 Petition to determine incapacity.—

(2) The petition must be verified and must:

(a) State the name, age, and present address of the petitioner and his or her relationship to the alleged incapacitated person;

(b) State the name, age, county of residence, and present address of the alleged incapacitated person;

(c) Specify the primary language spoken by the alleged incapacitated person, if known;

(d) State whether the alleged incapacitated person uses assistance to exercise his or her rights, including, but not limited to, supported decisionmaking, and if so, why the assistance is inappropriate or insufficient to allow the person to independently exercise the person's rights;

(e) ~~(d)~~ Allege that the petitioner believes the alleged incapacitated person to be incapacitated and specify the factual information on which such belief is based and the names and addresses of all persons known to the petitioner who have knowledge of such facts through personal observations;

(f) ~~(e)~~ State the name and address of the alleged

incapacitated person's attending or family physician, if known;

(g) ~~(f)~~ State which rights enumerated in s. 744.3215 the alleged incapacitated person is incapable of exercising, to the best of petitioner's knowledge. If the petitioner has insufficient experience to make such judgments, the petition must so state; and

(h) ~~(g)~~ State the names, relationships, and addresses of the next of kin of the alleged incapacitated person, so far as are known, specifying the dates of birth of any who are minors.

Section 5. Paragraph (e) of subsection (3) of section 744.331, Florida Statutes, is amended to read:

744.331 Procedures to determine incapacity.—

(3) EXAMINING COMMITTEE.—

(e) Each member of the examining committee shall examine the person. Each examining committee member must determine the alleged incapacitated person's ability to exercise those rights specified in s. 744.3215. An examining committee member may allow a person to assist in communicating with the alleged incapacitated person when requested by the court-appointed counsel for the alleged incapacitated person and shall identify the person who provided assistance and describe the nature and method of assistance provided in his or her report. In addition to the examination, each examining committee member must have access to, and may consider, previous examinations of the person, including, but not limited to, habilitation plans,

school records, and psychological and psychosocial reports voluntarily offered for use by the alleged incapacitated person. Each member of the examining committee must file his or her report with the clerk of the court within 15 days after appointment.

Section 6. Paragraph (a) of subsection (2) of section 744.464, Florida Statutes, is amended to read:

744.464 Restoration to capacity.—

(2) SUGGESTION OF CAPACITY.—

(a) Any interested person, including the ward, may file a suggestion of capacity. The suggestion of capacity must state that the ward is currently capable of exercising some or all of the rights which were removed, including the capability to independently exercise his or her rights with appropriate assistance.

Section 7. Paragraph (d) of subsection (1) of section 1003.5716, Florida Statutes, is amended to read:

1003.5716 Transition to postsecondary education and career opportunities.—All students with disabilities who are 3 years of age to 21 years of age have the right to a free, appropriate public education. As used in this section, the term "IEP" means individual education plan.

(1) To ensure quality planning for a successful transition of a student with a disability to postsecondary education and career opportunities, during the student's seventh grade year or

when the student attains the age of 12, whichever occurs first, an IEP team shall begin the process of, and develop an IEP for, identifying the need for transition services before the student with a disability enters high school or attains the age of 14 years, whichever occurs first, in order for his or her postsecondary goals and career goals to be identified. The plan must be operational and in place to begin implementation on the first day of the student's first year in high school. This process must include, but is not limited to:

(d) At least 1 year before the student reaches the age of majority, provision of information and instruction to the student and his or her parent on self-determination and the legal rights and responsibilities regarding the educational decisions that transfer to the student upon attaining the age of 18. The information must include the ways in which the student may provide informed consent to allow his or her parent to continue to participate in educational decisions, including:

1. Informed consent to grant permission to access confidential records protected under the Family Educational Rights and Privacy Act (FERPA) as provided in s. 1002.22.

2. Powers of attorney as provided in chapter 709.

3. Guardian advocacy as provided in s. 393.12.

4. Guardianship as provided in chapter 744.

5. Supported decisionmaking agreements as provided in s. 709.2209.

The State Board of Education shall adopt rules to administer this paragraph.

Section 8. This act shall take effect July 1, 2024.

CS/HB 89

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 89 Naloxone Awareness Day
SPONSOR(S): Healthcare Regulation Subcommittee, Plakon
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 66

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N, As CS	Osborne	McElroy
2) Health & Human Services Committee		Osborne	Calamas

SUMMARY ANALYSIS

Opioids are psychoactive substances derived from the opium poppy, or their synthetic analogues. Opioids include prescription medications legitimately prescribed to treat pain, as well as illegal drugs with no sanctioned medical use. An overabundance of opioids in the body can lead to a fatal overdose. Opioids are the most lethal group of drugs; worldwide they account for two thirds of all deaths relating to drug use, most of which are the result of overdoses. In 2023 the number of overdose deaths surpassed 112,000 in a 12-month period for the first time.

An opioid antagonist is a drug that rapidly reverses the effects of an opioid overdose. Opioid antagonists can quickly restore normal breathing to a person if their breathing has slowed, or even stopped due to an opioid overdose. Opioid antagonists have no potential for abuse and will not cause harm if mistakenly administered to a person who is not overdosing on an opioid.

On March 29, 2023, the US Food & Drug Administration approved the first opioid antagonist nasal spray available for over-the-counter, nonprescription, use. This allows an accessible, easily administered opioid antagonist to be sold directly to consumers without the need for a prescription.

Victoria's Voice Foundation was established in 2019 by Jackie and David Siegal after losing their 18-year-old daughter, Victoria, to an accidental drug overdose. Victoria's Voice is dedicated to providing drug prevention education and raising awareness of the availability and safe use of opioid antagonists in order to support those affected by substance use.

CS/HB 89 creates "Victoria's Law," and designates June 6th of each year as "Revive Awareness Day." The bill allows the Governor to issue an annual proclamation designating June 6th as "Revive Awareness Day."

The bill encourages the Department of Health (DOH) to hold events with the purpose of raising awareness of the dangers of opioid overdose and the availability and safe use of opioid antagonists.

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

The bill is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Opioids

Opioids are psychoactive substances derived from the opium poppy, or their synthetic analogues.[1] Opioids are highly effective pain relievers, and as such are commonly used to treat acute and chronic pain. An individual experiences pain because of a series of electrical and chemical exchanges across the individual's peripheral nerves, spinal cord, and brain.[2] Opioid receptors occur naturally and are distributed widely throughout the central nervous system and in peripheral sensory and autonomic nerves and modulate the body's perception of pain.[3] Opioids bind to specific opioid receptors, disrupt the transmission of pain signals through the central nervous system and reduce the perception of pain.[4]

Opioids include prescription medications legitimately prescribed to treat pain, as well as illegal drugs with no sanctioned medical use.[5] Opioids can create a euphoric feeling because they affect the regions of the brain involved with pleasure and reward, which can lead people to misuse the substance.[6] Opioids are commonly misused; in 2020 an estimated 61 million people worldwide used opioids for non-medical reasons.[7] Continued use of opioids can lead to the development of tolerance and psychological and physical dependence.[8] This dependence is characterized by a strong desire to take opioids, impaired control over opioid use, persistent opioid use despite harmful consequences, a higher priority given to opioid use than to other activities and obligations, and a physical withdrawal reaction when opioids are discontinued.[9]

Opioid Overdose

Opioids are the most lethal group of drugs; worldwide they account for two thirds of all deaths relating to drug use, most of which are the result of overdoses.[10] More than 109,000 Americans died from a drug overdose in the 12-month period ending in February, 2023.[11]

Opioid overdoses result from an overabundance of opioids in the body which leads to the suppression of the respiratory system. The opioid receptors that are found in major pain pathways, thus enabling

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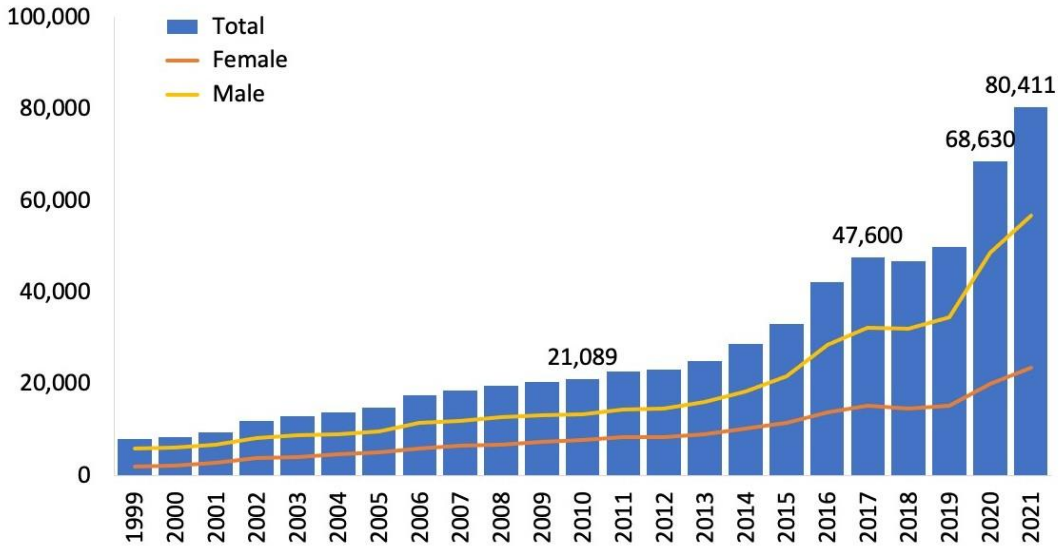
[1] World Health Organization, *Opioid Overdose.* Available at https://www.who.int/news-room/fact-sheets/detail/opioid-overdose (last visited January 12, 2024).
[2] Medical News Today, *What is pain, and how do you treat it?* (2020). Available at https://www.medicalnewstoday.com/articles/145750#:~:text=People%20feel%20pain%20when%20specific,immediate%20contraction%20of%20the%20muscles (last visited January 12, 2024).
[3] Henriksen, G. & Willoch, F., *Imaging of Opioid Receptors in the Central Nervous System,* Brain (2008) 131 (5): 1171-1196. doi: 10.1093/brain/awm255
[4] *Id*.
[5] Opioids legally prescribed to treat pain include morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine. Heroine is an example of an illicit opioid with no medical use. *See also*, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA Opioid Overdose Toolkit: Facts for Community Members* (2018). Available at https://store.samhsa.gov/sites/default/files/d7/priv/sma18-4742.pdf (last visited January 12, 2024).
[6] National Institute on Drug Abuse, *How Do Opioids Affect the Brain and Body?* (2020). Available at http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/how-do-opioids-affect-brain-body (last visited January 12, 2024).
[7] United Nations Office on Drugs and Crime, World Drug Report 2022, *Global Overview: Drug Demand and Drug Supply* (2022). Available at https://www.unodc.org/res/wdr2022/MS/WDR22_Booklet_1.pdf (last visited January 12, 2024).
[8] *Supra,* note 6.
[9] *Supra,* note 1.
[10] *Supra*, note 7.
[11] Ahmad, F.B., Cisewski, J.A., Rossen, L.M., & Sutton, P., *Provisional Drug Overdose Death Counts*. Centers for Disease Control and Prevention: National Center for Health Statistics. (2023). Available at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (last visited January 12, 2024).

opioids to alleviate the sensation of pain, are also found in the respiratory control centers of the brain.[12] Opioids disrupt the transmission of signals for respiration in the identical manner as they disrupt the transmission of pain signals; when there is an excess of opioids present in the body, this can lead to a reduction, and eventual cessation, of a person's breathing. Oxygen starvation will eventually stop vital organs like the heart and brain and can lead to unconsciousness, coma, and possible death.[13] Within 3-5 minutes without oxygen, brain damage starts to occur, soon followed by death.[14]

Once a person stops breathing damage to vital organs is rapid, however, a person's breathing will typically slow gradually over time and breathing may not stop until minutes to hours after the drug or drugs were used.[15] Medical intervention during the period of time between opioid overdose and the cessation of breathing is the key to preventing an overdose death. An opioid overdose can be identified by a combination of three signs and symptoms referred to as the "opioid overdose triad":[16] pinpoint pupils, unconsciousness; and respiratory depression.

Opioid overdose and death have increased significantly over the last three decades. The graph below demonstrates the total number of U.S. overdose deaths involving any opioid[17] from 1999 to 2021.[18]

Opioid Deaths in the Unites States, 1999-2021



Prior to the COVID-19 pandemic, the increase in opioid overdose deaths formed three distinct waves:

- The first wave began with increased prescribing of opioids in the 1990s, with overdose deaths involving prescription opioids increasing since at least 1999.
- The second wave began in 2010, with rapid increase in overdose deaths involving heroin.
- The third wave began in 2013, with significant increases in overdose deaths involving synthetic opioids, particularly those involving illicitly manufactured fentanyl. The market for illicitly

[12] Pattinson, K.T.S., *Opioids and the Control of Respiration*, BJA, Vol. 100, Issue 6, Pages 747-758. Available at https://doi.org/10.1093/bja/aen094. (last visited January 12, 2024).
[13] Harm Reduction Coalition, *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, (Aug. 31, 2020). Available at http://harmreduction.org/our-work/overdose-prevention/ (last visited January 12, 2024).
[14] *Id*.
[15] *Id*.
[16] *Supra,* note 1.
[17] Any opioid includes prescription opioids (natural and semi-synthetic opioids and methadone), heroin and synthetic opioids other than methadone (primarily fentanyl).
[18] National institute on Drug Abuse, *Overdose Death Rates*. Available at https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates (last January 12, 2024).

manufactured fentanyl continues to change, and the drug can be found in combination with heroin, counterfeit pills, and cocaine.[19]

In 2021, 6,442 opioid overdose deaths were reported in Florida, a 22% increase from 2019.[20] Additionally, 50,803 all-drug, non-fatal overdoses resulted in an emergency department visit in 2021.[21] Fentanyl, an extremely potent opioid drug, is the leading cause of overdose deaths in Florida, and the incidence of fentanyl overdose deaths increased by 38 percent from 2,348 in 2019 to 3,244 in 2020.[22]

Opioid Antagonists

An opioid antagonist is a drug that rapidly reverses the effects of an opioid overdose. Opioid antagonists counteract the central nervous system depression which is the primary cause of opioid overdose deaths by attaching to opioid receptors and blocking the effects of other opioids. Opioid antagonists can quickly restore normal breathing to a person if their breathing has slowed, or even stopped due to an opioid overdose.[23] This effect lasts only for a short period of time, with the narcotic effect of the opioids returning if still present in large quantities in the body. In this scenario, additional doses of an opioid antagonist would be required, which is why it is generally recommended that anyone who has experienced an overdose seek medical attention.[24]

Opioid antagonists can be safely given to people of all ages and will not cause harm if mistakenly administered to a person who is not overdosing on an opioid.[25]

On March 29, 2023, the US Food & Drug Administration approved the first opioid antagonist nasal spray available for over-the-counter, nonprescription, use.[26] This allows an accessible, easily administered opioid antagonist to be sold directly to consumers without the need for a prescription.

Victoria's Voice Foundation

Victoria's Voice Foundation was established in 2019 by Jackie and David Siegal after losing their 18-year-old daughter, Victoria, to an accidental drug overdose. Victoria's Voice is dedicated to providing drug prevention education and raising awareness of the availability and safe use of opioid antagonists in order to support those affected by substance use.[27]

Effect of the Bill

[19] Centers for Disease Control and Prevention, *Understanding the Opioid Overdose Epidemic.* Available at https://www.cdc.gov/opioids/basics/epidemic.html (last visited January 12, 2024).
[20] Florida Department of Health, *FL Health Charts: Substance Use Dashboard.* Available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=SubstanceUse.Overdose (last visited January 12, 2024).
[21] *Id*.
[22] Project Opioid, *A Pandemic Fueling an Epidemic in Florida in 2020.* Available at https://projectopioid.org/wp-content/uploads/2020/12/PO-2020-Data-Study-Final_New-Section.pdf (last visited January 12, 2024).
[23] National Institute on Drug Abuse, *What is Naloxone?* (2022). Available at https://nida.nih.gov/publications/drugfacts/naloxone (last visited January 12, 2024). *See also*, Harm Reduction Coalition, *Understanding Naloxone,* (2020). Available at http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/ (last visited May January 12, 2024).
[24] *Id*.
[25] Centers for Disease Control and Prevention, *5 Things to Know About Naloxone* (2022). Available at https://www.cdc.gov/drugoverdose/featured-topics/naloxone.html#:~:text=Naloxone%20is%20safe.,Small%2C%20constricted%20%E2%80%9Cpinpoint%20pupils%E2%80%9D (last visited January 12, 2024).
[26] US Food & Drug Administration, *FDA Approves First Over-the-Counter Naloxone Nasal Spray* (2023). Available at https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray (last visited January 12, 2024).
[27] Victoria's Voice Foundation, *Victoria's Voice Foundation Launches First Ever National Naloxone Awareness Day on June 6 with Support from a Bipartisan Congressional Resolution* (2023). Available at https://www.prnewswire.com/news-releases/victorias-voice-foundation-launches-first-ever-national-naloxone-awareness-day-on-june-6-with-support-from-a-bipartisan-congressional-resolution-301843527.html (last visited January 12, 2024).

CS/HB 89 creates "Victoria's Law," and designates June 6th of each year as "Revive Awareness Day." The bill allows the Governor to issue an annual proclamation designating June 6th as "Revive Awareness Day."

The bill encourages the Department of Health to hold events with the purpose of raising awareness of the dangers of opioid overdose and the availability and safe use of opioid antagonists.

The bill is effective upon becoming law.

B. SECTION DIRECTORY:

Section 1: Provides a name for the act: "Victoria's Law."
Section 2: Creates s. 683.3342, F.S., relating to Revive Awareness Day.
Section 3: Provides the bill is effective upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill may have an insignificant, negative fiscal impact on the Department of Health which is able to be absorbed by current agency resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not require rule-making for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Revive Awareness Day; providing a short title; creating s. 683.3342, F.S.; designating June 6 of each year as "Revive Awareness Day"; authorizing the Governor to issue an annual proclamation; encouraging the Department of Health to hold events to raise awareness of the dangers of opioid overdose and the availability and safe use of opioid antagonists as an effective way to rapidly reverse the effects of opioid overdose; providing an effective date.

WHEREAS, the opioid epidemic continues to ravage American families across the United States, and

WHEREAS, the Centers for Disease Control and Prevention reported more than 100,000 overdose deaths in the United States during the 12-month period that ended in February 2023, and

WHEREAS, most of these deaths were caused by illicit synthetic drugs like clandestinely manufactured fentanyl, often in combination with other drugs, and

WHEREAS, in 2021, nearly 71,000 drug overdose deaths involving synthetic opioids occurred in the United States, which was more deaths that year than from any other type of opioid, and

WHEREAS, synthetic-opioid-involved death rates increased by

more than 22 percent from 2020 to 2021 and synthetic opioids accounted for nearly 88 percent of all opioid-involved deaths in 2021, and

WHEREAS, by comparison, from 1999 to 2021, nearly 280,000 people died in the United States from overdoses involving prescription opioids, and

WHEREAS, the number of drug overdose deaths involving prescription opioids in 2021 was nearly five times the number in 1999, and

WHEREAS, in 2021, an average of 45 people died each day from a prescription opioid overdose, for a total of nearly 17,000 deaths, and

WHEREAS, in 2021, nearly 21 percent of all opioid overdose deaths involved prescription opioids, and

WHEREAS, 60 percent of all opioid overdose deaths occur in the home, and

WHEREAS, in 67 percent of opioid overdose deaths, another person was present at the time and witnessed the death, and

WHEREAS, opioid antagonists are a safe, powerful medication that can reverse opioid-related overdoses and prevent overdose deaths, and

WHEREAS, most Americans remain unaware of the safety, availability, and efficacy of opioid antagonist medications as a life-saving treatment for opioid overdose, and

WHEREAS, the national advocacy efforts of David Siegel and

Jackie Siegel are recognized as they advocate for widespread availability of opioid antagonists through the Victoria's Voice Foundation, named in honor of their daughter, who died from an accidental overdose, NOW, THEREFORE,

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

Section 1. This act may be cited as "Victoria's Law."

Section 2. Section 683.3342, Florida Statutes, is created to read:

683.3342 Revive Awareness Day.-

(1) June 6 of each year is designated as "Revive Awareness Day."

(2) The Governor may issue an annual proclamation designating June 6 as "Revive Awareness Day."

(3) The Department of Health is encouraged to hold events to raise awareness of the dangers of opioid overdose and the availability and safe use of opioid antagonists as an effective way to rapidly reverse the effects of opioid overdose.

Section 3. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 99 Social Work Licensure Interstate Compact
SPONSOR(S): Healthcare Regulation Subcommittee, Hunschofsky
TIED BILLS: HB 101 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	15 Y, 1 N, As CS	Curry	McElroy
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Aderibigbe	Clark
3) Health & Human Services Committee		Curry	Calamas

SUMMARY ANALYSIS

Licensed social workers provide counsel and advocacy for those affected by mental illness, addiction, abuse, and discrimination, among other economic difficulties, and are the largest group of providers of mental and behavioral health services. The Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling within the Department of Health (DOH) regulates the practices of social work, marriage and family therapy, and mental health counseling.

In 2023, the National Center for Interstate Compacts adopted the model legislation for the Social Work Licensure Interstate Compact (Social Work Compact or compact) which authorizes both telehealth and in person practice across state lines in compact states. Social Workers who are licensed or are eligible for licensure in the compact state where they reside are eligible for a multistate license which authorizes them to practice through either telehealth or in-person in member states. Additionally, the compact allows an active military member or their spouse to designate a home state where the individual has a multistate license and retain his or her home state designation as long as the service member is on active duty.

The compact requires all participating states to report certain licensure information to a shared data system, including identifying information, licensure data, and adverse actions taken against a social worker's license in a compact state. The compact establishes the Social Work Licensure Interstate Compact Commission (Commission), made up of representatives from each party's state licensing board. The Commission is responsible for administering the compact. The compact becomes effective on the date of enactment by the seventh state. Currently, the compact has one member state.

CS/HB 99 enacts the Social Work Licensure Interstate Compact and authorizes Florida to enter into the compact. This allows a social worker licensed or eligible for licensure in Florida to obtain a multistate license to provide services in all member states once the compact is enacted.

The bill will have a significant, negative fiscal impact on DOH and no fiscal impact on local governments. *See* Fiscal Analysis.

The bill is effective upon the enactment of the Social Work Licensure Interstate Compact into law by seven states.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Professional Shortage

There is currently a health care provider shortage in the U.S.[1] This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[2] and the passage of the Patient Protection and Affordable Care Act.[3] Aging populations create a disproportionately higher health care demand. Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

Currently, the U.S. is facing a growing shortage of licensed behavioral health care specialists, which include psychiatrists, psychologists, and clinical social workers. This shortage has severely limited access to treatment.[4] According to the U.S. Health Resources and Services Administration (HRSA), the U.S. will experience a 15% increase in demand for social workers between 2016 and 2030.[5] The demand for social workers specializing in mental health and treating substance use disorders is projected to increase by 17% between 2019 to 2029, according to the 2021 U.S. Bureau of Labor Statistics report.[6] Studies predict that by 2030 there will be a significant deficit (greater than 200,000) in the number of social workers needed to care for children, the elderly and those with addictions, mental health, and other health issues.[7]

Social Work Licensure in Florida

Licensed social workers provide counsel and advocacy for those affected by mental illness, addiction, abuse, and discrimination, among other economic difficulties, and are the largest group of providers of mental and behavioral health services.[8] The Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling (Board) within the Department of Health (DOH) regulates the practices of social work, marriage and family therapy, and mental health counseling.[9] Chapter 491,

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[1] For example, as of September 30, 2023, the U.S. Department of Health and Human Services has designated 8,352 Primary Care Health Professional Shortage Area (HPSA) (requiring 17,396 additional primary care physicians to eliminate the shortage), 7,3 95 Dental HPSAs (requiring 12,757 additional dentists to eliminate the shortage), and 6,622 Mental Health HPSAs (requiring 8,326 additional mental health providers to eliminate the shortage). U.S. Department of Health and Human Services, *Designated Health Professional Shortage Areas Statistics* (September 30, 2023), https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport (last visited December 1, 2023).

[2] According to the U.S. Census Bureau, the U.S population is expected to increase by nearly 79 million between 2017 and 2060.The nation's 65-and-older population is projected to nearly double (from 49 million to 95 million) between 2016 and 2060. By 2030, one in five Americans is projected to be 65 and over. Jonathan Vespa, Lauren Medina, and David M. Armstrong, U.S. Census Bureau, *Demographic Turning Points for the United States: Population Projections for 2020 to 2060* (February 2020), https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf (last visited December 1, 2023).

[3] U.S. Dep't of Health and Human Services, *Department of Health and Human Services Strategic Plan: Goal 1: Strengthen Health Care*, *available at* http://www.hhs.gov/secretary/about/goal5.html (last visited on May 9, 2023).

[4] Bipartisan Policy Center, *Filing the Gaps in the Behavioral Health Workforce*, (January 2023), at https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2023/01/BPC_2022_Behavioral-Health-Integration-Report_RV6Final.pdf, (last visited December 1, 2023).

[5] Health Resources Services Administration, *Behavioral Health Workforce Projections, 2016-2030: Social Workers*, https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/social-workers-2018.pdf, (last visited December 1, 2023).

[6] Florida Department of State, Division of Library and Information Services, *Social Workers at the Library,* at https://dos.fl.gov/library-archives/library-development/innovation/stars/social-workers/, (last visited December 2, 2023).

[7] Quality Improvement Center for Workforce Development, *Social Worker Shortages and The Rise in Competition for a Competent Child Welfare Workforce*, at https://www.qic-wd.org/blog/social-worker-shortages-and-rise-competition-competent-child-welfare-workforce, (last visited December 2, 2023).

[8] *The Shortage of Licensed Social Workers in Central Florida*, Helen M. Burrows, Walden University (2019) at https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=8101&context=dissertations, (last visited December 1, 2023).

[9] S. 491.004, F.S.

F.S., sets forth the licensure requirements for each profession, as well as requirements for licensure renewal, continuing education, discipline, and professional conduct.

DOH must issue a license as a clinical social worker to an applicant whom the Board has certified has meet all of the following criteria:[10]

- Submitted an application and appropriate fees;
- Earned a doctoral degree in social work from a graduate school of social work accredited by an accrediting agency recognized by the U.S. Department of Education, or a master's degree in social work from a graduate school of social work which was accredited by the:
    - Council on Social Work Education (CSWE);
    - Canadian Association of Schools of Social Work (CASSW); or
    - Has been determined to be an equivalent program to programs approved by the CSWE by the Foreign Equivalency Determination Service of the CSWE;
    - Completed all of the following coursework:
        - A supervised field placement during which the applicant provided clinical services directly to clients; and
        - Twenty-four (24) semester hours or thirty-two (32) quarter hours in theory of human behavior and practice methods as courses in clinically oriented services, with a minimum of one course in psychopathology and no more than one course in research;
- Completed at least 2 post graduate years of clinical social work experience under the supervision of a licensed clinical social worker or the equivalent supervisor as determined by the Board;[11]
- Passed a theory and practice examination; and
- Demonstrated in a manner designated by Board rule, knowledge of the laws and rules governing the practice of clinical social work, marriage and family therapy, and mental health counseling.

Telehealth

A Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[12] or a registered out-of-state-health care provider is authorized to provide health care services to Florida patients via telehealth.[13] Current law sets the standard of care for telehealth providers at the same level as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

Under current law, in-state and out-of-state licensed or registered health care practitioners may use telehealth to provide health care services to patients physically located in Florida.[14] The law does not allow health care practitioners, including Florida licensed clinical social workers, to use telehealth to provide services to out-of-state patients.

Sovereign Immunity

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly

[10] S. 491.005(1), F.S.
[11] S. 491.005(1)(c), F.S. An individual who intends to practice in Florida to satisfy clinical experience requirements must register with the DOH pursuant to s. 491.0045, F.S., before commencing practice.
[12] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[13] S. 456.47(4), F.S.
[14] S. 456.47(1) and (4), F.S.

waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through an enactment of general law. [15]

Current law partially waives sovereign immunity, allowing individuals to sue state government and its subdivisions.[16] Individuals may sue the government under circumstances where a private person "would be liable to the claimant, in accordance with the general laws of [the] state . . . . " Section 768.28(5), F.S., imposes a $200,000 limit on the government's liability to a single person, and a $300,000 total limit on liability for claims arising out of a single incident.

Impaired Practitioner Program

The impaired practitioner treatment program was created to provide resources to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or both, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety.[17] For a profession that does not have a program established within its individual practice act, the Department of Health (DOH) is required to designate an approved program by rule.[18] By rule, DOH designates the approved program by contract with a consultant to initiate intervention, recommend evaluation, refer impaired practitioners to treatment providers, and monitor the progress of impaired practitioners. The impaired practitioner program may not provide medical services.[19]

Interstate Compacts

An interstate compact is a legal contractual agreement between two or more states to address common problems or issues, create an independent, multistate governmental authority, or establish uniform guidelines, standards or procedures for the compact's member states.[20] Article 1, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other, without the consent of Congress. However, the case law has provided that not all interstate agreements are subject to congressional approval, but only those that may encroach on the federal government's power.[21]

Florida is a party to multiple interstate health care compacts, including the Nurse Licensure Compact,[22] the Professional Counselors Licensure Compact,[23] and the Psychology Interjurisdictional Compact.[24]

Social Work Licensure Interstate Compact

Currently, social workers must seek a separate license in each state in which they chose to practice, which can be labor and time intensive. The compact enables licensed social workers to obtain a multistate license to practice in all compact member states, once the social worker has demonstrated that he or she meets the compact requirements.

The primary purpose of the Social Work Compact is to facilitate interstate practice of regulated social workers by improving public access to competent social work services. Under the compact, a multistate license to practice as a regulated social worker is issued by the licensing authority in the applicant's home state and authorizes the social worker to practice in all compact member states. Member states are required to accept multistate licenses from other compact member states as authorization to practice corresponding to each category of licensure in each member state.

[15] Fla. Const. art. X, s. 13.
[16] S. 768.28, F.S.[17] S. 456.076, F.S. The provisions of s. 456.076, also apply to veterinarians under s. 474.221, F.S. and radiological personnel under s. 486.315, F.S.
[17] S. 456.076, F.S. The provisions of s. 456.076, also apply to veterinarians under s. 474.221, F.S. and radiological personnel under s. 486.315, F.S.
[18] S. 456.076(1), F.S.
[19] Rule 64B31-10.001(1)(a), F.A.C.
[20] National Center for Interstate Compacts, *What Are Interstate Compacts?,* https://compacts.csg.org/compacts/ (last visited November 30, 2024).
[21] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[22] S. 464.0095, F.S.
[23] S. 491.017, F.S.
[24] S. 490.0075, F.S.

The compact allows for three categories of social work multistate licensure, clinical, master's and bachelor's. Member states must designate which licensure category will be accepted in that state.

To be eligible for a multistate license, all social workers in a member state must:

- Hold, or be eligible for, an active, unencumbered license to practice social work in the compact member state in which they are domiciled;
- Abide by the laws, regulations, and rules of the state of the member state where the client is located at the time service is provided;
- Submit to a review of criminal history (background screening). (Any disqualifying events are subject to the discretion of the member state.); and
- Pay all applicable fees, including any member state fees and other fees required by the compact, for multistate license.

To be eligible for a clinical-category multistate license a social worker must:

- Fulfill a competency requirement, which shall be satisfied by either:
    - Passing a clinical-category Qualifying National Exam; or
    - Hold and continuously maintain a clinical-category social work license in their home state prior to a Qualifying National Exam being required by the home state as further governed by the rules of the Commission; or
    - Proving clinical competency through a substantially equivalent standard which the Commission may determine by rule.
- Attain at least a master's degree in social work from a program that is accredited, or in candidacy by an institution that subsequently becomes accredited.
- Fulfill the supervised practice requirement, which shall be satisfied by demonstrating completion of:
    - A minimum of 3,000 hours of postgraduate supervised clinical practice; or
    - A minimum two (2) years of full-time postgraduate supervised clinical practice; or
    - Be found to have proven clinical competency through a substantially equivalent standard which the Commission may determine by rule.

To be eligible for a master's category multistate license a social worker must:

- Fulfill a competency requirement, which shall be satisfied by either:
    - Passing a master's-category Qualifying National Exam; or
    - Hold and continuously maintain a master's-category social work license in their home state prior to a Qualifying National Exam being required by the home state as further governed by the Rules of the Commission; or
    - Proving master's-category competency through a substantially equivalent standard which the Commission may determine by rule.
- Attain at least a master's degree in social work from a program that is accredited, or in candidacy by an institution that subsequently becomes accredited.

To be eligible for a bachelor's category multistate license a social worker must:

- Fulfill a competency requirement, which shall be satisfied by either:
    - Passing a bachelor's-category Qualifying National Exam;
    - Hold and continuously maintain a bachelor's-category social work license in their home state prior to a Qualifying National Exam being required by the home state as further governed by the rules of the Commission; or
    - Proving bachelor's-category competency through a substantially equivalent standard which the Commission may determine by rule.
- Attain at least a bachelor's degree in social work from a program that is accredited, or in candidacy by an institution that subsequently becomes accredited.

To maintain a multistate license, a social worker must meet the renewal requirements of their home state.

State Participation in the Compact

The compact preserves the regulatory authority of member states to protect public health and safety through the current system of state licensure. To join the compact, states must enact compact legislation and meet all of the following criteria:

- License and regulate the practice of social work at either the clinical, master's, or bachelor's category;
- Require applicants for licensure to graduate from a program that is accredited, or in candidacy by an institution that subsequently becomes accredited and that corresponds to the licensure sought; and
- Require applicants for clinical licensure to complete a period of supervised practice.

To maintain membership in the compact, a state must:

- Require applicants for a multistate license to pass a Qualifying National Exam corresponding to the category of multistate license sought; and
- Implement procedures for considering the criminal history records (background screening) of applicants for a multistate license.

The compact gives states the discretion to collect fees for social workers to participate in the compact. However, the compact does not authorize the Department of Health (DOH) to collect a fee, but rather states that fees of this kind are allowable under the compact. In order for DOH to have the required authority to collect fees, the Legislature would have to enact legislation in the application practice act expressly authorizing DOH to collect such fees.

Social Work Licensure Compact Commission

The compact establishes the Social Work Licensure Interstate Compact Commission (Commission) as the governing body and the entity responsible for creating and enforcing the rules and regulations that administer and govern the compact. The Commission membership is composed of compact member states. The licensing authority of each member state must select one delegate to serve on the Commission. The compact requires the Commission to establish and elect an executive committee, which shall have the power to act on behalf of the Commission.

All Commission and executive committee meetings must be open to the public unless confidential or privileged information must be discussed. The compact does not waive sovereign immunity by the member states or by the Commission.

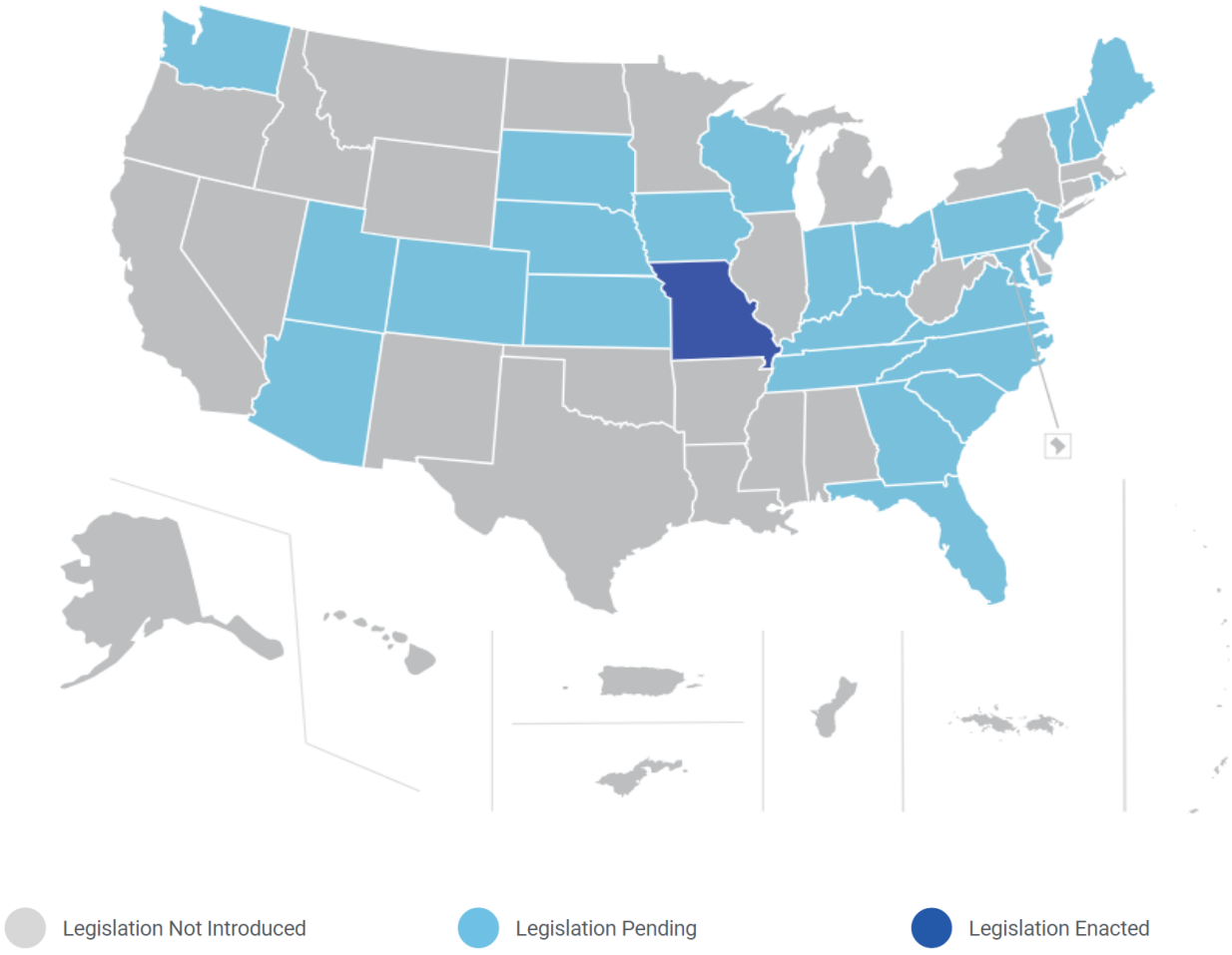
Shared Data System

The compact requires member states to use a shared data system which will enable states to verify instantaneously that social workers have met the requirements to practice under the compact and are in good standing with other state regulatory boards. Compact member states must submit licensure information to the data system for all social workers to whom the compact applies, including, identifying information, licensure data, and any adverse actions taken against a social worker's license. The data system will allow for expedited sharing of licensee, investigative and disciplinary information between member states.[25] Investigative information pertaining to a licensee in any member state will only be available to other member states. A member state may designate information submitted to the data system that may not be shared with the public without the express permission of that member state.

[25] SWLC, Summary of Key Provisions, at https://swcompact.org/wp-content/uploads/sites/30/2023/02/Social-Work-Licensure-Compact-Section-by-Section-Summary.pdf, (last visited December 5, 2023).

Enactment of Compact

The Social Work Compact is currently not active.[26] The compact becomes effective when enacted into law by seven states.[27] Currently, the compact has one-member state (Missouri). However, legislation is currently pending to enact the compact in twenty-four states, including Florida.[28]



Effect of the Bill

HB 99 enacts the Social Work Licensure Interstate Compact and authorizes Florida to enter into the compact. The compact allows for three categories of social work multistate licensure, clinical, master's and bachelor's. Member states must designate which licensure category will be accepted in that state. Currently, only individuals who have a master's degree or higher are eligible for licensure as a clinical social worker in Florida.

Under the compact, individuals licensed or eligible for licensure as a clinical social worker in Florida will be able to obtain a multistate license to provide services to out-of-state patients through either telehealth or in-person in any of the compact member states. The compact also allows multistate

[26] Since the compact is not active yet, multistate licenses for social work are currently not available. SWLC, About, https://swcompact.org/, (last visited November 28, 2023).
[27] Social Work Licensure Compact Makes Progress in 2023 Legislative Sessions. (2023), *ASWB Newsletter Volume 33 No. 2*, https://www.aswb.org/social-work-licensure-compact-makes-progress-in-2023, (last visited November 28, 2023).
[28] SWLC, Compact Map, at https://swcompact.org/compact-map/, (last visited February 5, 2024).

licensed clinical social workers in other compact states to provide services to Florida patients through telehealth and in-person.

The bill amends current law to allow compact implementation. The bill requires DOH to report any significant investigation information relating to a licensed clinical social worker practicing under the compact to the coordinated data system. It requires social workers to withdraw from all practice under the compact if the social worker is in an impaired practitioner program. It also exempts out-of-state licensed clinical social workers who practice under the compact from licensure requirements in this state. The bill requires the Board to appoint a delegate to serve on the Commission and authorizes the Board to take adverse action against a licensed clinical social worker's authority to practice under the compact and impose disciplinary actions for violation of prohibited acts.

The bill makes conforming changes to statute to reference the compact and the requirements under the compact. The bill does not require changes to Florida's licensure and license renewal requirements.

Additionally, the bill allows an active military member or their spouse to designate a home state where the individual has a multistate license and retain his or her home state designation as long as the service member is on active duty.

The bill is effective upon the enactment of the Social Work Licensure Interstate Compact into law by seven states.

B. SECTION DIRECTORY:

Section 1: Creates s. 491.022, F.S., relating to the Social Work Licensure Interstate Compact.
Section 2: Amends s. 456.073, F.S., relating to disciplinary proceedings.
Section 3: Amends s. 456.076, F.S., relating to impaired practitioner programs.
Section 4: Amends s. 491.004, F.S., relating to the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.
Section 5: Amends s. 491.005, F.S., relating to licensure by examination.
Section 6: Amends s. 491.006, F.S., relating to licensure or certification by endorsement.
Section 7: Amends s. 491.009, F.S., relating to discipline.
Section 8: Amends s. 768.28, F.S., relating to the waiver of sovereign immunity in tort actions.
Section 9: Provides the Department of Health shall notify the Division of Law Revision upon the enactment of the Social Work Licensure Interstate Compact into law by seven states.
Section 10: Provides the bill shall take effect upon the enactment of the Social Work Licensure Interstate Compact into law by seven states.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The provisions of this bill do not provide authority to DOH to collect fees, but rather states that fees of this kind are allowable under the compact. In order for DOH to have the required authority to collect fees, the Legislature would have to enact legislation in the applicable practice act expressly authorizing DOH to collect such fees.

2. Expenditures:

DOH estimates the total cost to comply with the bill is $491,714 ($360,000 recurring, $131,714 non-recurring).[29]

DOH will experience a recurring increase in workload associated with processing applications and issuing initial and renewal licenses, completing background screening requirements, and with additional systems supporting functions including the Licensing and Enforcement Information System Database (LEIDS), updating the Cognitive Virtual Agent (ELI), Continuing Education Tracking System (CE Broker and other supporting systems). This increased workload will require an additional 3 full-time equivalent (FTE) positions at total estimated cost of $375,374 ($327,692/Salary $46,602/Expense $1,080/HR).

In addition, updates to fully integrate this bill are estimated to take six months. This reflects a minimum of 927 initial non-recurring contracted hours at a rate of $120/hr for a total cost of $111,240 ($120/hr x 927) and annual recurring system maintenance costs of $5,100. Total estimated increase in workload and cost is $116,340 in Contracted Services.

See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The compact becomes effective when enacted into law by seven states. Currently, the compact has one-member state (Missouri). Once the compact is fully enacted with a seven-state participation, the Department of Health may request resources needed to implement this act through either the Legislative Budget Request process or through the Legislative Budget Commission.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

As discussed below in the section entitled, "RULE-MAKING AUTHORITY," the bill delegates authority to the Commission to adopt rules that facilitate and coordinate the implementation and administration of the Social Work Licensure Interstate Compact.

If enacted into law, the state will effectively bind itself to rules not yet adopted by the Commission. The Florida Supreme Court has held that while it is within the province of the Legislature to adopt federal statutes enacted by Congress and rules promulgated by federal administrative bodies that are in existence at the time the Legislature acts, it is an unconstitutional delegation of legislative power to prospectively adopt federal statutes not yet enacted by Congress and rules not yet

[29] DOH, *Agency Bill Analysis*, HB 99 (2023) pgs. 8-10.

promulgated by federal administrative bodies.[30,31] Under this holding, the constitutionality of the bill's adoption of prospective rules might be questioned, and there does not appear to be binding Florida case law that squarely address this issue in the context of interstate compacts.

The most recent opportunity Florida courts have had to address this issue appears to be in *Department of Children and Family Services v. L.G.*, involving the Interstate Compact for the Placement of Children (ICPC).[32] The First District Court of Appeal considered an argument that the regulations adopted by the Association of Administrators of the Interstate Compact were binding and that the lower court's order permitting a mother and child to relocate to another state was in violation of the ICPC. The court denied the appeal and held that the Association's regulations did not apply as they conflicted with the ICPC and the regulations did not apply to the facts of the case.

Any regulations promulgated before Florida adopted the ICPC did not, of course, reflect the vote of a Florida compact administrator, and no such regulations were ever themselves enacted into law in Florida. When the Legislature did adopt the ICPC, it did not (and could not) enact as the law of Florida or adopt prospectively regulations then yet to be promulgated by an entity not even covered by the Florida Administrative Procedure Act. *See Freimuth v. State,* 272 So.2d 473, 476 (Fla.1972); *Fla. Indus. Comm'n v. State ex rel. Orange State Oil Co.,* 155 Fla. 772, 21 So.2d 599, 603 (1945) ("[I]t is within the province of the legislature to approve and adopt the provisions of federal statutes, and all of the administrative rules made by a federal administrative body, that are in existence and in effect at the time the legislature acts, but it would be an unconstitutional delegation of legislative power for the legislature to adopt in advance any federal act or the ruling of any federal administrative body that Congress or such administrative body might see fit to adopt in the future."); *Brazil v. Div. of Admin.,* 347 So.2d 755, 757–58 (Fla. 1st DCA 1977), *disapproved on other grounds by LaPointe Outdoor Adver. v. Fla. Dep't of Transp.,* 398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.

In accordance with the discussion provided by the court in this above-cited footnote, it may be argued that the bill's delegation of rule-making authority to the commission is similar to the delegation to the ICPC compact administrators, and thus, could constitute an unlawful delegation of legislative authority. This case, however, does not appear to be binding as precedent as the court's footnote discussion is dicta.[33]

B. RULE-MAKING AUTHORITY:

The bill authorizes the Commission to adopt rules to facilitate and coordinate the implementation and administration of the compact. The compact specifies that the rules have the force and effect of law and are binding in all compact states. If a compact state fails to meet its obligations under the compact or the promulgated rules, the state may be subject to remedial training, alternative dispute resolution, suspension, termination, or legal action.

The compact details the rule-making process that must be followed including, notice, an opportunity for public participation, and hearings. The compact also provides a procedure for emergency rule-making in cases of imminent danger to public health, safety, or welfare, to prevent financial loss to the state's or commission, or to comply with federal laws or regulations. All rules and amendments are binding on party state as of the effective date specified.

C. DRAFTING ISSUES OR OTHER COMMENTS:

[30] *Freimuth v. State*, 272 So.2d 473, 476 (Fla. 1972) (quoting *Fla. Ind. Comm'n v. State ex rel. Orange State Oil Co.*, 155 Fla. 772 (1945).

[31] This prohibition is based on the separation of powers doctrine, set forth in Article II, Section 3 of the Florida Constitution, which has been construed in Florida to require the Legislature, when delegating the administration of legislative programs, to establish the minimum standards and guidelines ascertainable by reference to the enactment creating the program. *See Avatar Development Corp. v. State*, 723 So.2d 199 (Fla. 1998).

[32] 801 So.2d 1047 (Fla. 1st DCA 2001).

[33] Dicta are statements of a court that are not essential to the determination of the case before it and are not a part of the law of the case. Dicta has no binding legal effect and is without force as judicial precedent. 12A FLA JUR. 2D *Courts and Judges* s. 191 (2015).

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On December 13, 2023, the Healthcare Regulation Subcommittee adopted an amendment and reported the bill favorable. The amendment:

- Requires DOH to report any significant investigatory information relating to a licensed social worker practicing under the compact to a coordinated data system;
- Requires the terms of a monitoring contract for an impaired practitioner who is a licensed clinical social worker to include withdrawal from all practice under the compact;
- Exempts a licensed social worker in a remote state who holds a multi-state license under the compact from Florida licensure requirements;
- Authorizes the Board to delegate a member to serve on the Social Work Licensure Interstate Compact Commission;
- Authorizes the Board to take adverse action against a social worker's license under the compact and impose penalties for specified infractions;
- Recognizes certain individuals, when acting within the official scope of their employment, duties, and responsibilities with the Commission, as agents of the state for sovereign immunity purposes; and
- Requires the Commission to pay any claims or judgements up to the statutory waived amounts of sovereign immunity and authorizes the Commission to maintain insurance coverage to pay any such claims or judgements.
- Makes the bill effective upon the enactment of the compact into law by seven states.

This analysis is drafted to the committee substitute as passed by the Healthcare Regulation Subcommittee.

A bill to be entitled

An act relating to the Social Work Licensure Interstate Compact; creating s. 491.022, F.S.; creating the Social Work Licensure Interstate Compact; providing purposes, objectives, and definitions; specifying requirements for state participation in the compact and duties of member states; specifying that the compact does not affect an individual's ability to apply for, and a member state's ability to grant, a single state license pursuant to the laws of that state; providing for recognition of compact privilege in member states; specifying criteria a licensee must meet for compact privilege; providing for the expiration and renewal of compact privilege; specifying that a licensee with compact privilege in a remote state must adhere to the laws and rules of that state; authorizing member states to act on a licensee's compact privilege under certain circumstances; specifying the consequences and parameters of practice for a licensee whose compact privilege has been acted on or whose home state license is encumbered; specifying that a licensee may hold a home state license in only one member state at a time; specifying requirements and procedures for changing a home state license designation; authorizing

active duty military personnel or their spouses to keep their home state designation during active duty; authorizing member states to take adverse actions against licensees and issue subpoenas for hearings and investigations under certain circumstances; providing requirements and procedures for such adverse action; authorizing member states to engage in joint investigations under certain circumstances; providing that a licensee's compact privilege 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; establishing the Social Work Licensure Interstate Compact Commission; providing for jurisdiction and venue for court proceedings; providing for membership and powers of the commission; specifying powers and duties of the commission's executive committee; providing for the financing of the commission; providing specified individuals immunity from civil liability under certain circumstances; providing exceptions; requiring the commission to defend the specified individuals in civil actions under certain circumstances; requiring the commission to indemnify and hold harmless

specified 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; authorizing the commission to receive notice of process, and have standing to intervene, in certain 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 for implementation of, withdrawal from, and amendment to the compact; specifying that licensees practicing in a remote state under the compact must adhere to the laws

and rules of that state; specifying that the compact, commission rules, and commission actions are binding on member states; providing construction; providing for 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 certain impaired practitioners 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's delegate and other members or employees of the commission as state agents for the purpose of applying waivers of sovereign immunity; requiring the commission to pay certain claims or judgments; authorizing the commission to maintain insurance coverage to pay such claims or judgments; requiring the department to notify the Division of Law Revision upon enactment of the compact into law by seven

states; providing a contingent effective date.

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

Section 1. Section 491.022, Florida Statutes, is created to read:

491.022 Social Work Licensure Interstate Compact.—The Social Work Licensure Interstate Compact is hereby enacted into law and entered into by this state with all other states legally joining therein in the form substantially as follows:

ARTICLE I

PURPOSE

The purpose of this compact is to facilitate interstate practice of regulated social workers by improving public access to competent social work services. The compact preserves the regulatory authority of member states to protect public health and safety through the current system of licensure. This compact is designed to achieve all of the following objectives:

(1) Increase public access to social work services.

(2) Reduce overly burdensome and duplicative requirements associated with holding multiple licenses.

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

(4) Encourage the cooperation of member states in regulating multistate practice.

(5) Promote mobility and address workforce shortages by eliminating the necessity for licenses in multiple states by providing for the mutual recognition of other member state licenses.

(6) Support military families.

(7) Facilitate the exchange of licensure and disciplinary information among member states.

(8) Authorize all member states to hold a regulated social worker accountable for abiding by a member state's laws, regulations, and applicable professional standards in the member state in which the client is located at the time care is rendered.

(9) Allow for the use of telehealth to facilitate increased access to social work services.

ARTICLE II

DEFINITIONS

As used in this compact, the term:

(1) "Active military member" means any individual with full-time duty status in the active Armed Forces of the United states including members of the National Guard and Reserve.

(2) "Adverse action" means any administrative, civil,

equitable or criminal action permitted by a state's laws which is imposed by a licensing authority or other authority against a regulated social worker, including actions against an individual's license or multistate authorization to practice such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a regulated social worker's authorization to practice, including issuance of a cease and desist action.

(3) "Alternative program" means a nondisciplinary monitoring or practice remediation process approved by a licensing authority to address practitioners with an impairment.

(4) "Charter member states" means member states that have enacted legislation to adopt this compact where such legislation predates the effective date of this compact as described in Article XIV.

(5) "Commission" means the government agency whose membership consists of all states that have enacted this compact, which is known as the Social Work Licensure Interstate Compact commission, as described in Article X, and which shall operate as an instrumentality of the member states.

(6) "Current significant investigative information" means:

(a) Investigative information that a licensing authority, after a preliminary inquiry that includes notification and an opportunity for the regulated social worker to respond, has

reason to believe is not groundless and, if proved true, would indicate more than a minor infraction as may be defined by the commission; or

(b) Investigative information that indicates that the regulated social worker represents an immediate threat to public health and safety, as may be defined by the commission, regardless of whether the regulated social worker has been notified and has had an opportunity to respond.

(7) "Data system" means a repository of information about licensees, including continuing education, examination, licensure, current significant investigative information, disqualifying events, multistate licenses, and adverse action information or other information as required by the commission.

(8) "Disqualifying event" means any adverse action or incident which results in an encumbrance that disqualifies or makes the licensee ineligible to obtain, retain, or renew a multistate license.

(9) "Domicile" means the jurisdiction in which the licensee resides and intends to remain indefinitely.

(10) "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of social work licensed and regulated by an authority.

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

(12) "Home state" means the member state that is the licensee's primary domicile.

(13) "Impairment" means a condition that may impair a practitioner's ability to engage in full and unrestricted practice as a regulated social worker without some type of intervention and may include alcohol and drug dependence, mental health impairment, and neurological or physical impairments.

(14) "Licensee" means an individual who currently holds a license from a state to practice as a regulated social worker.

(15) "Licensing authority" means the board or agency of a member state, or an equivalent, that is responsible for the licensing and regulation of regulated social workers.

(16) "Member state" means a state, commonwealth, district, or territory of the United States of America that has enacted this compact.

(17) "Multistate authorization to practice" means a legally authorized privilege to practice, which is equivalent to a license, associated with a multistate license permitting the practice of social work in a remote state.

(18) "Multistate license" means a license to practice as a regulated social worker issued by a home state licensing authority that authorizes the regulated social worker to practice in all member states under multistate authorization to practice.

(19) "Qualifying National Exam" means a national licensing

examination approved by the commission.

(20) "Regulated social worker" means any clinical, master's, or bachelor's social worker licensed by a member state regardless of the title used by that member state.

(21) "Remote state" means a member state other than the licensee's home state.

(22) "Rules" or "rules of the commission" means a regulation or regulations duly adopted by the commission, as authorized by the compact, that has the force of law.

(23) "Single state license" means a social work license issued by any state that authorizes practice only within the issuing state and does not include multistate authorization to practice in any member state.

(24) "Social work" or "social work services" means the application of social work theory, knowledge, methods, ethics, and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities through the care and services provided by a regulated social worker as set forth in the member state's statutes and regulations in the state where the services are being provided.

(25) "State" means any state, commonwealth, district, or territory of the United States of America that regulates the practice of social work.

(26) "Unencumbered license" means a license that

authorizes a regulated social worker to engage in the full and unrestricted practice of social work.

ARTICLE III

STATE PARTICIPATION IN THE COMPACT

(1) To be eligible to participate in the compact, a potential member state must currently meet all of the following criteria:

(a) License and regulate the practice of social work at the clinical, master's, or bachelor's category.

(b) Require applicants for licensure to graduate from a program that is:

1. Operated by a college or university recognized by a licensing authority;

2. Accredited, or in candidacy by an institution that subsequently becomes accredited, by an accrediting agency recognized by either:

a. The Council for Higher Education Accreditation or its successor; or

b. The United States Department of Education; and

3. Corresponds to the licensure sought as outlined in Article IV.

(c) Require applicants for clinical licensure to complete a period of supervised practice.

(d) Have a mechanism in place for receiving, investigating, and adjudicating complaints about licensees.

(2) To maintain membership in the compact, a member state shall:

(a) Require that applicants for a multistate license pass a Qualifying National Exam for the corresponding category of multistate license sought as outlined in Article IV.

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

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

(d) Implement procedures for considering the criminal history records of applicants for a multistate license. Such procedures shall 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.

(e) Comply with the rules of the commission.

(f) 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 home state laws.

(g) Authorize a licensee holding a multistate license in any member state to practice in accordance with the terms of the compact and rules of the commission.

(h) Designate a delegate to participate in the commission meetings.

(3) A member state meeting the requirements under subsections (1) and (2) shall designate the categories of social work licensure that are eligible for issuance of a multistate license for applicants in such member state. To the extent that any member state does not meet the requirements for participation in the compact at any particular category of social work licensure, such member state may choose, but is not obligated to, issue a multistate license to applicants that otherwise meet the requirements of Article IV for issuance of a multistate license in such category or categories of licensure.

(4) The home state may charge a fee for granting the multistate license.

ARTICLE IV
SOCIAL WORKER PARTICIPATION IN THE COMPACT

(1) To be eligible for a multistate license under this compact, an applicant, regardless of category, must meet all of the following requirements:

(a) Hold or be eligible for an active, unencumbered license in the home state.

(b) Pay any applicable fees, including any member state fee, for the multistate license.

(c) Submit, in connection with an application for a multistate license, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

(d) Notify the home state of any adverse action, encumbrance, or restriction on any professional license taken by any member state or nonmember state within 30 days after the date the action is taken.

(e) Meet any continuing competence requirements established by the home state.

(f) Abide by the laws, regulations, and applicable standards in the member state where the client is located at the time care is rendered.

(2) An applicant for a clinical-category multistate license must meet all of the following requirements:

(a) Fulfill a competency requirement, which shall be satisfied by:

1. Passage of a clinical-category Qualifying National Exam;

2. Licensure of the applicant in their home state at the

clinical category, beginning before such time as a Qualifying National Exam was required by the home state and accompanied by a period of continuous social work licensure thereafter, all of which may be further governed by the rules of the commission; or

3. The substantial equivalency of the foregoing competency requirements which the commission may determine by rule.

(b) Attain at least a master's degree in social work from a program that is:

1. Operated by a college or university recognized by a licensing authority.

2. Accredited, or in candidacy that subsequently becomes accredited, by an accrediting agency recognized by either:

a. The Council for Higher Education Accreditation or its successor; or

b. The United States Department of Education.

(c) Fulfill a practice requirement, which shall be satisfied by demonstrating completion of:

1. A period of postgraduate supervised clinical practice equal to a minimum of 3,000 hours;

2. A minimum of 2 years of full-time postgraduate supervised clinical practice; or

3. The substantial equivalency of the foregoing practice requirements which the commission may determine by rule.

(3) An applicant for a master's-category multistate license must meet all of the following requirements:

(a) Fulfill a competency requirement, which shall be satisfied by:

1. Passage of a masters-category Qualifying National Exam;

2. Licensure of the applicant in their home state at the master's category, beginning before such time as a Qualifying National Exam was required by the home state at the master's category and accompanied by a continuous period of social work licensure thereafter, all of which may be further governed by the rules of the commission; or

3. The substantial equivalency of the foregoing competency requirements which the commission may determine by rule.

(b) Attain at least a master's degree in social work from a program that is:

1. Operated by a college or university recognized by a licensing authority.

2. Accredited, or in candidacy by an institution that subsequently becomes accredited, by an accrediting agency recognized by either:

a. The Council for Higher Education Accreditation or its successor; or

b. The United States Department of Education.

(4) An applicant for a bachelor's-category multistate license must meet all of the following requirements:

(a) Fulfill a competency requirement, which shall be satisfied by:

1. Passage of a bachelor's-category Qualifying National Exam;

2. Licensure of the applicant in his or her home state at the bachelor's category, beginning before such time as a Qualifying National Exam was required by the home state and accompanied by a period of continuous social work licensure thereafter, all of which may be further governed by the rules of the commission; or

3. The substantial equivalency of the foregoing competency requirements which the commission may determine by rule.

(b) Attain at least a bachelor's degree in social work from a program that is:

1. Operated by a college or university recognized by the licensing authority.

2. Accredited, or in candidacy that subsequently becomes accredited, by an accrediting agency recognized by either:

a. The Council for Higher Education Accreditation or its successor; or

b. The United States Department of Education.

(5) The multistate license for a regulated social worker is subject to the renewal requirements of the home state. The regulated social worker must maintain compliance with the requirements of subsection (1) to be eligible to renew a multistate license.

(6) The regulated social worker's services in a remote

state are subject to that member state's regulatory authority. A remote state may, in accordance with due process and that member state's laws, remove a regulated social worker's multistate authorization to practice in the remote state for a specific period of time, impose fines, and take any other necessary actions to protect the health and safety of its citizens.

(7) If a multistate license is encumbered, the regulated social worker's multistate authorization to practice shall be deactivated in all remote states until the multistate license is no longer encumbered.

(8) If a multistate authorization to practice is encumbered in a remote state, the regulated social worker's multistate authorization to practice may be deactivated in that state until the multistate authorization to practice is no longer encumbered.

ARTICLE V

ISSUANCE OF A MULTISTATE LICENSE

(1) Upon receipt of an application for multistate license, the home state licensing authority shall determine the applicant's eligibility for a multistate license in accordance with Article IV.

(2) If such applicant is eligible pursuant to Article IV, the home state licensing authority shall issue a multistate

license that authorizes the applicant or regulated social worker to practice in all member states under a multistate authorization to practice.

(3) Upon issuance of a multistate license, the home state licensing authority shall designate whether the regulated social worker holds a multistate license in the bachelor's, master's, or clinical category of social work.

(4) A multistate license issued by a home state to a resident in that state shall be recognized by all compact member states as authorizing social work practice under a multistate authorization to practice corresponding to each category of licensure regulated in each member state.

ARTICLE VI

AUTHORITY OF INTERSTATE COMPACT COMMISSION AND MEMBER STATE LICENSING AUTHORITIES

(1) This compact, or any rule of the commission, does not limit, restrict, or in any way reduce the ability of a member state to:

(a) Enact and enforce laws, regulations, or other rules related to the practice of social work in that state when those laws, regulations, or other rules are not inconsistent with the provisions of this compact.

(b) Take adverse action against a licensee's single state

license to practice social work in that state.

(c) Take adverse action against a licensee's multistate authorization to practice in that state.

(2) This compact, or any rule of the commission, does not limit, restrict, or in any way reduce the ability of a licensee's home state to take adverse action against a licensee's multistate license based upon information provided by a remote state.

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

ARTICLE VII

REISSUANCE OF A MULTISTATE LICENSE BY A NEW HOME STATE

(1) A licensee can hold a multistate license, issued by his or her home state, in only one member state at any given time.

(2) If a licensee changes his or her home state by moving between two member states:

(a) The licensee shall immediately apply for the reissuance of his or her multistate license in his or her new home state. The licensee shall pay all applicable fees and notify the prior home state in accordance with the rules of the commission.

(b) Upon receipt of an application to reissue a multistate license, the new home state shall verify that the multistate license is active, unencumbered, and eligible for reissuance under the terms of the compact and the rules of the commission. The multistate license issued by the prior home state will be deactivated and all member states notified in accordance with the applicable rules adopted by the commission.

(c) Before the reissuance of the multistate license, the new home state shall conduct procedures for considering the criminal history records of the licensee. Such procedures shall 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.

(d) If required for initial licensure, the new home state may require completion of jurisprudence requirements in the new home state.

(e) Notwithstanding any other provision of this compact, if a licensee does not meet the requirements set forth in this compact for the reissuance of a multistate license by the new home state, then the licensee shall be subject to the new home state requirements for the issuance of a single state license in that state.

(3) If a licensee 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, then the licensee shall be subject to the state requirements for the issuance of a single state license in the new home state.

(4) This compact does not interfere with a licensee's ability to hold a single state license in multiple states; however, for the purposes of this compact, a licensee shall have only one home state, and only one multistate license.

(5) This compact does not interfere with the requirements established by a member state for the issuance of a single state license.

ARTICLE VIII

MILITARY FAMILIES

An active military member or his or her spouse shall designate a home state where the individual has a multistate license. The individual may retain his or her home state designation during the period the servicemember is on active duty.

ARTICLE IX

ADVERSE ACTIONS

(1) In addition to the other powers conferred by general

law, a remote state shall have the authority, in accordance with existing state due process law, to:

(a) Take adverse action against a regulated social worker's multistate authorization to practice only within that member state, and issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses as well as the production of evidence. Subpoenas issued by a licensing authority in a member state for the attendance and testimony of witnesses or the production of evidence from another member state shall 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 licensing 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 are located.

(b) Only the home state shall have the power to take adverse action against a regulated social worker's multistate license.

(2) 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. In so doing, the home state shall apply its own state laws to determine appropriate action.

(3) The home state shall complete any pending

investigations of a regulated social worker who changes his or her home state during the course of the investigations. The home state shall also have the authority to take appropriate actions 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.

(4) A member state, if otherwise permitted by state law, may recover from the affected regulated social worker the costs of investigations and dispositions of cases resulting from any adverse action taken against that regulated social worker.

(5) A member state may take adverse action based on the factual findings of another member state, provided that the member state follows its own procedures for taking the adverse action.

(6)(a) In addition to the authority granted to a member state by its respective social work 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.

(7) If adverse action is taken by the home state against the multistate license of a regulated social worker, the regulated social worker's multistate authorization to practice

in all other member states shall be deactivated until all encumbrances have been removed from the multistate license. All home state disciplinary orders that impose adverse action against the license of a regulated social worker shall include a statement that the regulated social worker's multistate authorization to practice is deactivated in all member states until all conditions of the decision, order, or agreement are satisfied.

(8) If a member state takes adverse action, it shall promptly notify the administrator of the data system. The administrator of the data system shall promptly notify the home state and all other member states of any adverse actions by remote states.

(9) This compact does not override a member state's decision that participation in an alternative program may be used in lieu of adverse action.

(10) This compact does not authorize a member state to demand the issuance of subpoenas for attendance and testimony of witnesses or the production of evidence from another member state for lawful actions within that member state.

(11) This compact does not authorize a member state to impose discipline against a regulated social worker who holds a multistate authorization to practice for lawful actions within another member state.

ARTICLE X

ESTABLISHMENT OF SOCIAL WORK LICENSURE INTERSTATE COMPACT COMMISSION

(1) The compact member states hereby create and establish a joint government agency whose membership consists of all member states that have enacted the compact known as the Social Work Licensure Interstate Compact Commission. The commission is an instrumentality of the compact states acting jointly and not an instrumentality of any one state. The commission shall come into existence on or after the effective date of the compact as set forth in Article XIV.

(2)(a) Each member state shall have and be limited to one delegate appointed by that member state's licensing authority. The delegate shall be either:

1. A current member of the licensing authority at the time of appointment who is a regulated social worker or public member of the state licensing authority; or

2. An administrator of the licensing authority or his or her designee.

(b) The commission shall by rule or bylaw establish a term of office for delegates and may by rule or bylaw establish term limits.

(c) The commission may recommend removal or suspension of any delegate from office.

(d) A member state's licensing authority shall fill any vacancy of its delegate occurring on the commission within 60 days after the vacancy.

(e) Each delegate shall be entitled to one vote on all matters before the commission requiring a vote by commission delegates.

(f) A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates to meet by telecommunication, videoconference, or other means of communication.

(g) The commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws. The commission may meet by telecommunication, video conference, or other similar electronic means.

(3) The commission shall have the following powers:

(a) Establish the fiscal year of the commission.

(b) Establish code of conduct and conflict of interest policies.

(c) Establish and amend rules and bylaws.

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

(e) Meet and take such actions as are consistent with the provisions of this compact, the commission's rules, and the bylaws.

(f) Initiate and conclude legal proceedings or actions in

the name of the commission, provided that the standing of any licensing authority to sue or be sued under applicable law may not be affected.

(g) Maintain and certify records and information provided to a member state as the authenticated business records of the commission, and designate an agent to do so on the commission's behalf.

(h) Purchase and maintain insurance and bonds.

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

(j) Conduct an annual financial review.

(k) Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the compact, and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(l) Assess and collect fees.

(m) Accept any and all appropriate gifts, donations, grants of money, other sources of revenue, equipment, supplies, materials, and services, and receive, utilize, and dispose of the same; provided that at all times the commission shall avoid any appearance of impropriety or conflict of interest.

(n) Lease, purchase, retain, own, hold, improve, or use any property, real, personal, or mixed, or any undivided

interest therein.

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

(p) Establish a budget and make expenditures.

(q) Borrow money.

(r) Appoint committees, including standing committees, composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this compact and the bylaws.

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

(t) Establish and elect an executive committee, including a chair and a vice chair.

(u) Determine whether a state's adopted language is materially different from the model compact language such that the state would not qualify for participation in the compact.

(v) Perform such other functions as may be necessary or appropriate to achieve the purposes of this compact.

(4)(a) The executive committee shall have the power to act on behalf of the commission according to the terms of this compact. The powers, duties, and responsibilities of the executive committee shall include:

1. Oversee the day-to-day activities of the administration

of the compact, including enforcement and compliance with the provisions of the compact, its rules and bylaws, and other such duties as deemed necessary.

2. Recommend to the commission changes to the rules or bylaws, changes to this compact legislation, fees charged to compact member states, fees charged to licensees, and other fees.

3. Ensure compact administration services are appropriately provided, including by contract.

4. Prepare and recommend the budget.

5. Maintain financial records on behalf of the commission.

6. Monitor compact compliance of member states and provide compliance reports to the commission.

7. Establish additional committees as necessary.

8. Exercise the powers and duties of the commission during the interim between commission meetings, except for adopting or amending rules, adopting or amending bylaws, and exercising any other powers and duties expressly reserved to the commission by rule or bylaw.

9. Other duties as provided in the rules or bylaws of the commission.

(b) The executive committee shall be composed of up to 11 members:

1. The chair and vice chair of the commission shall be voting members of the executive committee.

2. The commission shall elect five voting members from the current membership of the commission.

3. Up to four ex-officio, nonvoting members from four recognized national social work organizations, selected by their respective organizations.

(c) The commission may remove any member of the executive committee as provided in the commission's bylaws.

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

1. Executive committee meetings shall be open to the public, except that the executive committee may meet in a closed, nonpublic meeting as provided in subsection (6).

2. The executive committee shall give 7 days' notice of its meetings, posted on its website and as determined to provide notice to persons with an interest in the business of the commission.

3. The executive committee may hold a special meeting in accordance with subsection (6).

(5) The commission shall adopt and provide to the member states an annual report.

(6) All meetings shall be open to the public, except that the commission may meet in a closed, nonpublic meeting as provided in s. 491.023.

(a) Public notice for all meetings of the full commission of meetings shall be given in the same manner as required under the rulemaking provisions in Article XII, except that the

commission may hold a special meeting as provided in paragraph (b).

(b) The commission may hold a special meeting when it must meet to conduct emergency business by giving 48 hours' notice to all commissioners, on the commission's website, and by other means as provided in the commission's rules. The commission's legal counsel shall certify that the commission's need to meet qualifies as an emergency.

(c) If a meeting, or portion of a meeting, is closed, the presiding officer shall state that the meeting will be closed and reference each relevant exempting provision, and such reference shall be recorded in the minutes.

(d) 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 shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the commission or order of a court of competent jurisdiction.

(7)(a) The commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The commission may accept any and all appropriate

revenue sources as provided in paragraph (3)(m).

(c) The commission may levy on and collect an annual assessment from each member state and impose fees on licensees of member states to whom it grants a multistate license to cover the cost of the operations and activities of the commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount for member states shall be allocated based upon a formula that the commission shall adopt by rule.

(d) The commission may not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall 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 shall be subject to the financial review and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission shall be subject to an annual financial review by a certified or licensed public accountant, and the report of the financial review shall be included in and become part of the annual report of the commission.

(8)(a) The members, officers, executive director, employees, and representatives of the commission shall be immune

from suit and liability, both personally and in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that this paragraph does not 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. The procurement of insurance of any type by the commission may not in any way compromise or limit the immunity granted hereunder.

(b) The commission shall defend any member, officer, executive director, employee, and representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or as determined by the commission that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities; provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel at his or her own expense; and provided further that the actual or alleged act, error, or omission did not result

from that person's intentional or willful or wanton misconduct.

(c) The commission shall indemnify and hold harmless any member, officer, executive director, employee, and representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

(d) Nothing herein shall be construed as a limitation on the liability of any licensee for professional malpractice or misconduct, which shall be governed solely by any other applicable state laws.

(e) This compact may not be interpreted to waive or otherwise abrogate a member state's state action immunity or state action affirmative defense with respect to antitrust claims under the Sherman Antitrust Act, Clayton Antitrust Act of 1914, or any other state or federal antitrust or anticompetitive law or regulation.

(f) This compact may not be construed to be a waiver of sovereign immunity by the member states or by the commission.

ARTICLE XI

DATA SYSTEM

(1) The commission shall provide for the development, maintenance, operation, and utilization of a coordinated data system.

(2) The commission shall assign each applicant for a multistate license a unique identifier, as determined by the rules of the commission.

(3) 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 individuals to whom this compact is applicable as required by the rules of the commission, including:

(a) Identifying information.

(b) Licensure data.

(c) Adverse actions against a license and information related thereto.

(d) Nonconfidential information related to alternative program participation, the beginning and ending dates of such participation, and other information related to such participation not made confidential under member state law.

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

(f) The presence of current significant investigative

information.

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

(4) The records and information provided to a member state pursuant to this compact or through the data system, when certified by the commission or an agent thereof, shall constitute the authenticated business records of the commission, and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial, or administrative proceedings in a member state.

(5)(a) Current significant investigative information pertaining to a licensee in any member state will only be available to other member states.

(b) It is the responsibility of the member states to report any adverse action against a licensee and to monitor the database to determine whether adverse action has been taken against a licensee. Adverse action information pertaining to a licensee in any member state will be available to any other member state.

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

(7) Any information submitted to the data system that is subsequently expunged pursuant to federal law or the laws of the

member state contributing the information shall be removed from the data system.

ARTICLE XII

RULEMAKING

(1) The commission shall adopt reasonable rules in order to effectively and efficiently implement and administer the purposes and provisions of the compact. A rule shall be invalid and have no force or effect only if a court of competent jurisdiction holds that the rule is invalid because the commission exercised its rulemaking authority in a manner that is beyond the scope and purposes of the compact, or the powers granted hereunder, or based upon another applicable standard of review.

(2) The rules of the commission shall have the force of law in each member state, provided, however, that if the rules of the commission conflict with the laws of the member state that establish the member state's laws, regulations, and applicable standards that govern the practice of social work as held by a court of competent jurisdiction, the rules of the commission shall be ineffective in that state to the extent of the conflict.

(3) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section and the rules

adopted thereunder. Rules shall become binding on the day following adoption or the date specified in the rule or amendment, whichever is later.

(4) If a majority of the legislatures of the member states rejects a rule or portion of 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, then such rule shall have no further force and effect in any member state.

(5) Rules shall be adopted at a regular or special meeting of the commission.

(6) Before adoption of a proposed rule, the commission shall hold a public hearing and allow persons to provide oral and written comments, data, facts, opinions, and arguments.

(7) Before adoption of a proposed rule by the commission, and at least 30 days in advance of the meeting at which the commission will hold a public hearing on the proposed rule, the commission shall provide a notice of proposed rulemaking:

(a) On the website of the commission or other publicly accessible platform.

(b) To persons who have requested notice of the commission's notices of proposed rulemaking.

(c) In such other way as the commission may by rule specify.

(8) The notice of proposed rulemaking shall include:

(a) The time, date, and location of the public hearing at

which the commission will hear public comments on the proposed rule and, if different, the time, date, and location of the meeting where the commission will consider and vote on the proposed rule.

(b) If the hearing is held via telecommunication, video conference, or other electronic means, the commission shall include the mechanism for access to the hearing in the notice of proposed rulemaking.

(c) The text of the proposed rule and the reason therefor.

(d) A request for comments on the proposed rule from any interested person.

(e) The manner in which interested persons may submit written comments.

(9) All hearings will be recorded. A copy of the recording and all written comments and documents received by the commission in response to the proposed rule shall be available to the public.

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

(11) The commission shall, by majority vote of all members, take final action on the proposed rule based on the rulemaking record and the full text of the rule.

(a) The commission may adopt changes to the proposed rule provided the changes do not enlarge the original purpose of the

proposed rule.

(b) The commission shall provide an explanation of the reasons for substantive changes made to the proposed rule as well as reasons for substantive changes not made that were recommended by commenters.

(c) The commission shall determine a reasonable effective date for the rule. Except for an emergency as provided in subsection (12), the effective date of the rule shall be no sooner than 30 days after issuing the notice that it adopted or amended the rule.

(12) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule with 48 hours' notice, with opportunity to comment, provided that the usual rulemaking procedures provided in the compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, but in no event later than 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to:

(a) Meet an imminent threat to public health, safety, or welfare;

(b) Prevent a loss of commission or member state funds;

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

(d) Protect public health and safety.

(13) The commission or an authorized committee of the commission may direct revisions to a previously adopted rule for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the commission.

(14) No member state's rulemaking requirements shall apply under this compact.

ARTICLE XIII

OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

(1)(a) The executive and judicial branches of state government in each member state shall enforce this compact and take all actions necessary and appropriate to implement the compact.

(b) Except as otherwise provided in this compact, 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 it adopts or consents to participate in alternative dispute resolution proceedings. Nothing herein shall affect or limit the selection or propriety of venue in any action against a licensee for professional malpractice, misconduct, or any such similar matter.

(c) The commission shall be entitled to receive service of process in any proceeding regarding the enforcement or interpretation of the compact and shall have standing to intervene in such a proceeding for all purposes. Failure to provide the commission service of process shall render a judgment or order void as to the commission, this compact, or adopted rules.

(2)(a) If the commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this compact or the adopted rules, the commission shall provide written notice to the defaulting state. The notice of default shall describe the default, the proposed means of curing the default, and any other action that the commission may take, and shall offer training and specific technical assistance regarding the default.

(b) The commission shall provide a copy of the notice of default to the other member states.

(3) 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 delegates of the member states, and all rights, privileges, and benefits conferred on that state by this compact may be 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.

(4) Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the commission to the Governor, the majority and minority leaders of the defaulting state's legislature, the defaulting state's state licensing authority, and each of the member states' licensing authority.

(5) A 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.

(6) Upon the termination of a state's membership from this compact, that state shall immediately provide notice to all licensees within that state of such termination. The terminated state shall continue to recognize all licenses granted pursuant to this compact for a minimum of 6 months after the date of said notice of termination.

(7) The commission may not bear any costs related to a 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 state.

(8) The defaulting 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 shall be awarded all costs of such litigation, including reasonable attorney fees.

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

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

(10)(a) By majority vote as provided by rule, the commission may initiate legal action against a member state in default in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices to enforce compliance with the provisions of the compact and its adopted rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded

all costs of such litigation, including reasonable attorney fees. The remedies herein may not be the exclusive remedies of the commission. The commission may pursue any other remedies available under federal or the defaulting member state's law.

(b) A member state may initiate legal action against the commission in the United States District Court for the District of Columbia or the federal district where the commission has its principal offices to enforce compliance with the provisions of the compact and its adopted rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) Only a member state may enforce this compact against the commission.

ARTICLE XIV

EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

(1) The compact shall come into effect on the date on which the compact statute is enacted into law in the seventh member state.

(2)(a) On or after the effective date of the compact, the commission shall convene and review the enactment of each of the first seven charter member states to determine if the statute

enacted by each such charter member state is materially different than the model compact statute.

1. A charter member state whose enactment is found to be materially different from the model compact statute shall be entitled to the default process set forth in Article XIII.

2. If any member state is later found to be in default, or is terminated or withdraws from the compact, the commission shall remain in existence and the compact shall remain in effect even if the number of member states should be less than seven.

(b) Member states enacting the compact subsequent to the seven initial charter member states shall be subject to the process provided in paragraph (3)(u) of Article X to determine if their enactments are materially different from the model compact statute and whether they qualify for participation in the compact.

(c) All actions taken for the benefit of the commission or in furtherance of the purposes of the administration of the compact prior to the effective date of the compact or the commission coming into existence shall be considered to be actions of the commission unless specifically repudiated by the commission.

(d) Any state that joins the compact subsequent to the commission's initial adoption of the rules and bylaws shall be subject to the rules and bylaws as they exist on the date on which the compact becomes law in that state. Any rule that has

been previously adopted by the commission shall have the full force and effect of law on the day the compact becomes law in that state.

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

(a) A member state's withdrawal may not take effect until 180 days after enactment of the repealing statute.

(b) Withdrawal may not affect the continuing requirement of the withdrawing state's licensing authority to comply with the investigative and adverse action reporting requirements of this compact before the effective date of withdrawal.

(c) Upon the enactment of a statute withdrawing from this compact, a state shall immediately provide notice of such withdrawal to all licensees within that state. Notwithstanding any subsequent statutory enactment to the contrary, such withdrawing state shall continue to recognize all licenses granted pursuant to this compact for a minimum of 180 days after the date of such notice of withdrawal.

(4) This compact does not invalidate or prevent any licensure agreement or other cooperative arrangement between a member state and a nonmember state that does not conflict with the provisions of this compact.

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

states.

ARTICLE XV

CONSTRUCTION AND SEVERABILITY

(1) This compact and the commission's rulemaking authority shall be liberally construed so as to effectuate the purposes and the implementation and administration of the compact. Provisions of the compact expressly authorizing or requiring the adoption of rules may not be construed to limit the commission's rulemaking authority solely for those purposes.

(2) The provisions of this compact shall be severable and if any phrase, clause, sentence, or provision of this compact is held by a court of competent jurisdiction to be contrary to the constitution of any member state, a state seeking participation in the compact, or of the United states, or the applicability thereof to any government, agency, person, or circumstance is held to be unconstitutional by a court of competent jurisdiction, the validity of the remainder of this compact and the applicability thereof to any other government, agency, person, or circumstance may not be affected thereby.

(3) Notwithstanding subsection (2), the commission may deny a state's participation in the compact or, in accordance with the requirements of subsection (2) of Article XIII, terminate a member state's participation in the compact, if it

determines that a constitutional requirement of a member state is a material departure from the compact. Otherwise, if this compact shall be held to be contrary to the constitution of any member state, the compact shall remain 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.

ARTICLE XVI

CONSISTENT EFFECT AND CONFLICT WITH OTHER STATE LAWS

(1) A licensee providing services in a remote state under a multistate authorization to practice shall adhere to the laws and regulations, including laws, regulations, and applicable standards, of the remote state where the client is located at the time care is rendered.

(2) Nothing herein shall prevent or inhibit the enforcement of any other law of a member state that is not inconsistent with the compact.

(3) Any laws, statutes, regulations, or other legal requirements in a member state in conflict with the compact are superseded to the extent of the conflict.

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

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, ~~and~~ any significant investigatory information relating to a psychologist practicing under the Psychology Interjurisdictional Compact to the coordinated licensure information system pursuant to s. 490.0075, and any significant investigatory information relating a clinical social worker practicing under the Social Work Licensure Interstate Compact to the data system pursuant to s. 491.022. 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. If the impaired practitioner is a psychologist practicing under the Psychology Interjurisdictional Compact pursuant to s. 490.0075, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact. If the impaired practitioner is a clinical social worker practicing under the Social Work Licensure Interstate Compact, pursuant to s. 491.022, the terms of the monitoring contract must include the impaired practitioner's withdrawal from all practice under the compact.

Section 4. Subsection (9) 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.—

(9) The board shall appoint an individual to serve as the state's delegate on the Social Work Licensure Interstate Compact Commission as required under s. 491.022.

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

491.005 Licensure by examination.—

(6) EXEMPTIONS ~~EXEMPTION~~.—

(a) 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.

(b) A person licensed as a clinical social worker in another state who is practicing under the Social Worker Licensure Interstate Compact pursuant to s. 491.022, and only within the scope provided therein, is exempt from the licensure requirements of this section, as applicable.

Section 6. Subsection (4) is added to section 491.006, Florida Statutes, to read:

491.006 Licensure or certification by endorsement.—

(4) A person licensed as a clinical social worker in another state who is practicing under the Social Worker Licensure Interstate Compact pursuant to s. 491.022, and only within the scope provided therein, is exempt from the licensure requirements of this section, as applicable.

Section 7. Subsection (1) of section 491.009, Florida Statutes, is amended, and paragraph (c) is added to subsection

(2) of that section, 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, or s. 491.022:

(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 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 who 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)

(c) The board may take adverse action against a clinical social worker's privilege to practice under the Social Worker Licensure Interstate Compact pursuant to s. 491.022, and may impose any of the penalties in s. 456.072(2) if the clinical social worker commits an act specified in subsection (1) or s. 456.072(1).

Section 8. Paragraph (j) is added 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)

(j) For purposes of this section, the individual appointed under s. 491.004(9) as the state's delegate on the Social Work Licensure Compact Commission, pursuant to s. 491.022, and any administrator, officer, executive director, employee, or

representative of the commission, when acting within the scope of his or her employment, duties, or responsibilities in this state, is considered an agent of the state. The commission shall pay any claims or judgments pursuant to this section and may maintain insurance coverage to pay any such claims or judgments.

Section 9. The Department of Health shall notify the Division of Law Revision upon the enactment of the Social Work Licensure Interstate Compact into law by seven states.

Section 10. This act shall take effect upon enactment of the Social Work Licensure Interstate Compact into law by seven states.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 101 Pub. Rec. & Meetings/Social Work Licensure Interstate Compact
SPONSOR(S): Healthcare Regulation Subcommittee, Hunschofsky and others
TIED BILLS: CS/HB 99 **IDEN./SIM. BILLS:** SB 70

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	14 Y, 1 N, As CS	Curry	McElroy
2) Ethics, Elections & Open Government Subcommittee	15 Y, 0 N	Robinson	Toliver
3) Health & Human Services Committee		Curry	Calamas

SUMMARY ANALYSIS

CS/HB 99, with which this bill is linked, authorizes Florida to enter into the Social Work Licensure Interstate Compact (Social Work Compact or compact) by enacting its provisions into Florida law. The Social Work Compact is an interstate compact that facilitates multistate practice of social work both in-person and through telehealth to patients in other compact states. The compact requires member states to submit each social worker's licensure records, including, any adverse actions taken against a social worker's ability to practice, to a coordinated data system. The compact creates the Social Work Licensure Interstate Compact Commission (Commission), which is responsible for creating and enforcing the rules and regulations that administer and govern the compact.

CS/HB 101 creates a public records exemption for a social worker's personal identifying information, other than the name, licensure information, or licensure number, obtained from the data system and held by the Department of Health (DOH) or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling from public record requirements, unless the laws of the state that originally reported the information authorizes disclosure.

The bill allows the Commission to convene in a closed meeting if the meeting is held to receive legal advice or to discuss certain specified items. The bill also creates a public meeting exemption for Commission meetings in which a matter discussed is specifically exempted from disclosure by federal or state statute. The bill provides that any recordings, minutes, and records generated from such a meeting, or portions of such meeting, are also exempt from public record requirements.

The bill provides that the public records and public meeting exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, unless saved from repeal by reenactment by the Legislature. The bill also includes the constitutionally required public necessity statements.

The bill will become effective on the same date as CS/HB 99 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

This bill will have a significant, negative fiscal impact on DOH and no fiscal impact on local governments. *See* Fiscal Analysis.

Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill creates a public record and public meeting exemption; thus, it requires a two-thirds vote for final passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Open Government

The Florida Constitution sets forth the state's public policy regarding access to government records and meetings. Every person is guaranteed a right to inspect or copy any public record of the legislative, executive, and judicial branches of government and all meetings of any collegial public body of a county, municipality, school district, or special district, at which official acts are to be taken or at which public business of such body is to be transacted or discussed, must be open and noticed to the public.[1] The Legislature, however, may provide by general law for an exemption[2] from public record or meeting requirements provided the exemption passes by two-thirds vote of each chamber, states with specificity the public necessity justifying the exemption, and is no broader than necessary to meet its public purpose.[3]

Pursuant to the Open Government Sunset Review Act (OGSR Act),[4] a new public record or meeting exemption or substantial amendment of an existing exemption is repealed on October 2nd of the fifth year following enactment, unless the Legislature reenacts the exemption.[5]

Public Records

The Florida Statutes also address the public policy regarding access to government records, guaranteeing every person a right to inspect and copy any state, county, or municipal record, unless the record is exempt.[6] Furthermore, the OGSR Act provides that a public record exemption may be created, revised, or maintained only if it serves an identifiable public purpose and the Legislature finds that purpose to be "sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption."[7] An identifiable public purpose is served if the exemption meets one of the following purposes:

- Allow the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protect sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety; however, only an individual may be exempted under this provision; or
- Protect trade or business secrets.[8]

Public Meetings

The Florida Statutes also address public policy regarding access to government meetings, further requiring all meetings of any board or commission of any state agency or authority, or of any agency or authority of any county, municipality, or political subdivision, at which official acts are to be taken be open to the public at all times, unless the meeting is exempt.[9] The board or commission must provide

[1] Art. I, s. 24(a) and (b), FLA. CONST.
[2] An "exemption" means a provision of general law which provides that a specified record or meeting, or portion thereof, is not subject to the access requirements of s. 119.07(1), F.S., s. 286.011, or s. 24, Art. I of the State Constitution. *See* s. 119.011(8), F.S.
[3] Art. I, s. 24(c), FLA. CONST.
[4] S. 119.15, F.S.
[5] S. 119.15(3), F.S.
[6] *See* s. 119.01, F.S.
[7] S. 119.15(6)(b), F.S.
[8] *Id.*
[9] S. 286.011(1), F.S.

reasonable notice of all public meetings.[10] Public meetings may not be held at any location that discriminates on the basis of sex, age, race, creed, color, origin, or economic status or that operates in a manner that unreasonably restricts the public's access to the facility.[11] Minutes of a public meeting must be promptly recorded and open to public inspection.[12] Failure to abide by public meeting requirements will invalidate any resolution, rule, or formal action adopted at a meeting.[13] A public officer or member of a governmental entity who violates public meeting requirements is subject to civil and criminal penalties.[14]

Social Work Licensure Interstate Compact

CS/HB 99 authorizes Florida to enter into the Social Work Licensure Interstate Compact (Social Work Compact or compact) by enacting its provisions into Florida law. The Social Work Compact was created to facilitate multistate practice of licensed social work both in-person and through telehealth. The compact is governed by the Social Work Licensure Interstate Compact Commission (Commission), which is responsible for creating and enforcing the rules and regulations that administer and govern the compact.

Under the compact, a multistate license to practice as a regulated social worker is issued by the licensing authority in the applicant's home state and authorizes the social worker to practice in all compact member states. Compact states are required to accept multistate licenses from other compact member states as authorization to practice in each member state. A social worker practicing under the compact practice privileges must comply with the practice laws of the state in which he or she is practicing or where the patient is located.

Under the compact, member states are required to report a social worker's identifying information, licensure data, any adverse actions taken against a social worker's license,[15] nonconfidential information related to the social worker's participation in alternative programs, licensure application denials and the reason for such denials, current significant investigative information, and any other information that may facilitate the administration of the compact or the protection of the public, as determined by Commission rules. A member state may designate information submitted to the data system that may not be shared with the public without the express permission of that member state.[16]

Coordinated Licensure Data System

The compact requires all compact states to share licensee information.[17] To expedite this data-sharing, compact member states must submit a uniform dataset to a coordinated data system on all social workers to whom the compact is applicable. Under the compact, Florida will be sharing information which is not currently exempt from disclosure requirements under s. 119.07(1), F.S. and s. 24(a), Art. 1 of the Florida Constitution, including:[18]

- Identifying information;
- Licensure data;
- Significant investigatory information;
- Adverse actions against a counselor's license;
- Nonconfidential information related to participation in alternative programs;
- Any licensure application denials and reasons for such denial; and

[10] *Id*.
[11] S. 286.011(6), F.S.
[12] S. 286.011(2), F.S.
[13] S. 286.011(1), F.S.
[14] S. 286.011(3), F.S. Penalties include a fine of up to $500 or a second degree misdemeanor.
[15] Adverse action is any disciplinary action that is a matter of public record which is taken by a state's counselor regulatory authority against a counselor's license to practice in that state.
[16] Social Work Licensure Compact Model Legislation, at https://swcompact.org/wp-content/uploads/sites/30/2023/11/Social-Work-Licensure-Compact-Final-PDF.pdf (last visited January 4, 2024).
[17] *Id*.
[18] *Id*.

- Other information, determined by Commission rule, which may facilitate the administration of the compact.

Under the compact, data system information that is expunged according to federal law or the laws of the reporting compact state are removed from the data system.[19]

Commission Meetings

Under the compact, Commission meetings must be open to the public and public notice must be given. However, for the discussion of certain specified topics, the compact does require that the Commission be allowed to conduct closed meetings in certain circumstances. To conduct closed meetings in Florida, a specific exemption from the public meeting requirements under s. 24, Art. I of the State Constitution and s. 286.011, F.S. is needed. Current law does not provide a public meeting exemption for Commission meetings.

Effect of the Bill

CS/HB 101 allows the Commission or the executive committee or other committee of the Commission to convene in a closed meeting if the meeting is held to receive legal advice or if the Commission must discuss certain items including:

- Noncompliance of a compact member state with its obligations under the compact;
- The employment, compensation, discipline, or other matter, practices or procedures related to specific employees;
- Current or threatened discipline of a licensee by the Commission or by a member state's licensing authority;
- 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;
- Trade secrets or commercial or financial information that is privileged or confidential;
- Information of a personal nature if disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Investigative records compiled for law enforcement purposes;
- Information related to any investigative reports prepared by, or on behalf of, or for use of the Commission or other committee charged with the responsibility of investigation or determination of compliance issues pursuant to the compact;
- Matters specifically exempted from disclosure by federal or member state law; or
- Other matters as adopted by the commission by rule.

Additionally, under CS/HB 101 recordings, minutes, and records generated during any portion of an exempt meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

The bill exempts a social worker's personal identifying information, other than the social worker's name, licensure information, or licensure number, obtained from the data system and held by DOH or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling[20] from public records requirements, unless the laws of the state that originally reported the information authorize its disclosure. Disclosure under such circumstance is limited to the extent permitted under the laws of the reporting state.

[19] *Id*.

[20] There is a difference between records the Legislature designates *exempt* from public record requirements and those the Legislature deems *confidential and exempt*. A record classified as exempt from public disclosure may be disclosed under certain circumstances. *See WFTV, Inc. v. Sch. Bd. of Seminole*, 874 So.2d 48, 53 (Fla. 5th DCA 2004), *review denied* 892 So.2d 1015 (Fla. 2004); *City of Rivera Beach v. Barfield*, 642 So.2d 1135 (Fla. 4th DCA 1994); *Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential and exempt from public disclosure, such record may not be released by the custodian of public records to anyone other than the persons or entities specifically designated in statute. *See* Op. Att'y Gen. Fla. 04-09 (2004).

The bill also creates a public meeting exemption for Commission meetings at which the Commission discusses matters specifically exempt from disclosure by state or federal law. Recordings, minutes, and records generated during an exempt portion of a Commission meeting, or portion of a meeting, are also exempt from public disclosure.

Additionally, the bill provides public necessity statements for the public meeting and public record exemptions, as required by the State Constitution. The public necessity statement for the public meeting exemption provides that, without the exemption, the state will be prohibited from becoming a party to the compact and would be unable to effectively and efficiently administer the compact. The public necessity statement for the public record exemption provides that, without the exemption for the recordings, minutes, and records generated during an exempt meeting, the release of such information would negate the public meeting exemption.

The bill provides that the public records and public meeting exemptions are subject to the OGSR Act and will stand repealed on October 2, 2029, unless saved from repeal by reenactment by the Legislature.

The effective date of the bill is the same date that CS/HB 99 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

B. SECTION DIRECTORY:

Section 1: Creates section 491.023, F.S., relating to Social Work Licensure Interstate Compact Commission; public meetings and public records exemptions.
Section 2: Provides public necessity statements as required by the State Constitution.
Section 3: Provides that the bill is effective on the same date as HB 99 (2024) or similar legislation takes effect.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will experience a non-recurring increase in workload associated with updating the License Verification Search Site and data exchange services due to differences in exempt information for current licensees and those practicing under the compact. These costs cannot be absorbed by current budget authority, and the Department will need additional contractual services for set-up costs. Total estimated increase in workload and costs are $116,340 in contracted services.[21]

   Updates to fully integrate the bill are estimated to take six months. This reflects a minimum of 927 initial non-recurring contracted hours at a rate of $120/hr for a total cost of $111,240 ($120/hr x 927) and annual recurring system maintenance costs of $5,100, for a total estimated cost of $116, 340.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[21] DOH, *Agency Bill Analysis*, HB 101 (2023) pgs. 4-5.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

Vote Requirement
Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public record or public meeting exemption. The bill creates a public record and public meeting exemption; thus, it requires a two-thirds vote for final passage.

Public Necessity Statement
Article I, s. 24(c) of the Florida Constitution requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill creates a public record and public meeting exemption; thus, it includes the required public necessity statements. The public necessity statement for the public meeting exemption provides that, without the exemption, the state will be prohibited from becoming a party to the compact and would be unable to effectively and efficiently administer the compact. The public necessity statement for the public record exemption provides that, without the exemption for the recordings, minutes, and records generated during an exempt meeting, the release of such information would negate the public meeting exemption.

Breadth of Exemption
Article I, s. 24(c) of the State Constitution provides that an exemption must be created by general law and the law must contain only exemptions from public record or public meeting requirements. The exemption does not appear to be in conflict with the constitutional requirement.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rule-making or rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The statutory change in the bill does not state that it is exempting certain public meetings from s. 286.011 and s. 24(b), Art. I of the State Constitution. The bill also places a public record exemption in an uncodified section of law, this can be problematic as agencies are required to cite a statute — s. 119.07(1)(e), F.S. — when claiming a public record exemption.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On December 13, 2023, the Healthcare Regulation Subcommittee adopted an amendment and reported the bill favorable. The amendment exempts from public record certain personal identifying information of a social worker and certain closed meeting and closed records requirements of the compact.

This analysis is drafted to the committee substitute as passed by the Healthcare Regulation Subcommittee.

A bill to be entitled

An act relating to public records and meetings; creating s. 491.023, F.S.; providing an exemption from public meetings requirements for certain portions of meetings of the Social Work Licensure Interstate Compact Commission and the executive committee and other committees of the commission; providing an exemption from public records requirements for a regulated social worker's personal identifying information and recordings, minutes, and records generated during exempt meetings or portions thereof; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Section 491.023, Florida Statutes, is created to read:

491.023 Social Work Licensure Interstate Compact Commission; public meetings and public records exemptions.—

(1) The commission or the executive committee or other committees of the commission may convene in a closed, nonpublic meeting to receive legal advice or to discuss:

(a) Noncompliance of a member state with its obligations

under the compact;

(b) The employment, compensation, discipline or other matters, practices, or procedures related to specific employees;

(c) Current or threatened discipline of a licensee by the commission or by a member state's licensing authority;

(d) Current, threatened, or reasonably anticipated litigation;

(e) Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;

(f) Accusing any person of a crime or formally censuring any person;

(g) Trade secrets or commercial or financial information that is privileged or confidential;

(h) Information of a personal nature if disclosure would constitute a clearly unwarranted invasion of personal privacy;

(i) Investigative records compiled for law enforcement purposes;

(j) Information related to any investigative reports prepared by or on behalf of or for use by the commission or the executive committee or other committees of the commission responsible for investigating or determining compliance with the compact;

(k) Matters specifically exempted from disclosure by federal or member state law; or

(l) Other matters as adopted by the commission by rule.

(2) Recordings, minutes, and records generated during any portion of an exempt meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) A social worker's personal identifying information, other than such social worker's name, licensure status, or licensure number, obtained from the data system, as described in Article XI of s. 491.022, Florida Statutes, and held by the Department of Health or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling is exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution unless the state that originally reported the information to the data system authorizes the disclosure of such information by law. If disclosure is so authorized, such information may be disclosed only to the extent authorized by law by the reporting state.

(2) The Legislature finds that it is a public necessity that any meeting of the Social Work Licensure Interstate Compact Commission or the executive committee or other committees of the commission held as provided in s. 491.022, Florida Statutes, in which matters specifically exempted from disclosure by federal or state law are discussed be made exempt from s. 286.011,

Florida Statutes, and s. 24(b), Article I of the State Constitution.

(3) The Social Work Licensure Interstate Compact requires that any portion of a meeting in which any information in this section is discussed be closed to the public. In the absence of a public meetings exemption, this state would be prohibited from becoming a member state of the compact. Thus, this state would be unable to effectively and efficiently administer the compact.

(4) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during any meeting, or any portion of a meeting, that is exempt pursuant to this section be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meetings exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 3. This act shall take effect on the same date that HB 99 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Hunschofsky offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 491.023, Florida Statutes, is created to read:

491.023 Social Work Licensure Interstate Compact; public records and meetings exemptions.—

(1) A social worker's personal identifying information, other than the social worker's name, licensure status, or licensure number, obtained from the data system, as described in Article XI of s. 491.022, and held by the department or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling is exempt from s. 119.07(1) and s.

24(a), Art. I of the State Constitution unless the state that originally reported the information to the data system authorizes the disclosure of such information by law. If disclosure is so authorized, information may be disclosed only to the extent authorized by the law of the reporting state.

(2)(a) A meeting or a portion of a meeting of the Social Work Licensure Interstate Compact Commission or the executive committee or other committee of the commission held as provided in s. 491.022 is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution if the commission or committee needs to receive legal advice or discuss any of the following:

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

2. The employment, compensation, discipline of, or other matters, practices, or procedures related to, specific employees.

3. Current or threatened discipline of a licensee by the commission or by a member state's licensing authority.

4. Current, threatened, or reasonably anticipated litigation.

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

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

7. Trade secrets or commercial or financial information that is privileged or confidential.

8. Information of a personal nature when disclosure would constitute a clearly unwarranted invasion of personal privacy.

9. Investigative records compiled for law enforcement purposes.

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

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

12. Other matters as adopted by commission rule.

(b) The presiding officer of the meeting shall state that the meeting will be closed and reference each relevant exempting provision, which must be recorded in the meeting minutes.

(c) In keeping with the intent of the Social Work Licensure Interstate Compact, recordings, minutes, and records generated during an exempt meeting or portion of such a meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that a social worker's personal identifying information, other than the social worker's name, licensure status, or licensure number, obtained from the data system, as described in Article XI of s. 491.022, Florida Statutes, and held by the Department of Health or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Social Work Licensure Interstate Compact, which a state must adopt in order to become a member state of the compact. Without the public records exemption, this state will be unable to effectively implement and administer the compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting of the Social Work Licensure Interstate Compact Commission or the executive committee or other committee of the commission held as provided in s. 491.022, Florida Statutes, in which matters specifically exempted from disclosure by federal or state law are discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution.

(b) The Social Work Licensure Interstate Compact requires the closure of any meeting, or any portion of a meeting, of the Social Work Licensure Interstate Compact Commission or the

executive committee or other committee of the commission if the presiding officer announces in a public meeting that, in connection with the performance of the commission's duties, the commission must discuss certain sensitive and confidential subject matters. In the absence of a public meeting exemption, this state would be prohibited from becoming a member state of the compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting held as provided in s. 491.022 that is exempt from public meeting requirements be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meetings exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 3. This act shall take effect on the same date that HB 99 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

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

Remove everything before the enacting clause and insert: An act relating to public records and meetings; creating s. 491.023, F.S.; providing an exemption from public records

requirements for certain information held by the Department of Health or the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling pursuant to the Social Work Licensure Interstate Compact; authorizing the disclosure of such information under certain circumstances; providing an exemption from public meetings requirements for certain meetings or portions of certain meetings of the Social Work Licensure Interstate Compact Commission or its executive committee or other committees; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portions of such meetings; providing for future legislative review and repeal of the exemptions; providing statements of public necessity; providing a contingent effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 115 Progressive Supranuclear Palsy and Other Neurodegenerative Diseases Policy Workgroup
SPONSOR(S): Healthcare Regulation Subcommittee, Bankson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 186

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N, As CS	Guzzo	McElroy
2) Health Care Appropriations Subcommittee	11 Y, 0 N	Aderibigbe	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Progressive supranuclear palsy (PSP) is a rare neurodegenerative disease that can severely inhibit an individual's balance and ability to walk, speech and ability to swallow, eye movements and vision, mood and behavior, and cognition. There is no cure for PSP and treatment is limited to managing the signs and symptoms. PSP is not fatal, but complications from PSP often lead to death, usually resulting from pneumonia or a serious fall. PSP worsens over time, so early diagnosis is preferred, however, it shares many symptoms with, and is often misdiagnosed as other neurogenerative diseases, including Parkinson's disease and Alzheimer's disease.

The bill creates the Justo R. Cortes Progressive Supranuclear Palsy Act to require the State Surgeon General to establish a progressive supranuclear palsy and other neurogenerative diseases policy workgroup. The bill tasks the workgroup with identifying PSP incidence and other data, identifying the standard of care for PSP, and developing a risk surveillance system and various policy recommendations, among other tasks.

The bill requires the workgroup to be composed of health care providers, family members or caretakers of patients who have been diagnosed with PSP and other neurogenerative diseases, advocates, and other interested parties and associations. The bill requires the Speaker of the House of Representatives and the President of the Senate to appoint two members each. Further, the bill requires the State Surgeon General to appoint the chair of the workgroup and authorizes the chair to create subcommittees to assist with research, scheduling speakers on important subjects, and drafting a workgroup report and policy recommendations. The bill authorizes meetings of the workgroup to be held via teleconference or other electronic means.

Finally, the bill requires the Department of Health to submit an annual report and a final report with findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by January 4, 2026.

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

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Neurodegenerative Diseases

Neurodegenerative diseases are conditions that gradually destroy parts of the nervous system, especially the brain.[1] These conditions usually develop slowly, and the effects and symptoms tend to appear later in life.[2] Neurodegenerative diseases are permanent and incurable, but many are now treatable, with the goal being to treat the symptoms and slow the progress of these conditions when possible.[3] Neurodegenerative diseases include Alzheimer's disease, Lewy body dementia, Parkinson's disease, amyotrophic lateral sclerosis (also known as Lou Gehrig's disease), and progressive supranuclear palsy.[4]

Progressive Supranuclear Palsy

Progressive supranuclear palsy (PSP) is a neurodegenerative disease that affects an individual's balance and ability to walk, speech, swallowing, eye movements and vision, mood and behavior, and cognition.

PSP is not fatal, but complications from PSP often lead to death.[5] The most common first sign of PSP is trouble with balance, which can lead to abrupt and unexplained falls. A person with PSP will begin to experience eye problems, such as difficulty opening and closing their eyes, blinking, seeing clearly or moving their eyes side to side or up and down, which can also result in falls.[6] Falls causing bone fractures and head trauma are a common cause of death in people with PSP.[7]

Slow or slurred speech and difficulty swallowing are also common in individuals with PSP. The inability to correctly swallow food and liquids can lead to leakage of food into the windpipe, which can result in pneumonia, the most common cause of death in individuals with PSP.[8]

Other symptoms include:[9]

- Depression;
- Lack of motivation;
- Changes in judgement, insight, and problem solving;
- Difficulty finding words;
- Forgetfulness;
- Loss of interest in activities the person used to enjoy;
- Increased irritability;
- Sudden laughing, crying, or angry outbursts for no apparent reason;
- Personality changes;
- Blank stares with raised eyebrows; and

[1] Cleveland Clinic, Neurodegenerative Diseases, available at https://my.clevelandclinic.org/health/diseases/24976-neurodegenerative-diseases (last visited December 5, 2023).
[2] Id.
[3] Id.
[4] Id.
[5] Cleveland Clinic, Progressive Supranuclear Palsy, available at https://my.clevelandclinic.org/health/diseases/6096-progressive-supranuclear-palsy (last visited December 5, 2023).
[6] Id.
[7] Id.
[8] Id.
[9] National Institute of Neurological Disorders and Stroke, Progressive Supranuclear Palsy, available at https://www.ninds.nih.gov/health-information/disorders/progressive-supranuclear-palsy-psp (last visited December 5, 2023).

- Insomnia.

Diagnosis

PSP is considered a rare disorder. It is currently estimated that 10 to 12 people per 100,000 are living with PSP, about 30,000–40,000 in the United States.[10] However, recent autopsy studies indicate PSP is under-diagnosed. These studies found PSP pathology in 2 to 4% of elderly people that had no diagnosis of PSP before death.[11]

Currently, there are several challenges to diagnosing someone in the early stages of PSP. There is no diagnostic laboratory or radiologic test for PSP. Next, PSP shares many symptoms with, and is often misdiagnosed as Parkinson's disease.[12] However, unlike Parkinson's disease, symptoms of PSP typically begin later in life, usually in an individual's late 60s or 70s.[13] PSP also progresses more rapidly than Parkinson's disease.[14] Finally, some patients with PSP present to their health care provider with cognitive impairment and are misdiagnosed with dementia.[15] These patients ultimately develop abnormalities of eye movement, speech, swallowing and gait in a few years.[16] As a result, most patients are diagnosed fairly late in the course of the illness.[17]

Treatment

Currently, there is no treatment that effectively stops or slows the progression of PSP, and symptoms do not respond well to medications.[18]

The cause of PSP is not known, but it is a form of tauopathy, in which abnormal phosphorylation of the protein tau is associated with destruction of vital protein filaments in nerve cells, which is hypothesized to cause the death of nerve cells.[19] Most experimental treatments are aimed at preventing tau pathology.[20]

Executive Branch Adjunct Bodies

Chapter 20, F.S., creates the organizational structure of the Executive Branch of state government, including the creation of certain adjunct bodies to Executive Branch departments, agencies, or offices. Such bodies include committees or task forces, commissions, councils or advisory councils, and coordinating councils.

A committee or task force is an advisory body created without specific statutory enactment for a time not to exceed one year or created by specific statutory enactment for up to three years and appointed to study a specific problem and recommend a solution or policy alternative. Its existence terminates upon the completion of its assignment.[21]

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[10] Cure PSP, Unlocking the Secrets of Brain Disease, available at https://www.psp.org/iwanttolearn/progressive-supranuclear-palsy/ (last visited December 5, 2023).
[11] Kovacs GG, Milenkovic I, Wöhrer A, et al. Non-Alzheimer neurodegenerative pathologies and their combinations are more frequent than commonly believed in the elderly brain: a community-based autopsy series. Acta Neuropathol 2013; 126: 365–84. *See also* Yoshida K, Hata Y, Kinoshita K, Takashima S, Tanaka K, Nishida N. Incipient progressive supranuclear palsy is more common than expected and may comprise clinicopathological subtypes: a forensic autopsy series. Acta Neuropathol. 2017 May;133(5):809-823. doi: 10.1007/s00401-016-1665-7. Epub 2017 Jan 7. PMID: 28064358.
[12] *Supra* note 5.
[13] Mayo Clinic, Diseases and Conditions, Supranuclear Palsy, available at https://www.mayoclinic.org/diseases-conditions/progressive-supranuclear-palsy/symptoms-causes/syc-20355659 (last visited December 5, 2023).
[14] Id.
[15] *Supra* note 9.
[16] Id.
[17] Id.
[18] *Supra* note 11.
[19] *Supra* note 9.
[20] Id.
[21] S. 20.03(5), F.S.

A commission is a body created by specific statutory enactment within a department, the office of the Governor, or the Executive Office of the Governor and exercising limited quasi-legislative or quasi-judicial powers, or both, independently of the head of the department or Governor.[22]

A council or advisory council is an advisory body created by specific statutory enactment and appointed to function on a continuing basis for the study of the problems arising in a specified functional or program area of state government and to provide recommendations and policy alternatives.[23]

A coordinating council is an interdepartmental advisory body created by law to coordinate programs and activities for which one department has primary responsibility but in which one or more other departments have an interest.[24]

Effect of the Bill

The bill creates the Justo R. Cortes Progressive Supranuclear Palsy Act to require the State Surgeon General, to establish a progressive supranuclear palsy and other neurogenerative diseases policy workgroup. For purposes of chapter 20, F.S., the workgroup is considered a committee or task force. The bill tasks the workgroup with:

- Identifying the aggregate number of people in this state who are diagnosed with PSP and other neurogenerative diseases annually;
- Identifying how data is collected regarding diagnoses of PSP and other neurogenerative diseases, and adverse outcomes associated with these conditions;
- Identifying how PSP and other neurogenerative diseases impact the lives of Floridians;
- Identifying the standard of care for PSP and other neurogenerative diseases surveillance, detection, and treatment;
- Identifying emerging treatments, therapies, and research relating to PSP and other neurogenerative diseases;
- Developing a risk surveillance system to help health care providers identify patients who may be at a higher risk of developing PSP and other neurogenerative diseases;
- Developing policy recommendations to help improve patient awareness of PSP and other neurogenerative diseases;
- Developing policy recommendations to help improve surveillance and detection of patients who may be at a higher risk of being diagnosed with PSP and other neurogenerative diseases in licensed health care facilities, including hospitals, nursing homes, assisted living facilities, residential treatment facilities, and ambulatory surgical centers;
- Developing policy recommendations relating to guidelines used that affect the standard of care for patients with PSP and other neurogenerative diseases; and
- Developing policy recommendations relating to providing patients and their families with written notice of increased risks of being diagnosed with PSP and other neurogenerative diseases.

The bill requires the workgroup to be composed of health care providers, family members or caretakers of patients who have been diagnosed with PSP and other neurogenerative diseases, advocates, and other interested parties and associations. The bill requires the Speaker of the House of Representatives and the President of the Senate to appoint two members each. Further, the bill requires the State Surgeon General to appoint the chair of the workgroup and authorizes the chair to create subcommittees to assist with research, scheduling speakers on important subjects, and drafting a workgroup report and policy recommendations. The bill authorizes meetings of the workgroup to be held via teleconference or other electronic means.

Finally, the bill requires the Department of Health (DOH) to submit an annual report and a final report with findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives, by January 4, 2026.

[22] S. 20.03(4), F.S.
[23] S. 20.03(7), F.S.
[24] S. 20.03(6), F.S.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Cites the act as the "Justo R. Cortes Progressive Supranuclear Palsy Act."
Section 2: Creates s. 381.991, F.S., relating to progressive supranuclear palsy and other neurogenerative diseases policy workgroup.
Section 3: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not require rule adoption to implement it.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On December 14, 2023, the Healthcare Regulation Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Required DOH to establish the workgroup instead of AHCA; and
- Required DOH, instead of AHCA, to submit the annual and final reports to the Governor and the Legislature.

This analysis is drafted to the committee substitute as passed by the Healthcare Regulation Subcommittee.

A bill to be entitled

An act relating to a progressive supranuclear palsy and other neurodegenerative diseases policy workgroup; providing a short title; creating s. 381.991, F.S.; requiring the State Surgeon General to establish a progressive supranuclear palsy and other neurodegenerative diseases policy workgroup; providing for duties, membership, and meetings of the workgroup; requiring the State Surgeon General to submit annual reports and a final report by a specified date to the Governor and the Legislature; providing an effective date.

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

Section 1. This act may be cited as the "Justo R. Cortes Progressive Supranuclear Palsy Act."

Section 2. Section 381.991, Florida Statutes, is created to read:

381.991 Progressive supranuclear palsy and other neurodegenerative diseases policy workgroup.—

(1) The State Surgeon General shall establish a progressive supranuclear palsy and other neurodegenerative diseases policy workgroup.

(2) The workgroup shall:

(a) Identify the aggregate number of people in the state diagnosed with progressive supranuclear palsy and other neurodegenerative diseases annually.

(b) Identify how data is collected regarding diagnoses of progressive supranuclear palsy and other neurodegenerative diseases and adverse health outcomes associated with such conditions.

(c) Identify how progressive supranuclear palsy and other neurodegenerative diseases impact the lives of people in the state.

(d) Identify the standard of care for the surveillance, detection, and treatment of progressive supranuclear palsy and other neurodegenerative diseases.

(e) Identify emerging treatments, therapies, and research relating to progressive supranuclear palsy and other neurodegenerative diseases.

(f) Develop a risk surveillance system to help health care providers identify patients who may be at a higher risk of developing progressive supranuclear palsy and other neurodegenerative diseases.

(g) Develop policy recommendations to help improve patient awareness of progressive supranuclear palsy and other neurodegenerative diseases.

(h) Develop policy recommendations to help improve surveillance and detection of patients who may be at a higher

risk of being diagnosed with progressive supranuclear palsy and other neurodegenerative diseases in licensed health care facilities, including hospitals, nursing homes, assisted living facilities, residential treatment facilities, and ambulatory surgical centers.

(i) Develop policy recommendations relating to guidelines that affect the standard of care for patients with progressive supranuclear palsy and other neurodegenerative diseases.

(j) Develop policy recommendations relating to providing patients and their families with written notice of increased risks of being diagnosed with progressive supranuclear palsy and other neurodegenerative diseases.

(3)(a) The workgroup shall be composed of health care providers, family members or caretakers of patients who have been diagnosed with progressive supranuclear palsy and other neurodegenerative diseases, advocates, and other interested parties and associations.

(b) The President of the Senate and the Speaker of the House of Representatives shall each appoint two members to the workgroup.

(c) Members of the workgroup shall serve without compensation.

(d) The State Surgeon General shall appoint the chair of the workgroup.

(e) The chair of the workgroup may create subcommittees to

help conduct research, schedule speakers on important subjects, and draft reports and policy recommendations.

(f) Meetings of the workgroup may be held through teleconference or other electronic means.

(4)(a) The State Surgeon General shall submit an annual report detailing his or her findings and providing recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(b) The State Surgeon General shall submit a final report detailing his or her findings and providing recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 4, 2026.

Section 3. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 197 Health Care Practitioners and Massage Therapy
SPONSOR(S): Health Care Appropriations Subcommittee, Healthcare Regulation Subcommittee, Lopez, V. and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 896

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	18 Y, 0 N, As CS	Osborne	McElroy
2) Health Care Appropriations Subcommittee	11 Y, 0 N, As CS	Aderibigbe	Clark
3) Health & Human Services Committee		Osborne	Calamas

SUMMARY ANALYSIS

The Board of Massage Therapy (Board), within the Department of Health (DOH), regulates massage therapists and massage establishments. Massage practice is the manipulation of the soft tissues of the human body with the hand, foot, knee, arm, or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation or thermal therapy, or any electrical or mechanical device, or the application of a chemical or herbal preparation to the human body. DOH is required to annually inspect massage establishments for compliance with statutory requirements. Under current law, DOH is required to issue an emergency licensure suspension for certain criminal convictions or arrests.

Human trafficking is a form of modern-day slavery involving the transporting, soliciting, recruiting, harboring, providing, enticing, maintaining, or obtaining another person for the purpose of exploiting that person. Illicit Massage Businesses (IMBs) are licensed or unlicensed massage establishments that purport to operate as legal businesses, but where sexual services are illegally bought and sold. IMBs are considered one of the primary venues for sex trafficking involving adults and comprised the largest group of citizen calls to the National Human Trafficking Hotline in 2019. Florida has implemented several statutory measures in an effort to obstruct the operation of IMBs without interfering with legitimate massage establishments.

CS/CS/HB 197 significantly expands the circumstances under which DOH must issue an emergency order suspending the license of a massage therapist or of a massage establishment. The bill requires DOH to issue an emergency suspension of a massage therapist or establishment license if any employee of a massage establishment is arrested for committing or attempting, soliciting, or conspiring to commit certain offenses, including offenses relating to kidnapping, human trafficking, and prostitution.

The bill expressly prohibits any sexual activity within a massage establishment. The bill prohibits advertisement by a massage therapist or establishment from being posted in any medium or website that advertises prostitution, escort, or other sexual services. The bill outlines further requirements for the operation of massage establishments and provides exemptions.

The bill expands the circumstances under which a massage establishment may be declared a public nuisance to include sexual activity and the failure to maintain required records.

The bill appropriates $925,080 in recurring funds and $108,952 in nonrecurring funds from the Medical Quality Assurance Trust Fund to the DOH, for implementation, and has no fiscal impact on local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Massage Therapy

Massage therapy is the manipulation of the soft tissues of the human body with the hand, foot, knee, arm, or elbow, whether or not such manipulation is aided by hydrotherapy, including colonic irrigation or thermal therapy, or any electrical or mechanical device, or the application of a chemical or herbal preparation to the human body.[1] Massage is a therapeutic health care practice and a massage therapist must know anatomy and physiology and understand the relationship between the structure and function of the tissues being treated and the total function of the body.[2]

Chapter 480, F.S., entitled the "Massage Practice Act", governs the practice of massage therapy in Florida. The Board of Massage Therapy (Board), within the Department of Health (DOH), regulates massage practice.[3] The Board is responsible for establishing rules governing the licensure and practice of massage therapists and massage establishments. This includes approving massage therapy schools[4], licensure exams[5], establishing training requirements for massage therapy apprentices[6], as well as setting minimum standards for and conducting periodic inspections of massage establishments.[7] DOH is responsible for providing investigative services to ensure compliance with regulations,[8] while the Board has disciplinary authority over massage therapist and establishment licenses.[9]

Massage Therapist Licensure

A massage therapist is a person who administers massage for compensation.[10] There are approximately 36,178 massage therapists licensed to practice in Florida.[11]

To qualify for licensure as a massage therapist, an applicant must:[12]

- Be at least 18 years of age or have received a high school diploma or graduate equivalency diploma;
- Complete a course of study at a Board-approved massage school;
- Undergo background screening; and
- Pass an examination.[13]

A massage therapist is required to renew his or her license every two years and must complete 24 hours of continuing education for each renewal period.[14]

[1] S. 480.033(3), F.S.
[2] S. 480.032, F.S.
[3] S. 480.035, F.S.
[4] S. 480.033(3), F.S.
[5] S. 480.041(1)(c), F.S.
[6] S. 480.041(5), F.S.
[7] Ss. 480.043(3) and (10), F.S.
[8] S. 480.039, F.S.
[9] S. 480.046, F.S.
[10] S. 480.033(4), F.S.
[11] Department of Health, FLHealthSource.gov, Public Data Portal (search by Board/Council "Board of Massage Therapy", then by Profession "massage therapist", then by license status "practicing statuses only"). Available at https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders, (last visited February 5, 2024).
[12] S. 480.041(1), F.S.
[13] *See* rule 64B7-25.001, F.A.C. for Board approved examinations.
[14] S. 480.0415, F.S., and rule 64B7-28.009, F.A.C.

Massage Establishment Licensure

A massage establishment is the premises wherein a massage therapist practices massage therapy.[15] A massage establishment must be licensed by the Board and adhere to rules set by the Board regarding facilities, personnel, safety and sanitation requirements, financial responsibility, and insurance coverage.[16] Massage establishments must be licensed in order to operate legally.[17] There are approximately 8,966 massage establishments licensed in Florida.[18]

The Board requires the following be met for a license to be issued for a massage establishment:[19]

- Submit a completed application;[20]
- Pass an inspection by DOH;[21] and
- Submit proof of property damage and bodily injury liability insurance coverage.

The application includes background screening of the establishment owner and identification of the designated establishment manager (DEM).[22] Under current law, a DEM must be a licensed massage therapist who holds a clear and active license without restriction. The DEM is responsible for the operation of a massage establishment, and must be designated the manager by the rules or practices at the establishment.[23]

Massage establishment licenses may not be transferred from a licensee to another individual or entity.[24] Board approval is required for an establishment to move locations or change names.[25]

Denial of Massage Establishment Licensure

A proposed massage establishment may be denied licensure for failing to meet the standards adopted by the Board, or if the owner or DEM has been convicted of or plead guilty or nolo contendere for a felony or misdemeanor relating to any of the following offenses:[26] prostitution,[27] kidnapping,[28] false imprisonment,[29] luring or enticing a child,[30] human trafficking or smuggling,[31] sexual battery,[32] female genital mutilation,[33] lewd or lascivious offenses in the presence of a minor, elderly, or disabled person,[34] or obscene or sexual acts involving a minor.[35]

DOH may investigate the proposed massage establishment based on the application contents;[36] if DOH determines that the proposed establishment would fail to meet the standards adopted by the Board, DOH must deny the application for licensure and provide the denial in writing with a list of

[15] S. 480.033(7), F.S.
[16] S. 480.043, F.S.
[17] *Id*.
[18] Department of Health, *Agency Bill Analysis for House Bill 197* (2024). On file with the Health and Human Services Committee.
[19] Rule 64B7-26.002, F.A.C.
[20] *See also*, Board of Massage Therapy, *Application for Massage Establishment License*. Available at https://floridasmassagetherapy.gov/applications/app-bus-original-mt.pdf (last visited November 27, 2023).
[21] The inspection must demonstrate that the proposed massage establishment is to be used for "massage" as defined in Section 480.033(3), F.S. and that the proposed massage establishment is in compliance with Chapters 456 and 480, F.S. and related rules. *See* rule 64B7-26.002, F.A.C.
[22] *Supra*, note 20.
[23] S. 480.033(6), F.S.
[24] S. 480.043(9), F.S.
[25] *Id.*
[26] S. 480.043, F.S.
[27] Ch. 796, F.S.
[28] S. 787.01, FS.
[29] S. 787.02, F.S.
[30] S. 787.025, F.S.
[31] Ss. 787.06 and 787.07, F.S.
[32] S. 794.011, F.S.
[33] S. 794.08, F.S.
[34] Ss. 800.004 and 825.1025(2)(b), F.S.
[35] S. 827.071 and Ch. 847 F.S.
[36] S. 480.043(5), F.S.

reasons for the denial. The establishment may correct the recorded deficiencies and reapply for licensure.[37]

Human Trafficking

Human trafficking is a form of modern-day slavery involving the transporting, soliciting, recruiting, harboring, providing, enticing, maintaining, or obtaining another person for the purpose of exploiting that person.[38] Human trafficking can affect individuals of any age, gender, or nationality; however, some people are more vulnerable than others. Significant risk factors include recent migration or relocation, substance use, mental health concerns, and involvement in the child welfare system.[39]

Victims of human trafficking are often subjected to force, fraud, or coercion for the purpose of sexual exploitation or forced labor.[40] It is estimated that at any given time in 2021, there were approximately 27.6 million people engaging in forced labor.[41] In 2021, the National Human Trafficking Hotline[42] identified 16,710 trafficking victims in the US, of which 1,253 were in Florida;[43] however, these figures do not reflect the true scope and scale of the issue which cannot be easily quantified due to the underground nature of the issue. An analysis of data collected by the Hotline showed that approximately 6% of reported victims in 2021 were associated with illicit massage, health, and beauty services.[44]

Illicit Massage Businesses

Illicit Massage Businesses (IMBs) are licensed or unlicensed[45] massage establishments that purport to operate as legitimate businesses, but where sexual services are illegally bought and sold.[46] IMBs are considered one of the top venues for sex trafficking involving adults and comprised the largest group of citizen calls to the National Human Trafficking Hotline in 2019.[47] In 2018, a study estimated that there were approximately 9,000 IMBs operating in the US;[48] it is expected that his number has risen in the years since.[49] The Collier County Sheriff's Office estimates that there are currently 40 IMBs operating in Collier County.[50]

IMBs are successful in part due to their ability to operate in plain sight. They are often located in strip malls and present themselves publicly as legitimate massage establishments. Markers of an IMB include: opaque or covered windows, locked front doors with a buzzer to enter, listed prices

[37] S. 480.043(6), F.S.
[38] S. 787.06, F.S.
[39] National Human Trafficking Hotline. *Human Trafficking: What Human Trafficking is, and isn't*. Available at https://humantraffickinghotline.org/en/human-trafficking (last visited February 5, 2024).
[40] *Id.*
[41] International Labour Organization, *Global Estimates of Modern Slavery: Forced Labour and Forced Marriage* (2022). Available at https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---ipec/documents/publication/wcms_854733.pdf (last visited February 5, 2024).
[42] The National Human Trafficking Hotline is a free service to connect victims and survivors of sex and labor trafficking with services and supports to find help and safety. The Hotline also receives tips about potential situations of sex and labor trafficking and facilitates reporting that information to the appropriate authorities. *See also*, National Human Trafficking Hotline, *About Us*. Available at https://humantraffickinghotline.org/en/about-us (last visited February 5, 2024).
[43] National Human Trafficking Hotline, *National Statistics (2021)*. Available at https://humantraffickinghotline.org/en/statistics (last visited February 5, 2024).
[44] Polaris, *Analysis of 2021 Data from the National Human Trafficking Hotline*. Available at https://polarisproject.org/wp-content/uploads/2020/07/Polaris-Analysis-of-2021-Data-from-the-National-Human-Trafficking-Hotline.pdf (last visited February 5, 2024).
[45] In fiscal year 2022-23, DOH conducted 169 investigations of unlicensed massage establishments. *See,* Department of Health, Agency Bill Analysis for House Bill 197 (2024), p. 2. On file with the Health and Human Services Committee.
[46] Chin, J. & Takahashi, L. (2022). *Sex for Sale: Illicit Massage Parlors*. 3rd Edition. Routledge. ISBN: 9781003228639
[47] de Vries, I. (2020). Crime, place, and networks in the age of the internet: The case of online-promoted illicit massage businesses. Northeastern University. Available at https://repository.library.northeastern.edu/files/neu:m046sd37z/fulltext.pdf (last visited February 5, 2024).
[48] Polaris, *Human Trafficking in Illicit Massage Businesses* (2018). Available at https://massagetherapy.nv.gov/uploadedFiles/massagetherapy.nv.gov/content/Resources/FullReportHumanTraffickinginIllicitMassageBusinesses.pdf (last visited February 5, 2024).
[49] Det. Sgt. Wade Williams, Collier County Sheriff's Office, *Illicit Massage Businesses Presentation*. On file with the Health and Human Services Committee.
[50] *Id.*

significantly lower than the market value, serves exclusively or primarily male clientele, employees appearing to live on site, and advertising on commercial sex websites.[51]

The majority of people trafficked through IMBs are women of Chinese or South Korean origin who have recently arrived in the US. They are typically 35-55 years of age, have no more than a high school level education, and speak little to no English.[52]

Law Enforcement Response to IMBs

Traditional police techniques for controlling crime have proven to be largely ineffective in reducing the presence of IMBs and their impact on victims of human trafficking. Traditional tactics such as sting operations, undercover work, and reactive investigations are still relied on heavily for addressing human trafficking and IMBs; however, these approaches have been shown to be ineffective in holding traffickers accountable and decreasing the risk of victimization.[53]

Police response to human trafficking has been criticized for not being victim-oriented; few victims of human trafficking are identified by police as they often do not self-identify as victims, fear retribution from their exploiter, and mistrust the authorities.[54] Obtaining a conviction for human trafficking related crimes relies heavily on victim testimony which has proven difficult to obtain in IMB-related cases.[55] As a result very few police actions have resulted in prosecutions for human trafficking, thus signaling very little accountability for traffickers.[56]

Under certain circumstances, IMBs may also be identified as a public nuisance and enjoined.[57] Massage establishments may be declared a public nuisance under current law if they are operating outside of legal hours, serving as a person's principal domicile,[58] or are unable to provide the required identification and licensure documents upon the request of a law enforcement officer or DOH investigator.[59] When such a nuisance exists, the Attorney General, state attorney, city attorney, county attorney, or any citizen of the county where the nuisance exists may bring a nuisance abatement action in the name of the state to enjoin the nuisance, the person maintaining it, and the owner or agent of the premises where the nuisance is located.[60] Such actions may result in a permanent injunction requiring the establishment to cease operation or abate any such nuisance.

Regulatory Response to IMBs

Florida has implemented several regulatory measures intended to obstruct the operation of IMBs without interfering with legitimate massage establishments. These regulations include:

- Massage establishments are not authorized to operate between 12am and 5am;[61]
- Sexual misconduct[62] is expressly prohibited in massage establishments;[63]
- Advertisements must include the license number of the individual massage therapist or establishment being advertised;[64]
- Persons employed in a massage establishment must be able to produce government identification upon request by a DOH or law enforcement investigator;[65] and

[51] *Supra*, note 48.
[52] *Supra*, note 48.
[53] Vries, I. de, & Farrell, A. (2022). *Explaining the Use of Traditional Law Enforcement Responses to Human Trafficking Concerns in Illicit Massage Businesses*. Justice Quarterly, 1-26. doi:10.1080/07418825.2022.2051587
[54] Farrell, A., et al., (2019). *Failing victims? Challenges of the police response to human trafficking*. Criminology & Public Policy, 18: 649– 673. Available at https://onlinelibrary.wiley.com/doi/epdf/10.1111/1745-9133.12456 (last visited February 5, 2024).
[55] *Supra*, note 53.
[56] *Supra*, note 54.
[57] S. 823.05, F.S.
[58] *See*, s. 480.0475, F.S.
[59] *See*, s. 480.0535, F.S.
[60] S. 60.05. F.S.
[61] S. 480.0475, F.S.
[62] Rule 64B7-26.010, F.A.C. specifies that the statutory prohibition of sexual misconduct extends to sexual activity occurring within any massage establishment.
[63] S. 480.0485, F.S.
[64] S. 480.0465, F.S.

- Massage establishments are required to have a set procedure for reporting suspected human trafficking and conspicuously post a sign with the relevant procedures.[66]

Discipline of Massage Therapists and Establishments

The Board has disciplinary authority over massage therapists and massage establishment licenses.[67] The purpose of imposing fines and penalties is to protect the public by assuring compliance with an agency's rules.[68] DOH is required to inspect licensed massage establishments on an annual or more frequent basis. Such inspections include, but are not limited to, assessing whether the establishment is in compliance with the requirements for operation, personnel, safety, sanitation, and insurance coverage.[69] In Fiscal Year 2022-23, there were 8,966 licensed massage establishments in Florida, and DOH completed 9,513 inspections.[70]

Section 456.073, F.S., outlines the process for disciplinary proceedings for professionals licensed under DOH, including massage therapists. Disciplinary proceedings begin when a complaint is filed. DOH investigates complaints for legal sufficiency,[71] and if DOH determines a complaint to be legally sufficient, all investigative findings must be submitted to a panel to be assessed for probable cause.[72] Upon making a finding of probable cause, DOH is required to file a formal complaint, and may choose to prosecute the complaint pursuant to Chapter 120, F.S.[73]

The case may be referred to the Board for a hearing, or to the Division of Administrative Hearings to be heard before an administrative law judge if there are any disputed issues of material fact.[74] A judge may submit a recommended order,[75] but the final determination of whether or not a licensee has violated the laws and rules regulating the profession is a conclusion to be determined by the Board.[76] The Board considers the findings of fact and conclusions of law contained in the formal complaint, reviews the investigative materials, and determines the appropriate penalty for the violation.

The Board has established disciplinary guidelines specifying the range of penalties based upon the severity and repetition of specific offenses.[77] The board is provided some discretion to deviate from disciplinary guidelines based on mitigating or aggravating circumstances.[78] Dependent upon the severity of the massage therapist's or establishment's infraction, the Board may impose any of the following pursuant to the Board's disciplinary guidelines: letter of concern, reprimand, fines, license with conditions, probation, suspension, revocation and/or fines.[79]

Emergency Suspensions

DOH may issue an emergency license suspension, sometimes referred to as a summary suspension, if necessary to protect the public. DOH may issue an emergency suspension, restriction, or limitation on a license if it finds that immediate, serious danger to the public health, safety, or welfare exists. The procedure for issuing an emergency suspension must meet the following criteria:[80]

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[65] S. 480.0535, F.S.
[66] S. 480.043, F.S.
[67] S. 480.046, F.S.
[68] S. 120.695, F.S.
[69] Rule 64B7-26.004, F.A.C.
[70] *Supra*, note 18.
[71] S. 456.073(1), F.S.; a complaint is legally sufficient if it contains ultimate facts that show that a violation of Ch. 456, F.S., of any of the practice acts relating to the professions regulated by the department, or of any rule adopted by the department or a regulatory board in the department has occurred.
[72] S. 456.073(4), F.S.
[73] *Id.*
[74] S. 456.073(5), F.S.
[75] See, s. 120.52, F.S.
[76] *Supra*, note 74
[77] *See* s. 456.079, F.S.
[78] *Id.*
[79] Rule 64B7-30, F.A.C
[80] S. 120.60(6), F.S.

- The procedure provides at least the same procedural protection as is given by other statutes, the State Constitution, or the United States Constitution;
- DOH takes only that action necessary to protect the public interest under the emergency procedure; and
- DOH states in writing at the time of, or prior to, it's specific action the specific facts and reasons for finding an *immediate danger to the public health, safety, or welfare* and its reasons for concluding that the procedure used is fair under the circumstances.

Mandatory Emergency Suspensions

There are two types of emergency actions DOH may take: mandatory and discretionary. Mandatory emergency suspensions are those suspensions the Department is required to take by law, typically for criminal offenses. Discretionary emergency actions are those actions authorized when the Department finds that a licensee poses an immediate serious danger to the public health, safety, or welfare. All emergency actions are subject to appeal; however, discretionary emergency actions are subject to strict judicial review to ensure the order is necessary and only uses the minimum amount of restriction necessary to protect the public.[81]

Mandatory suspension applies to certain criminal convictions and arrests. DOH is required to immediately suspend the license of any health care practitioner who has plead guilty or nolo contendere to or has been *convicted* of the following offenses:[82]

- Felony Medicare or Medicaid fraud under ch. 409, F.S.;
- Felony fraud under ch. 817, F.S.;
- Felony drug offenses under ch. 893, F.S., and equivalent charges under federal law;
- Misdemeanors or felonies under federal law relating to the Medicaid program;
- Felonies under s. 784.086, F.S., relating to reproductive battery;[83] and
- Felonies under ch. 782, F.S., relating to homicide.

DOH is also required to issue an emergency suspension of the license of any health care practitioner, including massage therapists, who has been *arrested* for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of any of the following criminal offenses in this state or similar offenses in another jurisdiction:[84]

- Section 393.135(2), F.S., relating to sexual misconduct with an individual with a developmental disability;
- Section 394.4593(2), F.S., relating to sexual misconduct with a patient who resides in a receiving or treatment facility or is otherwise in the custody of the Department of Children and Families;
- Section 456.52(5)(b), F.S., relating to prescribing, administering, or performing sex-reassignment prescriptions or procedures for a patient younger than 18 years of age;
- Section 787.01, F.S., relating to kidnapping;
- Section 787.02, F.S., relating to false imprisonment;
- Section 787.025(2), F.S., relating to luring or enticing a child;
- Section 787.06(3)(b), (d), (f), or (g), F.S., relating to human trafficking for commercial sexual activity;
- Former s. 787.06(3)(h), F.S., relating to human trafficking of a child under the age of 15 for commercial sexual activity;
- Section 787.07, F.S. relating to human smuggling;
- Section 794.011, F.S., relating to sexual battery, excluding s. 794.011(10);

[81] *Supra*, note 18.
[82] S. 456.074(1), F.S.
[83] *See*, s. 786.086(2), F.S.; reproductive battery refers to a criminal act wherein a health care practitioner intentionally transfers into the body of a patient reproductive material of a donor knowing that the patient has not consented to the use of reproductive material from that donor.
[84] S. 456.074(5), F.S.

- Section 794.05, F.S., relating to unlawful sexual activity with certain minors;
- Section 794.08, F.S., relating to female genital mutilation;
- Former s. 796.03, F.S., relating to procuring a person under the age of 18 for prostitution;
- Former s. 796.035, F.S., relating to the selling or buying of minors into prostitution;
- Section 796.04, F.S., relating to forcing, compelling, or coercing another to become a prostitute;
- Section 796.05, F.S., relating to deriving support from the proceeds of prostitution;
- Section 796.07(4)(a)3., F.S., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, F.S., relating to prohibiting prostitution and related acts;
- Section 800.04, F.S., relating to lewd or lascivious offenses committed upon or in the presence of persons younger than 16 years of age;
- Section 810.145(8), F.S., relating to video voyeurism of a minor;
- Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled person;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 847.011, F.S., relating to prohibited acts in connection with obscene, lewd, and other materials;
- Section 847.012, F.S., relating to materials harmful to minors;
- Section 847.013, F.S., relating to exposing minors to harmful motion pictures, exhibitions, shows, presentations, or representations;
- Section 847.0133, F.S., relating to the protection of minors from obscene materials;
- Section 847.0135, F.S., relating to computer pornography, prohibited computer usage, or traveling to meet minors, excluding s. 847.0135(6);
- Section 847.0137, F.S., relating to the transmission of child pornography by electronic device or equipment;
- Section 847.0138, F.S., relating to the transmission of material harmful to minors to a minor by electronic device or equipment;
- Section 847.0145, F.S., relating to the selling or buying of minors;
- Section 856.022, F.S., relating to loitering or prowling in close proximity to children;
- Section 895.03, F.S, relating to racketeering activity, if the court makes a written finding that the racketeering activity involved at least one sexual offense listed in this subsection or at least one offense listed in this subsection which was committed with sexual intent or motive;
- Section 916.1075(2), F.S., relating to sexual misconduct against a forensic client of a civil or forensic facility for defendants who have a mental illness or an intellectual disability; and
- Section 985.701(1), F.S., relating to sexual misconduct against a juvenile offender.

DOH is required to suspend the license of a massage therapist or establishment when a therapist, or a person with any ownership interest in a massage establishment has pled guilty or nolo contendere to, or has been *convicted* of any offense related to prostitution or related acts under s. 796.07, F.S., or a felony under:[85]

- Section 787.01, F.S., relating to kidnapping;
- Section 787.02, F.S., relating to false imprisonment;
- Section 787.025, F.S., relating to luring or enticing a child;
- Section 787.06, F.S., relating to human trafficking;
- Section 787.07, F.S., relating to human smuggling;
- Section 794.011, F.S., relating to sexual battery;
- Section 794.08, F.S., relating to female genital mutilation;
- Former section 796.03, F.S., relating to procuring a person under the age of 18 for prostitution;
- Former section 796.04, F.S., relating to forcing, compelling, or coercing another to become a prostitute;
- Section 796.05, F.S., relating to deriving support from the proceeds of prostitution;
- Section 796.07(4)(a)3, F.S., relating to a felony of the third degree for a third or subsequent violation of section 796.07, F.S., relating to prohibiting prostitution and related acts;

[85] S. 456.074(4), F.S.

- Section 800.04, F.S., relating to lewd or lascivious offenses committed upon or in the presence of persons less than 16 years of age;
- Section 825.1025(2)(b), F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly or disabled person;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 847.0133, F.S., relating to the protection of minors;
- Section 847.0135, F.S., relating to computer pornography;
- Section 847.0138, F.S., relating to the transmission of material harmful to minors to a minor by electronic device or equipment; and
- Section 847.0145, F.S., relating to the selling or buying of minors.

Under current law, DOH is not authorized issue an emergency suspension of a massage establishment license in response to an *arrest* for the offenses listed above; DOH is required to issue an emergency suspension in response to a conviction to the specified offenses, but not arrests.[86]

Discretionary Emergency Suspensions

Not all cases involving prostitution or sexual misconduct require mandatory emergency suspensions under current law. In instances of a licensee's arrest or conviction for a first or second offense relating to prostitution, DOH is not required to issue an emergency suspension of the individual or establishment's license.[87] For some criminal arrests, DOH must issue an emergency suspension of a massage therapist's license, but not a massage establishment's license. As such, any emergency suspension of a massage establishment's license in response to such an arrest is a discretionary emergency action, rather than mandatory emergency action.[88]

According to DOH, the department's ability to take discretionary emergency action in cases involving prostitution has been limited by the courts. In 2015, the Second District Court of Appeal quashed DOH's emergency order restricting the license of a massage therapist who was arrested for prostitution on two different occasions with two different undercover officers. The Second District Court of Appeal found that the facts in the emergency order did not demonstrate an immediate danger to the public health, safety, or welfare. DOH continues to discipline massage therapists and establishments when there are arrests or convictions for prostitution; however, such discipline is undertaken without first suspending the license because such conduct does not fall within a mandatory emergency action and the Second District Court of Appeal has held that such conduct does not constitute grounds for discretionary emergency action.[89] Thus, massage therapists and establishments may continue to practice or operate throughout the disciplinary process.

Massage establishments are also required to maintain a designated establishment manager (DEM) on file with DOH as a condition of their licensure. DOH is authorized to issue an emergency suspension to an establishment who fails to identify a new DEM within 10 days of terminating the previous DEM.[90]

Under current law, DOH is required to annually report to the Legislature the total number of administrative complaints and description of disciplinary actions taken against health care professionals and establishments licensed and regulated by DOH.[91] Such figures are required to be categorized by profession, but not by the cause for the complaint or disciplinary action, such as sexual misconduct or failure to maintain a DEM.

[86] *Supra*, note 18.
[87] *See*, s. 456.074(4)-(5), F.S.
[88] S. 456.074(5), F.S.
[89] *Supra*, note 18.
[90] S. 480.043(12), F.S.
[91] S. 456.026, F.S. *See also*, Department of Health, Division of Medical Quality Assurance Annual Report and Long-Range Plan (2023). Available at https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/MQAAnnualReport2022-2023.pdf (last visited February 5, 2024).

During Fiscal Year 2022-23, 229 administrative complaints were filed related to massage therapists and massage establishments; of those, 70 related to sexual misconduct.[92] In the same year, DOH issued 20 emergency orders against massage establishments, and 23 emergency orders against individual massage therapists.[93]

Effect of the Bill

Discipline of Massage Therapists and Establishments

The bill expands DOH's reporting requirements regarding massage therapists and establishments. Under current law, DOH must report the number of complaints, investigations, and disciplinary actions taken for all professions regulated by DOH, but is not required to report the reason for such complaint, investigation, or disciplinary action. Under the bill, DOH must separately categorize complaints, investigations, and disciplinary actions against massage therapists and establishments by the specific statutory violations being alleged.

The bill requires DOH investigators to request valid government identification from all employees in the establishment at the time of an inspection. If any employee of a massage establishment is unable to provide a valid form of government identification, the bill requires DOH to notify a federal immigration office.

Emergency Suspensions

The bill significantly broadens the circumstances under which DOH is required to issue an emergency order suspending the license of a massage therapist or massage establishment.

The bill requires DOH to issue an emergency suspension of the license of a massage therapist *and* massage establishment upon the *arrest* of *any* massage establishment employee for committing or attempting, soliciting, or conspiring to commit any offense related to prostitution or related acts under s. 796.07, F.S., or a felony under:[94]

- Section 787.01, F.S., relating to kidnapping;
- Section 787.02, F.S., relating to false imprisonment;
- Section 787.025, F.S., relating to luring or enticing a child;
- Section 787.06, F.S., relating to human trafficking;
- Section 787.07, F.S., relating to human smuggling;
- Section 794.011, F.S., relating to sexual battery;
- Section 794.08, F.S., relating to female genital mutilation;
- Former section 796.03, F.S., relating to procuring a person under the age of 18 for prostitution;
- Former section 796.04, F.S., relating to forcing, compelling, or coercing another to become a prostitute;
- Section 796.05, F.S., relating to deriving support from the proceeds of prostitution;
- Section 796.07(4)(a)3, F.S., relating to a felony of the third degree for a third or subsequent violation of section 796.07, F.S., relating to prohibiting prostitution and related acts;
- Section 800.04, F.S., relating to lewd or lascivious offenses committed upon or in the presence of persons less than 16 years of age;
- Section 825.1025(2)(b), F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly or disabled person;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 847.0133, F.S., relating to the protection of minors;
- Section 847.0135, F.S., relating to computer pornography;
- Section 847.0138, F.S., relating to the transmission of material harmful to minors to a minor by electronic device or equipment; and

[92] *Supra*, note 18.
[93] *Supra*, note 91.
[94] S. 456.074(4), F.S.

- Section 847.0145, F.S., relating to the selling or buying of minors.

This provision broadens the circumstances under which DOH must issue an emergency suspension in three ways. First, it requires that DOH suspend the license of the offending massage therapist *and* the affiliated massage establishment in response to qualifying offenses. Under current law DOH has the discretion to suspend the license of the massage therapist *or* establishment, dependent on the facts of a specific case.

Second, it expands the type of events that constitute grounds for the emergency suspension of a license to include an *arrest*, rather than only a conviction, for committing or attempting, soliciting, or conspiring to commit any of the listed offenses.

Third, it expands the list of persons affiliated with a massage establishment whose actions necessitate an emergency license suspension. The bill requires DOH to issue an emergency suspension upon the arrest or conviction of *any* massage establishment employee for the offenses listed above. The bill specifies that an "employee" of a massage establishment includes independent contractors or lessees of a massage establishment, whose duties involve any aspect of the massage establishment, including preparing meals and cleaning, regardless of whether the employee is compensated for such duties. The term does not include a person who is exclusively engaged in the repair or maintenance of the massage establishment or the delivery of goods to the establishment.

The bill also establishes new grounds for emergency license suspension that broadly applies to health care professionals licensed by DOH in general.[95] The bill requires DOH to issue an emergency order suspending the license of any licensee upon a finding that probable cause exists to believe that the licensee has committed sexual misconduct[96] and that such violation constitutes an immediate danger to the public.

Regulation of Massage Therapists and Establishments

The bill expressly prohibits any sexual *activity* in a massage establishment, as opposed to specifically sexual *misconduct* which is prohibited under current law,[97] and prohibits the use of an establishment to arrange for sexual activity in another location. The bill broadly defines sexual activity to include any direct or indirect contact by any employee or person, or between any employees or persons, with the intent to abuse, humiliate, harass, degrade, or arouse, or gratify the sexual desire of, any employee or person, or which is likely to cause such abuse, humiliation, harassment, degradation, or arousal, or sexual gratification.

The bill requires all employees of a massage establishment to be fully clothed while in the establishment. The bill exempts the employees, except for licensed massage therapists, of nude resort clubs, those public lodging establishments[98] which are chartered with the American Association for Nude Recreation[99] as a clothing-optional establishment, from this requirement.

The bill also adds requirements for massage establishments related to the physical office and recordkeeping. Under the bill, massage establishments are required to:

[95] This requirement pertains to all licensees issued any permit, registration, certificate, or license, including a provisional license, issued by DOH. This includes 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.

[96] *See,* s. 456.063(1), F.S.; Sexual misconduct in the practice of a health care profession means violation of the professional relationship through which the health care practitioner uses such relationship to engage or attempt to engage the patient or client, or an immediate family member, guardian, or representative of the patient or client in, or to induce or attempt to induce such person to engage in, verbal or physical sexual activity outside the scope of the professional practice of such health care profession.

[97] *Id*.

[98] *See*, s. 509.013(4), F.S.; Public lodging establishments include transient and nontransient units/dwellings/buildings which are rented to guests at the frequency and length of stay specified in law.

[99] *See,* the American Association for Nude Recreation – Florida Region website for more information. Available at https://aanr-florida.org/ (last visited February 5, 2024).

- Cover no more than 50 percent of any outside windows into the reception area;
- Ensure that outside windows into the reception area allow for at least 35 percent light penetration;
- Post signage outside of the establishment including the establishment's name, license number, and telephone number as provided to DOH;
- Maintain specified employee records in English or Spanish;
- Conspicuously display 2-inch by 2-inch photos of all employees with licensure information; and
- Maintain complete records in English or Spanish of each service provided, with the full name, address, and telephone number of the patient for at least one year after the provision of the service.

Facilities wherein a licensed acupuncturist, allopathic physician, osteopathic physician, or chiropractic physician employs a massage therapist to perform massage on the practitioner's or physician's patients are exempt from the requirements listed above. The bill also exempts massage establishments within public lodging establishments as defined in s. 509.013(4), F.S., from the requirements relating to window visibility and signage

The bill expands the list of practitioners who may serve as the designated establishment manager (DEM) of a massage establishment to include licensed acupuncturists, allopathic physicians, osteopathic physicians, and chiropractic physicians. Current law requires that the DEM be a licensed massage therapist.

The bill requires all advertisements for a massage therapist or establishment to include the physical address and telephone number of the establishment as provided to DOH. Massage establishments with more than five locations are exempt from this requirement. Massage therapists, establishments, and employees of massage establishments are prohibited from advertising in any medium or website that expressly or implicitly advertises prostitution, escort, or other sexual services. The bill deletes the statutory clause allowing new massage establishments with pending licensure to advertise using the license number of a massage therapist.

The bill expands the circumstances under which a massage establishment may be declared a public nuisance. Under the bill, a massage establishment which has violated the prohibition of sexual activity in a massage establishment or failed to maintain records detailing the services provided may be declared a nuisance and abated or enjoined. When such a nuisance exists, the Attorney General, state attorney, city attorney, county attorney, or any citizen of the county where the nuisance exists may bring a nuisance abatement action in the name of the state to enjoin the nuisance, the person maintaining it, and the owner or agent of the premises where the nuisance is located.

The bill changes quorum of Board of Massage Therapy from four members to a majority of the current membership of the Board. Currently, there are two vacancies on the seven-member board, so three of the five current members would constitute a quorum.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.026, F.S., relating to annual report concerning finances, administrative complaints, disciplinary actions, and recommendations.
Section 2: Amends s. 456.074, F.S., relating to certain health care practitioners; immediate suspension of license.
Section 3: Amends s. 480.033, F.S., relating to definitions.
Section 4: Amends s. 480.035, F.S., relating to the Board of Massage Therapy.
Section 5: Amends s. 480.043, F.S., relating to massage establishments; requisites; licensure; inspection; human trafficking awareness training and policies.
Section 6: Amends s. 480.0465, F.S., relating to advertisement.
Section 7: Amends s. 480.0475, F.S., relating to massage establishments; prohibited practices.

Section 8: Amends s. 480.0535, F.S., relating to documents required while working in a massage establishment.
Section 9: Amends s. 823.05, F.S., relating to places and groups engaged in certain activities declared a nuisance; abatement and enjoinment.
Section 10: Provides an appropriation.
Section 11: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   According to DOH, they will experience a significant increase in workload associated with additional complaints, investigations, and prosecution cases resulting from the provisions of the bill. The bill appropriates eight additional full-time equivalent positions and $925,080 in recurring funds and $108,952 in nonrecurring funds from the Medical Quality Assurance Trust Fund to the DOH to address this additional workload.

   The total annual cost of $1,034,032 consists of the following:[100]

   - Salary - $846,102/Recurring
   - Salary Rate – 593,954 Units of Rate
   - Expense - $71,000/Recurring + $53,272/Non-Recurring
   - Human Resources - $2,878/Recurring
   - Contracted Services - $5,100/Recurring $55,680/Non-Recurring

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Some massage therapy establishments may experience a negative economic impact as a result of operational costs associated with the advertising, signage, record keeping, and facility requirements of the bill.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

[100] Department of Health, *Agency Bill Analysis for House Bill 197* (2024), p. 11. On file with the Health and Human Services Committee.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Board of Massage Therapy has sufficient rulemaking authority under current law to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 18, 2024, the Health Care Appropriations Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment appropriates 8.0 full-time equivalent positions and the associated salary rate and budget to the Department of Health for the implementation of this bill.

This analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.

A bill to be entitled

An act relating to health care practitioners and massage therapy; amending s. 456.026, F.S.; requiring the Department of Health to report specified data; amending s. 456.074, F.S.; authorizing the department to immediately suspend the license of certain health care practitioners and massage establishments in certain circumstances; amending s. 480.033, F.S.; revising and providing definitions; amending s. 480.035, F.S.; revising quorum requirements for the Board of Massage Therapy; amending s. 480.043, F.S.; revising certain rules the board is required to adopt; revising the timeframe in which establishment owners must report specified information to the department; prohibiting sexual activity and certain devices in massage establishments; specifying prohibited conduct by establishment owners and employees; providing requirements for outside windows and signs in massage establishments; providing exceptions; providing employee dress code requirements; requiring establishments to maintain certain employment records in English or Spanish; requiring that specified information be recorded before an employee may provide services or treatment; requiring massage establishments to conspicuously display a photo and

specified information for each employee; requiring that such photos and information be displayed before an employee may provide services or treatment; providing for such requirements in massage establishments within public lodging establishments; requiring massage establishments to maintain customer and patient records for services and treatment provided in the massage establishment in English or Spanish; providing that medical records satisfy certain requirements; requiring massage establishments to maintain such records for a specified timeframe; requiring massage establishments to collect and record specified information; requiring massage establishments to confirm the identification of a customer or patient before providing services or treatment; amending s. 480.0465, F.S.; revising advertising requirements for massage therapists and massage establishments; amending s. 480.0475, F.S.; prohibiting establishments from sheltering or harboring, or being used as sleeping quarters for, any person; amending s. 480.0535, F.S.; requiring Department of Health investigators to request valid government identification from all employees while in a massage establishment; specifying additional documents a person operating a massage establishment

must immediately present, upon request, to department investigators and law enforcement officers; requiring the department to notify a federal immigration office if specified persons fail to provide valid government identification; amending s. 823.05, F.S.; conforming a cross-reference; providing an appropriation; providing an effective date.

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

Section 1. Section 456.026, Florida Statutes, is amended to read:

456.026 Annual report concerning finances, administrative complaints, disciplinary actions, and recommendations.—

(1) The department is directed to prepare and submit a report to the President of the Senate and the Speaker of the House of Representatives by November 1 of each year. In addition to finances and any other information the Legislature may require, the report shall include statistics and relevant information, profession by profession, detailing:

(a) ~~(1)~~ The revenues, expenditures, and cash balances for the prior year, and a review of the adequacy of existing fees.

(b) ~~(2)~~ The number of complaints received and investigated.

(c) ~~(3)~~ The number of findings of probable cause made.

(d) ~~(4)~~ The number of findings of no probable cause made.

(e)~~(5)~~ The number of administrative complaints filed.

(f)~~(6)~~ The disposition of all administrative complaints.

(g)~~(7)~~ A description of disciplinary actions taken.

(h)~~(8)~~ A description of any effort by the department to reduce or otherwise close any investigation or disciplinary proceeding not before the Division of Administrative Hearings under chapter 120 or otherwise not completed within 1 year after the initial filing of a complaint under this chapter.

(i)~~(9)~~ The status of the development and implementation of rules providing for disciplinary guidelines pursuant to s. 456.079.

(j)~~(10)~~ Such recommendations for administrative and statutory changes necessary to facilitate efficient and cost-effective operation of the department and the various boards.

(2) The report shall separately categorize all complaints, investigations, probable cause, and disciplinary actions against a massage therapist or massage establishment licensed under chapter 480 related to a violation of:

(a) Section 480.043(12).

(b) Section 480.043(13).

(c) Section 480.043(14)(a)-(f).

(d) Section 480.0465.

(e) Section 480.0475.

(f) Section 480.0485.

(g) Section 480.0535.

Section 2. Subsection (4) of section 456.074, Florida Statutes, is amended, and subsection (7) is added to that section, to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(4) The department shall issue an emergency order suspending the license of a massage therapist and ~~or~~ establishment as those terms are defined in chapter 480 upon receipt of information that the massage therapist;~~,~~ the designated establishment manager as defined in chapter 480; an employee of the establishment; a person with an ownership interest in the establishment;~~,~~ or, for a corporation that has more than $250,000 of business assets in this state, the owner, officer, or individual directly involved in the management of the establishment has been arrested for committing or attempting, soliciting, or conspiring to commit, or convicted or found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, a violation of s. 796.07 ~~s. 796.07(2)(a) which is reclassified under s. 796.07(7)~~ or a felony offense under any of the following provisions of state law or a similar provision in another jurisdiction:

(a) Section 787.01, relating to kidnapping.

(b) Section 787.02, relating to false imprisonment.

(c) Section 787.025, relating to luring or enticing a child.

(d) Section 787.06, relating to human trafficking.

(e) Section 787.07, relating to human smuggling.

(f) Section 794.011, relating to sexual battery.

(g) Section 794.08, relating to female genital mutilation.

(h) Former s. 796.03, relating to procuring a person under the age of 18 for prostitution.

(i) Former s. 796.035, relating to the selling or buying of minors into prostitution.

(j) Section 796.04, relating to forcing, compelling, or coercing another to become a prostitute.

(k) Section 796.05, relating to deriving support from the proceeds of prostitution.

(l) Section 796.07(4)(a)3., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, relating to prohibiting prostitution and related acts.

(m) Section 800.04, relating to lewd or lascivious offenses committed upon or in the presence of persons less than 16 years of age.

(n) Section 825.1025(2)(b), relating to lewd or lascivious offenses committed upon or in the presence of an elderly or disabled person.

(o) Section 827.071, relating to sexual performance by a child.

(p) Section 847.0133, relating to the protection of minors.

(q) Section 847.0135, relating to computer pornography.

(r) Section 847.0138, relating to the transmission of material harmful to minors to a minor by electronic device or equipment.

(s) Section 847.0145, relating to the selling or buying of minors.

(7) The department shall issue an emergency order suspending the license of any licensee upon a finding of the State Surgeon General that probable cause exists to believe that the licensee has committed sexual misconduct as defined and prohibited in s. 456.063(1), or the applicable practice act, and that such violation constitutes an immediate danger to the public.

Section 3. Subsections (1) through (6) of section 480.033, Florida Statutes, are renumbered as subsections (2) through (7), respectively, subsections (7) through (12), are renumbered as subsections (9) through (14), respectively, present subsection (6) is amended, and new subsections (1), (8), and (15) are added to that section, to read:

480.033 Definitions.—As used in this act:

(1) "Advertising medium" means any newspaper; airwave or computer transmission; telephone directory listing, other than an in-column listing consisting only of a name, physical address, and telephone number; business card; handbill; flyer; sign, other than a building directory listing all building

tenants and their room or suite numbers; or any other form of written or electronic advertisement.

(7) ~~(6)~~ "Designated establishment manager" means a massage therapist who holds a clear and active license without restriction; a health care practitioner licensed under chapter 457; or a physician licensed under chapter 458, chapter 459, or chapter 460, who is responsible for the operation of a massage establishment in accordance with the provisions of this chapter, and who is designated the manager by the rules or practices at the establishment.

(8) "Employee" means any person, including, but not limited to, independent contractors or lessees of a massage establishment, whose duties involve any aspect or capacity of the massage establishment, including, but not limited to, preparing meals and cleaning regardless of whether such person is compensated for the performance of such duties. The term does not include a person who is exclusively engaged in the repair or maintenance of the massage establishment or the delivery of goods to the establishment.

(15) "Sexual activity" means any direct or indirect contact by any employee or person, or between any employees or persons, with the intent to abuse, humiliate, harass, degrade, or arouse, or gratify the sexual desire of, any employee or person, or which is likely to cause such abuse, humiliation, harassment, degradation, or arousal, or sexual gratification:

(a) With or without the consent of the employee or person.

(b) With or without verbal or nonverbal communication that the sexual activity is undesired.

(c) With or without the use of any device or object.

(d) With or without the occurrence of penetration, orgasm, or ejaculation.

(e) Including, but not limited to, intentional contact with the genitalia, groin, femoral triangle, anus, buttocks, gluteal cleft, breast or nipples, mouth, or tongue.

(f) Including, but not limited to, the intentional removal of any drape without specific written informed consent of the patient.

Section 4. Subsection (5) of section 480.035, Florida Statutes, is amended to read:

480.035 Board of Massage Therapy.—

(5) The board shall hold such meetings during the year as it may determine to be necessary, one of which shall be the annual meeting. The chair of the board shall have the authority to call other meetings at her or his discretion. A quorum of the board shall consist of not less than a majority of the current membership of the board ~~four members~~.

Section 5. Subsection (14) of section 480.043, Florida Statutes, is renumbered as subsection (15), subsection (3) and present subsection (14) are amended, and a new subsection (14) is added to that section, to read:

480.043 Massage establishments; requisites; licensure; inspection; human trafficking awareness training and policies.—

(3) The board shall adopt rules governing the operation of massage establishments and their facilities, employees ~~personnel~~, safety and sanitary requirements, financial responsibility, insurance coverage, and the license application and granting process.

(14) In order to provide the department and law enforcement agencies the means to more effectively identify persons engaging in human trafficking at massage establishments, the following apply:

(a) Sexual activity in a massage establishment is prohibited. An establishment owner or employee may not engage in or allow any person to engage in sexual activity in the establishment or use the establishment to make arrangements to engage in sexual activity in another location. Used or unused condoms are prohibited in a massage establishment.

(b) If there is an outside window or windows into the massage establishment's reception area, the outside window or windows must allow for at least 35 percent light penetration and no more than 50 percent of the outside window or windows may be obstructed with signage, blinds, curtains, or other obstructions, allowing the public to see the establishment's reception area. A sign must be posted on the front window of the establishment that includes the name and license number of the

massage establishment and the telephone number that has been provided to the department as part of licensure of the establishment. This paragraph does not apply to:

1. A massage establishment within a public lodging establishment as defined in s. 509.013(4).

2. A massage establishment located within a county or municipality that has an ordinance that prescribes requirements related to business window light penetration or signage limitations if compliance with this paragraph would result in noncompliance with such ordinance.

(c) All employees within the massage establishment must be fully clothed and such clothing must be fully opaque and made of nontransparent material that does not expose the employee's genitalia. This requirement does not apply to an employee, excluding a massage therapist, of a public lodging establishment, as defined in s. 509.013(4), that is licensed as a clothing-optional establishment and chartered with the American Association for Nude Recreation.

(d) A massage establishment must maintain a complete set of legible records in English or Spanish, which must include each employee's start date of employment, full legal name, date of birth, home address, telephone number, and employment position and a copy of the employee's government identification required under s. 480.0535. All information required under this paragraph must be recorded before the employee may provide any

service or treatment to a client or patient.

(e) A massage establishment must conspicuously display a 2 inch by 2 inch photo for each employee, which, for massage therapists, must be attached to the massage therapist's license. Such display must also include the employee's full legal name and employment position. All information required under this paragraph must be displayed before the employee may provide any service or treatment to a client or patient. A massage establishment within a public lodging establishment as defined in s. 509.013(4) may satisfy this requirement by displaying the photos and required information in an employee break room or other room that is used by employees, but is not used by clients or patients.

(f) A massage establishment must maintain a complete set of legible records in English or Spanish, which must include the date, time, and type of service or treatment provided; the full legal name of the employee who provided the service or treatment; and the full legal name, home address, and telephone number of the client or patient. Medical records may satisfy this requirement if the records include the specified information. A copy of the client's or patient's photo identification may be used to provide the full legal name and home address of the client or patient. Records required under this paragraph must be maintained for at least 1 year after a service or treatment is provided. All information required under

this paragraph must be collected and recorded before any service or treatment is provided to a client or patient. The establishment must confirm the identification of the client or patient before any service or treatment is provided to the client or patient.

(15) ~~(14)~~ Except for the requirements of subsection (13), this section does not apply to a practitioner ~~physician~~ licensed under chapter 457 or a physician licensed under~~,~~ chapter 458, chapter 459, or chapter 460 who employs a licensed massage therapist to perform massage therapy on the practitioner's or physician's patients at her or his ~~the physician's~~ place of practice. This subsection does not restrict investigations by the department for violations of chapter 456 or this chapter.

Section 6. Section 480.0465, Florida Statutes, is amended to read:

480.0465 Advertisement; prohibitions.—

(1) Each massage therapist or massage establishment licensed under this act shall include the number of the license in any advertisement of massage therapy services appearing in any advertising medium, including, but not limited to, ~~a~~ newspaper, airwave transmission, telephone directory, Internet, or other advertising medium. The advertisement must also include the physical address of the massage establishment and the telephone number that has been provided to the department as part of the licensing of the establishment. However, the

inclusion of the physical address and telephone number is not required for an advertisement by a massage establishment whose establishment owner operates more than five locations in this state.

(2) A massage therapist, an establishment owner, an employee, or any third party directed by the establishment owner or employee, may not place, publish, or distribute, or cause to be placed, published, or distributed, any advertisement in any advertising medium which states prostitution services, escort services, or sexual services are available.

(3) A massage therapist, an establishment owner, an employee, or any third party directed by the massage therapist, establishment owner, or employee may not place, publish, or distribute, or cause to be placed, published, or distributed, any online advertisement on any website known for advertising prostitution services, escort services, or sexual services.

~~Pending licensure of a new massage establishment under s. 480.043(7), the license number of a licensed massage therapist who is an owner or principal officer of the establishment may be used in lieu of the license number for the establishment.~~

Section 7. Subsection (2) of section 480.0475, Florida Statutes, is amended to read:

480.0475 Massage establishments; prohibited practices.—

(2) A person operating a massage establishment may not use or permit the establishment to be used as a principal or

temporary domicile for, to shelter or harbor, or as sleeping or napping quarters for any person unless the establishment is zoned for residential use under a local ordinance.

Section 8. Section 480.0535, Florida Statutes, is amended to read:

480.0535 Documents required while working in a massage establishment; penalties; reporting.—

(1) In order to provide the department and law enforcement agencies the means to more effectively identify, investigate, and arrest persons engaging in human trafficking, an employee ~~a person employed by a massage establishment~~ and any person performing massage therapy in a massage establishment ~~therein~~ must immediately present, upon the request of an investigator of the department or a law enforcement officer, valid government identification while in the establishment. An investigator of the department must request valid government identification from all employees while in the establishment. A valid government identification for the purposes of this section is:

(a) A valid, unexpired driver license issued by any state, territory, or district of the United States;

(b) A valid, unexpired identification card issued by any state, territory, or district of the United States;

(c) A valid, unexpired United States passport;

(d) A naturalization certificate issued by the United States Department of Homeland Security;

(e) A valid, unexpired alien registration receipt card (green card); or

(f) A valid, unexpired employment authorization card issued by the United States Department of Homeland Security.

(2) A person operating a massage establishment must:

(a) Immediately present, upon the request of an investigator of the department or a law enforcement officer:

1. Valid government identification while in the establishment.

2. A copy of the documentation specified in paragraph (1)(a) for each employee and any person performing massage therapy in the establishment.

3. A copy of the documents required under s. 480.043(14)(d) and (f).

(b) Ensure that each employee and any person performing massage therapy in the massage establishment is able to immediately present, upon the request of an investigator of the department or a law enforcement officer, valid government identification while in the establishment.

(3) A person who violates ~~any provision of~~ this section commits:

(a) For a first violation, a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(b) For a second violation, a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) For a third or subsequent violation, a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) The department shall notify a federal immigration office if a person operating a massage establishment, an employee, or any person performing massage therapy in a massage establishment fails to provide valid government identification as required under this section.

Section 9. Subsection (3) of section 823.05, Florida Statutes, is amended to read:

823.05 Places and groups engaged in certain activities declared a nuisance; abatement and enjoinment.—

(3) A massage establishment as defined in s. 480.033 which operates in violation of s. 480.043(14)(a) or (f), s. 480.0475, or s. 480.0535(2) is declared a nuisance and may be abated or enjoined as provided in ss. 60.05 and 60.06.

Section 10. For the 2024-2025 fiscal year, eight full-time equivalent positions, with associated salary rate of 593,954, are authorized and the sums of $925,080 in recurring and $108,952 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the Department of Health for the purpose of implementing this act.

Section 11. This act shall take effect July 1, 2024.

CS/HB 309

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 309 Rural Emergency Hospitals
SPONSOR(S): Select Committee on Health Innovation, Shoaf
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	11 Y, 0 N, As CS	Lloyd	Calamas
2) Health & Human Services Committee		Lloyd	Calamas

SUMMARY ANALYSIS

Rural hospital closures result in patients having to travel farther for medical care, which delays or reduces their health care access. Since 2020, five rural hospitals in Florida have closed. In response to rural hospital closures, in 2020, Congress created a special Rural Emergency Hospital (REH) licensure provision in Medicare. Once designated as an REH, the facility qualifies for a supplemental monthly payment which is re-calibrated every year based on hospital market basket pricing, as well as a five percent increase over Medicaid rates for outpatient services compared to rates for a general, acute care hospital.

Hospitals, including rural hospitals, are licensed by the Agency for Health Care Administration (AHCA)under Ch. 395, F.S. Current law does not recognize rural emergency hospitals as a licensure category. In addition, under Ch. 395, licensed hospitals must provide inpatient and other non-emergency services; not just emergency services.

CS/HB 309 changes Florida licensure requirements to allow rural hospitals complying with federal REH requirements to be designated as REH hospitals by AHCA. The bill exempts licensed REHs from those requirements applicable to all licensed hospitals but contrary to federal REH standards.
The bill has indeterminate, insignificant negative impact on the state Medicaid program and no fiscal impact on local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Rural Hospitals

More than 60 million Americans live in what is defined as "rural America".[1] As a population, rural residents tend to be sicker and older, therefore needing more health care services. However, access to these services in a rural area can be difficult and often require travel of greater than 20 miles. Since 2020, at least 120 rural hospitals have closed, with the worst year occurring in 2019, when there were 19 rural hospital closures nationwide.[2] Many other hospitals nationally, and some in Florida, are considered "vulnerable" to closure. In Florida, one report identified 10 vulnerable hospitals; and of those, five were considered the "most vulnerable"[3] and the other five were designated as "at risk".[4]

Hospital Licensure

Chapter 395, F.S. and Part II of Chapter 408, F.S., govern licensure of hospitals in Florida, including tasking the Agency for Health Care Administration (AHCA) to provide administrative oversight. Under s. 395.002, F.S., a "hospital" is any establishment that:

> (a) Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and
>
> (b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent, except that a critical access hospital, as defined in s. 408.07, shall not be required to make available treatment facilities for surgery, obstetrical care, or similar services as long as it maintains its critical access hospital designation and shall be required to make such facilities available only if it ceases to be designated as a critical access hospital.[5]

An applicant for a hospital license may apply online or through a hardcopy application, whether seeking initial licensure or renewal or re-activation of a license. However, before AHCA will accept an

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[1] United States Government Accountability Office, *Why Health Care is Harder to Access in Rural America,* available at: Why Health Care Is Harder to Access in Rural America | U.S. GAO (May 16, 2023 Blog) (last visited January 30, 2024). The definition of "rural" varies based on its purpose and which federal or state agency is using the word as a measurement. For hospitals, rural is defined by the Health Resources and Services Administration and means a non-metropolitan county; or a census tract that is a Rural Urban Community Code (RUCA) of 4 or greater; or a census tract in a metropolitan county that is (a) at least 400 square miles, (b) has a population density of 35 or fewer persons per square mile, and (c) has a RUCA code of 2 or 3; or an outlying county in a metropolitan area that does not have an urbanized area. This last criterion was added in 2022, causing several dozen hospitals to be reclassified as rural instead of urban.

[2] The Chartis Center for Rural Health, *The Rural Health Safety Net Under Pressure,* available at https://www.chartis.com/insights/rural-health-safety-net-under-pressure-rural-hospital-vulnerability last visited January 30, 2024).

[3] Id. The report defined the "most vulnerable" group as those hospitals whose median percentage change in total revenue was -1.4 percent, the median occupancy rate was 20,7, the median capital efficiency was -6.3, the percentage of outpatient revenue was 75.9 percent, and the median operating margin was -8.6 percent.

[4] Id. The report defined the "at risk" group as those hospitals have a lower likelihood of closure compared to the most vulnerable group. This group had a median change in total revenue of 1.7 percent, median occupancy 26.9 percent, the median capital efficiency was -1.1 percent, the median percentage of outpatient revenue is 77.6, and the median operating margin was -2.6 percent.

[5] Exceptions include any institution conducted by or for the adherents of any well-recognized church or religious denomination that depends exclusively upon prayer or spiritual means to heal, care for, or treat any person. Additionally, for purposes of local zoning matters, the term "hospital" includes a medical office building located on the same premises as a hospital facility, provided the land on which the medical office building is constructed is zoned for use as a hospital; provided the premises were zoned for hospital purposes on January 1, 1992.

application for initial licensure, an applicant must either have a current project order under review by AHCA's Office of Plans and Construction (OPC) for a new facility.[6]

The OPC reviews the plans to ensure compliance with ch. 395, F.S., including standards for the delivery of the minimum-level of required services and a physical review for the capacity, security and sufficiency of the building itself.[7] In addition to providing this evidence, the applicant organization must also submit financial information. The financial component includes detailed information about management of cash flow, staffing levels and salary costs, anticipated billing hours and billing charges for professional health care services, and expected budgets by department.[8]

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An applicant must identify the hospital's classification from one of four categories:

- Class I is a general hospital category which includes general acute care, long term care, rural hospitals, and a subcategory of rural hospitals, critical access hospitals.
- Class II Hospitals are the Specialty Hospitals for Children and the Specialty Hospitals for Women.
- Class III Specialty Hospitals include the specialty medical, rehabilitation, psychiatric, and substance abuse hospitals.
- Class IV Specialty Hospitals are intensive residential treatment facilities for children and adolescents.[9]

All Class I hospitals are considered general acute care hospitals, and as licensed hospital facilities, are required to have at least:

- Inpatient beds.
- A governing authority legally responsible for the conduct of the hospital.
- A chief executive officer or other similarly titled official to whom the governing authority delegates full-time authority for the operation of the hospital in accordance with the policy of the governing authority.
- An organized medical staff which maintains proper standards of care.
- Maintenance of a complete and accurate medical record for each admitted patient.
- A policy requirement that patients be admitted under the authority and care of a member of the organized medical staff;
- Facilities and staff with ability to provide patients with food that meets patients' nutritional needs.
- Procedures for provisions of emergency care.
- Methods for infection control.
- An ongoing organized program to enhance quality of patient care.[10]

Class I hospitals are also required to have certain professional staff and services either in the facility or by contract to meet patient needs, including access to clinical laboratory, diagnostic, operating room, anesthesia, and pharmaceutical services.[11] Hospitals can also seek exemptions from providing designated services or requirements if they meet certain conditions, such as when a required medical professional is not available in a region and cannot be contracted for coverage in the emergency room or hospital staff, or if a hospital seeks an exemption from the requirement for an emergency department.[12]

Rural Hospital Licensure

One type of Class I is a rural hospital. A rural hospital is an acute care hospital that has 100 or fewer beds and an emergency room, and also meets at least one of the following criteria:

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[6] 59A-3.066, F.A.C., Licensure Procedures.
[7] Agency for Health Care Administration, *Hospital and Outpatient Care Unit, available at Hospitals (myflorida.com) (last visited January 29, 2024).*
[8] Agency for Health Care Administration, *Health Care Policy and Oversight – Licensure and Forms,* Health Care Policy and Oversight Application for Licensure Forms (myflorida.com) (last visited January 29, 2024).)
[9] 59A-3.252, F.A.C., Classification of Hospitals.
[10] Id.
[11] Id.
[12] S. 395.1041, F.S.

- Is the sole provider within a county with a population density of up to 100 persons per square mile;
- Is an acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;
- Is a hospital supported by a tax district or sub-district whose boundaries encompass a population of up to 100 persons per square mile;
- Is a hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;
- Is a hospital with a service area[13] that has a population of up to 100 persons per square mile or
- Is a hospital designated as a critical access hospital, as defined in s. 408.07, F.S.[14]

However, the current definitions and provisions do not allow a rural hospital to seek an exclusion from any of the mandatory elements of being a hospital, such as providing inpatient services.[15]

According to AHCA, there are currently 22 licensed rural hospitals in Florida accounting for 948 licensed beds.[16] Of these,10 are critical access hospitals, and an additional 7 have 50 beds or fewer.[17]

Closure of Rural Hospitals

Rural hospitals face operational challenges due to low patient volumes, which can make it harder to meet fixed operating costs and performance standards, and because many of the patients treated in rural hospitals are older, sicker, and poorer when compared with the national average.[18]

Between 2017 and 2021, nationally, the total number of rural hospitals declined by 75.[19] In 2020 alone, a record number of 19 U.S. rural hospitals shuttered.[20] More than 100 rural hospitals have closed in the past 10 years, and another 400-600 rural hospitals are deemed "at risk" or vulnerable to closure by different health care analysts.[21] The chart below indicates rural hospital closures in Florida since 2000.

[13] The term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital discharge database in the Florida Center for Health Information and Transparency at the agency.
[14] A "critical access hospital" means a hospital that meets the definition of "critical access hospital" in s. 1861(mm)(1) of the Social Security Act and that is certified by the Secretary of Health and Human Services as a critical access hospital.
[15] Agency for Health Care Administration, *2024 Legislative Bill Analysis – HB 309* (November 7, 2023)(on file with Select Committee on Health Innovation).
[16] Id.
[17] Id.
[18] Rural Hospital Closures Threaten Access – Solutions to Preserve Care in Local Communities, The American hospital, September 2022, available at https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-accessreport.pdf (last visited January 30, 2024).
[19] American Hospital Association, *Fast Facts: U.S. Rural Hospitals Infographic, available at* *Fast Facts: U.S. Rural Hospitals Infographic | AHA* (last visited January 30, 2024).
[20] Id.
[21] Center for Healthcare Quality and Reform, *Saving Rural Hospitals,* available at https://ruralhospitals.chqpr.org/ (last visited January 30, 2024). *See also Supra,* n. 3.

Rural Hospital Closures in Florida since 2000[22]		
Hospital	**City**	**Year Closed**
Gadsden Community Hospital	Quincy	2005
Gulf Pines Hospital	Port St Joe	2000
Trinity Community Hospital	Jasper	2008
Campbellton Graceville Hospital	Graceville	2017
Regional General - Williston	Williston	2019
Shands Lake Shore Regional	Starke	2019
Lake City Medical Center Suwanee	Lake City	2020
North Florida Regional Medical Ctr	Starke	2020

In addition to the patient-side issues, rural hospitals also suffer from increased staffing shortages. For instance, only 10 percent of physicians practice in rural areas, despite 20 percent of the population residing in those areas.[23] The COVID-19 pandemic increased the severity of staffing shortages, increased costs, and worsened health outcomes.[24]

Medicare Rural Emergency Hospitals

To respond to a number of rural hospital closures, Congress created a new Medicare provider type, the Rural Emergency Hospital (REH),[25] through the federal Consolidated Appropriations Act of 2021 (Act).[26] Effective January 1, 2023, REH's were eligible for enhanced reimbursements through Medicare.

Recently finalized federal rules further define an REH. An REH is an entity that operates for the purpose of providing emergency department services, observational care, and other outpatient medical and health services specified by the Secretary of the Department of Health and Human Services in which the annual per patient length of stay does not exceed 24 hours.[27] However, the Act and regulations specify that an REH must provide emergency care and observation services, but they may *not* provide inpatient services.[28] Only rural hospitals with 50 or fewer beds and critical access hospitals that were enrolled and certified to participate in Medicare on or before the date of the enactment of the Act (December 27, 2020), qualify for certification as a REH.[29]

To be recognized as an REH, the Act requires the following:

- Compliance with applicable Federal laws and regulations related to the health and safety of patients.
- Assurances that personnel are licensed or meet other applicable standards that are required by state or local laws to provide services within the applicable scope of practice.
- Maintenance of a Medicare provider agreement with the Centers for Medicare and Medicaid Services (CMS) as provided for in 42 CFR s. 485.5 through 42 CFR s. 485.546.
- Have an organized medical staff that operates under bylaws approved by the governing body of the REH and which is responsible for the quality of medical care provided to patients in the REH. The medical staff must be composed of medical or osteopathic doctors, and may include other categories of physicians. Additionally, an REH may supplement the care provided through

[22] Data run from *Saving Rural Hospitals, Data on Rural Hospitals, Size and Financial Status of Rural Hospitals,* (Center for Healthcare Quality and Reform), available at Saving Rural Hospitals - Data on Rural Hospitals (chqpr.org) (last visited January 30, 2024).
[23] *Supra,* note 18.
[24] Id.
[25] 42 U.S.C. s.1395x(kkk).
[26] Pub. Law 116-260 (December 27, 2020).
[27] 42 CFR s, 485.502.
[28] *Supra,* note 30, and Id.
[29] *Rural Emergency Hospitals MLN Fact Sheet (November 2023),* Centers for Medicare and Medicaid Services, available at https://www.cms.gov/files/document/mln2259384-rural-emergency-hospitals.pdf (last visited January 30, 2024).

the use of telemedicine services provided by a distant site hospital as long as the distant-site hospital meets specified requirements.[30]
- Have an organized nursing service that is available to provide 24 hour care to patients of the REH.[31]
- Provide emergency, laboratory, radiological, pharmaceutical, and outpatient medical and other health services as detailed in the rule.[32] The Act specifically excludes inpatient services as a required component.
- Maintain an infection control program and a quality assessment and performance improvement program.[33]

In addition, each REH must be licensed by the state as an REH in which it operates, or approved by the state licensing agency as meeting standards for licensing established by the state.

Any REHs and Critical Access Hospitals that closed or let licenses go inactive since December 27, 2020, would also be eligible to reactivate their CMS Medicare certification after completion of a special review by the Medicare Administrative Contractor and CMS.[34]

An REH is eligible for payment through the Medicare program for services at the amount that would be paid to a hospital providing the equivalent outpatient service, increased by five percent.[35] An REH also receives a supplemental monthly facility payment.[36] Starting October 1, 2023, for CY 2024 the monthly facility payment is $276,233.58.[37] Each year, the supplemental facility payment increases based on the hospital market basket percentage increase.[38] The hospitals are required to maintain detailed information on how these supplemental payments are used.[39]

Currently, Florida rural hospitals are ineligible to become Medicare Rural Emergency Hospitals because Florida law does not include a licensure category or other approval mechanism for REHs. In addition, current law requires licensed hospitals to regularly make available inpatient services, facilities for surgery or obstetrical care clinical laboratory services, and similar services,[40] whereas Medicare prohibits these types of services at REHs.

Effect of Proposed Changes

CS/HB 309 authorizes AHCA to designate eligible rural hospitals and critical access hospitals as REHs, if they meet the federal criteria. This allows these hospitals to qualify for increased reimbursement rates from Medicare and Medicaid for the emergency and outpatient services they provide.

Federal regulations also allow eligible closed rural hospitals to receive enhanced payments if they become re-licensed and meet other requirements. If a rural hospital license is re-activated, AHCA would have to conduct a physical site visit of the location and the building would have to pass a building inspection.

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[30] 42 CFR s. 485.512.
[31] 42 CFR s. 485.530.
[32] 42 CFR s. 485.516 – 485.524.
[33] 42 CFR 485.508.
[34] *Supra,* n. 33.
[35] 42 CFR s. 419.92.
[36] Id.
[37] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, *CMS Manual System, Pub. 100-04, Medicare Claims Processing*; Subject: January 2024 Annual Rural Emergency Hospital (REH) Monthly Facility Payment Amount, https://www.cms.gov/files/document/r12373cp.pdf (last visited January 31, 2024).
[38] *Supra,* note 29. The term "hospital market basket" means all of the components in the overall costs of healthcare used to determine the consumer price index. Produced by the Office of the Chief Actuary at CMS, the calculation measures the change in price, over time, of the same mix of goods and services purchased in the base period. *See also FAQs Market Basket Based Definitions and General Information,* Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group (September 2023) available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/info.pdf (last visited January 30, 2024).
[39] Id.
[40] S. 395.002(12), F.S.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.1041, F.S.; relating to access to and ensurance of emergency services; transfers; patient rights; diversion programs; reports of controlled substance overdoses.
Section 2: Amends s. 395.602, F.S.; relating to rural hospitals.
Section 3: Creates s. 395.607, F.S.; relating to rural emergency hospitals.
Section 4: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill may have an indeterminate, but likely insignificant, impact on Medicaid expenditures due to higher reimbursement rates associated with rural emergency hospitals.

   Medicaid payment for REH services may require FMMIS system programming with an indeterminate insignificant impact that can be absorbed within existing resources.[41]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   To the extent that a rural hospital is supported by local government funds, increased federal reimbursement for the hospital as a REH may offset a portion of those funds.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private hospitals that achieve a REH designation may experience a five percent increase in Medicare reimbursements for certain outpatient services and a monthly supplemental facility payment that is modified each year based on the hospital market basket rate.

A previously closed or inactive licensed entity may be able to reopen with an REH designation.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

[41] *Supra*, n. 15.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rulemaking authority in current law to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 2, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Removed the commercial health insurance mandate and the Medicaid plan contract mandate.
- Authorized AHCA to designate eligible licensed rural hospitals and critical access hospitals as rural emergency hospitals.
- Provided exemptions from current hospital licensure requirements to provide inpatient service, surgical services, and similar services that will not be available in a rural emergency hospital.
- Extended the licensure expiration date for rural hospitals licensed in 2010-2012 from 2025 to 2031.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.

A bill to be entitled

An act relating to rural emergency hospitals; amending s. 395.1041, F.S.; requiring rural emergency hospitals to be subject to certain emergency services requirements for general hospitals; amending s. 395.602, F.S.; deleting obsolete language; creating s. 395.607, F.S.; providing definitions; authorizing certain hospitals to apply to the Agency for Health Care Administration for designation as rural emergency hospitals; establishing requirements for rural emergency hospitals; exempting such hospitals from certain requirements; providing for administrative enforcement; providing an effective date.

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

Section 1. Paragraph (a) of subsection (3) of section 395.1041, Florida Statutes, is amended to read:

395.1041 Access to and ensurance of emergency services; transfers; patient rights; diversion programs; reports of controlled substance overdoses.—

(3) EMERGENCY SERVICES; DISCRIMINATION; LIABILITY OF FACILITY OR HEALTH CARE PERSONNEL.—

(a) Every general hospital which has an emergency department, and every rural emergency hospital, shall provide

emergency services and care for any emergency medical condition when:

1. Any person requests emergency services and care; or

2. Emergency services and care are requested on behalf of a person by:

a. An emergency medical services provider who is rendering care to or transporting the person; or

b. Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

Section 2. Paragraph (b) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

(b) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict

whose boundaries encompass a population of up to 100 persons per square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;

5. A hospital with a service area that has a population of up to 100 persons per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. ~~A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2021, if the hospital continues to have up to 100 licensed beds and an emergency room.~~ An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the

agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2031 ~~2025~~, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 3. Section 395.607, Florida Statutes, is created to read:

395.607 Rural emergency hospitals.—

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

(a) "Rural emergency hospital" means a rural hospital or critical access hospital as defined in s. 408.07 which is designated by the agency under this section.

(b) "Rural emergency services" means services and care that include:

1. Emergency services and care that do not require more than 24 hours on average;

2. Observation care; and

3. At the election of the hospital, outpatient services specified in regulations adopted by the United States Secretary of Health and Human Services.

(2) A qualifying hospital may apply to the agency for designation as a rural emergency hospital on a form adopted by the agency. The agency may designate a hospital as a rural emergency hospital if the hospital demonstrates that it:

(a) Meets the requirements of the Consolidated

Appropriations Act, 2021, Pub. L. No. 116-260, and of the regulations adopted and guidance issued thereunder.

(b) Has no more than 50 beds.

(c) Is able to adequately provide rural emergency services in the facility 24 hours a day, 7 days a week.

(d) Is sufficiently staffed and equipped to provide rural emergency services of the types indicated by the applicant.

(e) Has a transfer agreement in effect with a Level I or Level II trauma center.

(3) A designated rural emergency hospital is exempt from the requirements of s. 395.002 to offer acute inpatient care or care beyond 24 hours or to make available treatment facilities for surgery, obstetrical care, or similar services, and shall be required to make such services available only if the hospital ceases to be designated as a rural emergency hospital.

(4) The agency shall suspend or revoke the rural emergency hospital designation if such a hospital fails at any time to meet the requirements of this section.

Section 4. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 415 Pregnancy and Parenting Resources Website
SPONSOR(S): Health Care Appropriations Subcommittee, Jacques and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 436

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	17 Y, 0 N	Clenord	McElroy
2) Health Care Appropriations Subcommittee	15 Y, 0 N, As CS	Aderibigbe	Clark
3) Health & Human Services Committee		Clenord	Calamas

SUMMARY ANALYSIS

The transition to parenthood can be an overwhelming life event, with more than half of parents reporting feeling inadequately prepared. Florida provides numerous programs and resources to expectant and new families to assist with this transition. The Department of Health (DOH), Department of Children and Families (DCF), and the Agency for Health Care Administration (AHCA) provide information related to a variety of pregnancy and parenting resources on their respective websites. However, unlike other states such as South Dakota, Texas, and North Dakota, Florida does not currently have a comprehensive state website containing information related to available public and private pregnancy and parenting resources.

CS/HB 415 requires DOH, in partnership with DCF and AHCA, to contract with a third-party to create a website that provides information and links to public and private pregnancy and parenting resources. The website must include, at a minimum, information on resources related to:

- Educational materials on pregnancy and parenting;
- Maternal health services;
- Prenatal and postnatal services;
- Educational and mentorship programs for fathers;
- Social services;
- Financial assistance;
- Adoption services.

The bill also requires DOH, DCF, and AHCA to include a clear and conspicuous link to the website on their respective websites. The pregnancy and parenting resources website must be functional by January 1, 2025.

The bill appropriates $466,200 in nonrecurring funds from the Administrative Trust Fund to DOH to implement its provisions, and has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

In 2022, there were 224,403 recorded births in Florida.[1] The transition to parenthood can be an overwhelming life event, with more than half of parents' report feeling inadequately prepared.[2] Florida provides a variety of resources, private and public, that can help expectant families and new parents to assist with this transition. The Department of Health (DOH), Department of Children and Families (DCF) and Agency for Health Care Administration (AHCA) provide information related to pregnancy and parenting resources on their respective websites. Florida does not currently have a comprehensive state website containing information related to available public and private pregnancy and parenting resources.

Department of Health

DOH is the designated agency for administering maternal and child health services.[3] DOH provides the following links related to pregnancy and parenting resources on its website:[4]

- After Pregnancy
- Community Involvement
- Count the Kicks
- Emergency Preparedness for Pregnant Women
- Family Health Line
- Florida Birth Defects Registry
- Florida Pregnancy Support Services Program
- Flu and Pregnancy
- Healthy Start
- High Blood Pressure and Preeclampsia
- Perinatal Hepatitis B
- Preconception Health
- Pregnancy and Diabetes
- Prenatal Care
- Safe Haven for Newborns
- Text4baby
- Tobacco Use in Pregnancy
- Umbilical Cord Blood Banking
- Zika Virus

DOH does not provide an explanation for the content of each of these topics. Instead, a user must explore each one of these items and determine if it contains the information they are seeking. This reduces ease of use and may potentially create confusion for individuals who are not familiar with pregnancy and parenting resources and programs. Additionally, the public and private resources identified in the website are generally limited to the types of services offered by DOH.

Department of Children and Families

[1] FL Health Charts, *Birth Counts Query System*, https://www.flhealthcharts.gov/FLQUERY_New/Birth/Count (last visited January 9, 2024).
[2] National Library of Medicine, *Preparing Parents for Parenthood: Protocol for a randomized controlled Trial of a Preventative Parenting Intervention for Expectant Parents*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6064107/ (last visited Jan. 9, 2024).
[3] S. 383.011 (1), F.S.
[4] Florida Department of Health, *Pregnancy*, https://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/index.html (last visited Jan. 9, 2024).

DCF's mission is to promote strong and economically self-sufficient families and advance personal and family recovery and resiliency.[5] DCF's website provides information on resources available to pregnant women and families related to food and cash assistance, Medicaid eligibility determination and resources for people experiencing homelessness, among other programs. The public and private resources identified in the website are generally limited to the types of services offered by DCF.

Agency for Health Care Administration

AHCA is the chief health policy and planning entity for the state and is responsible for implementation of the Medicaid program.[6] AHCA's website provides resources on the Medicaid program, including reproductive services available to Medicaid recipients. This includes a list of the procedures Medicaid reimburses such as prenatal visits, testing for sexually transmitted diseases, counseling, surgical excision during pregnancy and cesarean section, among others.[7] Similar to the DOH and DCF websites, the information provided on the AHCA website is limited to the types of services and programs that AHCA offers.

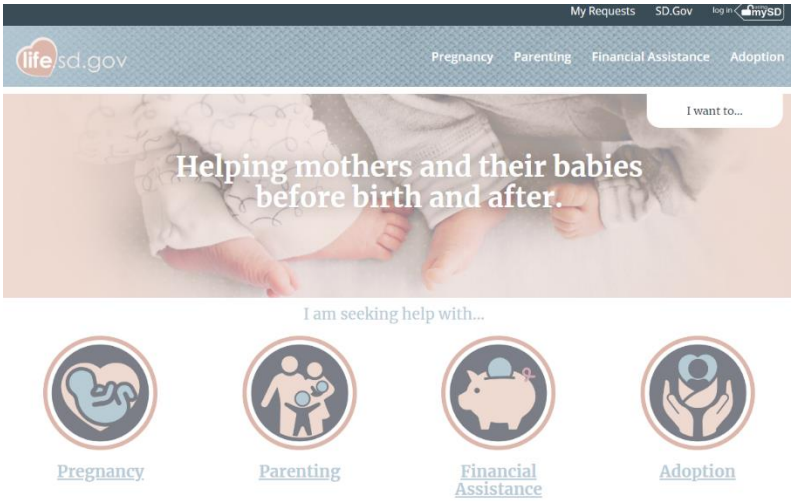
States with Comprehensive Pregnancy and Parenting Resource Websites

Several states have comprehensive pregnancy and parenting resource websites. For example, South Dakota, Texas, and North Dakota have comprehensive pregnancy and parenting resources websites which vary slightly and include:

- South Dakota - pregnancy, parenting, financial assistance, and adoption.[8]
- Texas - pregnancy support, parenting and caregiving, health care and financial assistance, adoption, and services available through Texas state agencies.[9]
- North Dakota - parenting, pregnancy, finance, behavioral health, programs, and locations.[10]

Below is an example of the South Dakota website.

Comprehensive websites may make it easier for expectant and new families to access available resources.



Effect of the Bill

[5] S. 20.19 (1), F.S.
[6] S. 20.42 (3), F.S.
[7] Florida Agency for Health Care Administration, *Reproductive Services*, Reproductive Services (myflorida.com) (last visited Jan. 8, 2024).
[8] SD Life, *Helping Mothers and their Babies Before Birth and After*, SD Life - SD Life (last visited Jan. 8, 2024).
[9] Family Resources, *Resources for Families in all Stages of Life*, https://www.familyresources.texas.gov/ (last visited Jan. 8, 2024)
[10] Life ND, *Welcome to North Dakota's Pregnancy and Parenting Website*, https://www.life.nd.gov/ (last visited Jan. 8, 2024).

CS/HB 415 requires DOH, in partnership with DCF and AHCA, to contract with a third-party to create a comprehensive website that provides information and links to public and private pregnancy and parenting resources. The website must include, at a minimum, information on resources related to:

- Educational materials on pregnancy and parenting;
- Maternal health services;
- Prenatal and postnatal services;
- Educational and mentorship programs for fathers;
- Social services;
- Financial assistance;
- Adoption services.

DOH, DCF, and AHCA must include a clear and conspicuous link to the website on their respective websites. The pregnancy and parenting resources website must be functional by January 1, 2025.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Creates s. 383.0131, F.S., relating to pregnancy and parenting resources website.
Section 2: Provides an appropriation.
Section 3: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH estimates the total cost to comply with the bill is $466,200.[11]

Service	Cost
URL Domain Name	$300
Advance Web Designer	$261,900
Project Management	$194,000
IT Support	$10,000

The bill appropriates $466,200 in nonrecurring funds from the Administrative Trust Fund to DOH to implement this bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[11] Correspondence from DOH to Health Care Regulation Subcommittee staff on file with the Health Care Regulation Subcommittee.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 29, 2024, the Health Care Appropriations Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Appropriated $466,200 in nonrecurring funds from the Administrative Trust Fund to DOH for implementation.

The analysis is drafted to the committee substitute as passed by the Health Care Appropriations Subcommittee.

A bill to be entitled

An act relating to a pregnancy and parenting resources website; creating s. 383.0131, F.S.; requiring the Department of Health, in consultation with the Department of Children and Families and the Agency for Health Care Administration, to maintain a website that provides information and links to certain pregnancy and parenting resources; requiring each department and the agency to provide a clear and conspicuous link to the website on their respective websites; requiring the Department of Health to contract with a third party to develop the website by a specified date; providing an appropriation; providing an effective date.

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

Section 1. Section 383.0131, Florida Statutes, is created to read:

383.0131 Pregnancy and parenting resources website.—

(1) The Department of Health, in consultation with the Department of Children and Families and the Agency for Health Care Administration, shall maintain a website, distinct from their own websites, which provides information and links to public and private resources for expectant families and new

parents, which resources include, but are not limited to:

(a) Educational materials on pregnancy and parenting.

(b) Maternal health services.

(c) Prenatal and postnatal services.

(d) Educational and mentorship programs for fathers.

(e) Social services.

(f) Financial assistance.

(g) Adoption services.

(2) The Department of Health, the Department of Children and Families, and the Agency for Health Care Administration shall include a clear and conspicuous link to the website on their respective websites.

(3) The Department of Health shall contract with a third party for the development of the website, which must be operational by January 1, 2025.

Section 2. For the 2024-2025 fiscal year, the sum of $466,200 in nonrecurring funds is appropriated from the Administrative Trust Fund to the Department of Health for the purpose of implementing the provisions of this act.

Section 3. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 505 Tax Collectors
SPONSOR(S): Local Administration, Federal Affairs & Special Districts Subcommittee, Truenow
TIED BILLS: **IDEN./SIM. BILLS:** SB 958

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Local Administration, Federal Affairs & Special Districts Subcommittee	14 Y, 0 N, As CS	Ray	Darden
2) Health & Human Services Committee		DesRochers	Calamas
3) Appropriations Committee			
4) State Affairs Committee			

SUMMARY ANALYSIS

The Florida Constitution requires the powers, duties, compensation and method of payment of state and county officers to be determined by general law. Current law provides a uniform salary schedule to ensure a fair and equitable payment of officers performing equal duties for the state across different counties. The final salary of county constitutional officers is calculated using a formula that includes a base salary, population adjustment, and variables based on wage growth over time.

Current law prohibits the payment of extra compensation to any public employee in the state for services that have been previously rendered. This provision has been interpreted to include the payment of a bonus to existing employees for services for which they have already performed and been compensated, in the absence of a preexisting employment contract making such bonuses a part of their salary.

Qualifying state employees, veterans, servicemembers, and law enforcement officers are eligible to receive a lump-sum monetary benefit for adopting a child within the child welfare system. This benefit provides a payment of $10,000 for adopting a child classified as difficult to place and $5,000 for other children. Adoption benefits are awarded on a first-come, first-served basis and are subject to appropriation.

CS/HB 505 makes the following revisions to current law concerning tax collectors:

- Increases the base salary used in the formula for calculating tax collector salaries by $5,000;
- Allows tax collector employees to be eligible for a lump-sum monetary benefit for adopting a child on the same terms as qualifying state employees, veterans, and servicemembers;
- Allows tax collectors to budget for and pay a hiring or retention bonus to employees, if the expenditure is approved of by the Department of Revenue or the board of county commissioners; and
- Allows district school boards to contract with the county tax collector to authorize a tax collector employee to administer road test on school grounds.

The bill does not appear to impact state government and may have an insignificant negative fiscal impact on local governments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Compensation of County Officials

The Florida Constitution requires the powers, duties, compensation and method of payment of state and county officers to be determined by general law.[1]

Current law provides a uniform salary schedule to ensure a fair and equitable payment of officers performing equal duties for the state across different counties.[2] The statutory salary schedule applies to all designated officers in all counties, except those officials whose salaries are set by a county charter or officials in a chartered consolidated form of government.[3]

The salary schedule classifies counties in six groups based on population.[4] These groups range from population group I, consisting of counties with less than 50,000 residents, to population group VI, consisting of counties with 1,000,000 or more residents.[5] The salary rate of the official is calculated by adding the base salary for the county's population group to the product of the county's group rate and the number of residents in excess of the minimum for the population group.[6] The current rates for all county officers, except the sheriff, are:

Population Group #	County Population Range		Current Law Base Salary
	Minimum	Maximum	
I	-0-	49,999	$21,250
II	50,000	99,999	$24,400
III	100,000	199,999	$27,550
IV	200,000	399,999	$30,175
V	400,000	999,999	$33,325
VI	1,000,000	N/A	$36,475

The salary paid to each county constitutional officer is determined by the product of the salary rate calculated from the relevant section of ch. 145, F.S., the annual factor,[7] the cumulative annual factor,[8] and the initial factor.[9] The annual factor and the cumulative annual factor are certified each year by the Department of Management Services.[10] Each constitutional officer is eligible for an additional $2,000 per year if that officer meets the certification requirement applicable to the office.[11]

[1] *See* art. II, s. 5(c), Fla. Const. (requiring compensation of county officers to be fixed by law), art. III, s. 11(a)(21), Fla. Const. (prohibiting special acts and general laws of local application on any subject when prohibited by a general law passed by a three-fifths vote of the membership of each house), and s. 145.16, F.S. (prohibiting special laws and general laws of local application for county commissioners, county constitutional officers, school superintendents, and school board members).
[2] S. 145.011(2), F.S.
[3] S. 145.012, F.S.
[4] *See* ss. 145.011 and 145.11, F.S.
[5] *See* s. 145.11(1), F.S.
[6] *See id*.
[7] S. 145.19(1)(a), F.S. The "annual factor" is 1 plus the lessor of the average percentage increase in the salaries of state career service employees for the current fiscal year or seven percent.
[8] S. 145.19(1)(b), F.S. The "cumulative annual factor" of the product of all annual factors prior to the current fiscal year.
[9] S. 145.19(1)(c), F.S. The "initial factor" is 1.292.
[10] S. 145.19(2), F.S.
[11] *See* s. 145.11(2), F.S. (certification requirements for tax collector established by Dept. of Revenue).

In 2023, the Office of Economic and Demographic Research provided the following sample computation for the Alachua County Clerk of Circuit Court, Property Appraiser, Supervisor of Elections, and Tax Collector:[12]

Sample Computation of Salary	
2022 Countywide Population Estimate	287,872
Group Number (IV) Minimum	200,000
Corresponding Base Salary (i.e., Group IV)	$30,175
Corresponding Group Rate (i.e., Group IV)	0.01575
Initial Factor	1.29200
Certified Annual Factor	1.05770
Certified Cumulative Annual Factor	3.90810

Salary = [$30,175 + [(287,872 - 200,000) x 0.01575]] x 1.292 x 1.0577 x 3.9081 = $168,544

Public Employee Bonuses

Current law generally prohibits the payment of extra compensation to any public employee in the state for services that have been previously rendered.[13] Numerous Florida Attorney General opinions have been issued interpreting this prohibition, including one that found a bonus to existing employees for services for which they have already performed and been compensated, in the absence of a preexisting employment contract making such bonuses a part of their salary, violated the prohibition.[14]

Adoption Benefits

A qualifying state employee,[15] veteran,[16] or servicemember[17] who adopts a child within the child welfare system is eligible to receive a lump-sum monetary benefit per child: $10,000 for a child who is classified as difficult-to-place[18] and $5,000 for other children. Law enforcement officers are also eligible for this benefit, except the lump-sums received are $25,000 and $10,000, respectively.[19]

The adoption monetary benefit is limited to one award per adopted child within the child welfare system.[20] Benefits are awarded on a first-come, first-served basis and subject to appropriation.[21] The chart below documents the total number of adoption monetary benefits requested and received:[22]

Child Welfare System Adoption Benefits 2019-2023

[12] Office of Economic and Demographic Research, *Salaries of Elected County Constitutional Officers and School District Officials for Fiscal Year 2023-24*, at 3, at http://edr.state.fl.us/Content/local-government/reports/finsal23.pdf (last visited Jan. 20, 2024).
[13] *See* s. 215.425(1), F.S. (prohibiting extra compensation and providing a list of exceptions).
[14] Op. Att'y Gen. Fla. 91-51(1991).
[15] Qualifying adoptive employee means a full-time or part-time employee of a state agency, a charter school, or the Florida Virtual School who adopts a child within the child welfare system on or after July 1, 2015. Independent contractors do not meet this definition. S. 409.1664(1)(c), F.S.
[16] Veteran means a person who served in the active military, naval, or air service and who was discharged or released under honorable conditions only or who later received an upgraded discharge under honorable conditions, notwithstanding any action by the United States Department of Veterans Affairs on individuals discharged or released with other than honorable discharges. Ss. 1.01(14), 409.1664(1)(f), F.S.
[17] Servicemember means any person serving as a member of the United States Armed Forces on active duty or state active duty and all members of the Florida National Guard and United States Reserve Forces. Ss. 250.01(19), 409.1664(1)(d), F.S.
[18] A difficult-to-place child means a child 1) who DCF or a licensed child-placing agency has permanent custody of, 2) who established a significant emotional ties with his or her foster parents or is not likely to be adopted because he or she is eight years of age or older, developmentally disabled, physical or emotionally handicapped, is a member of a racial group that is disproportionately represented among children in the permanent custody of DCF of a licensed child-placing agency, or is a member of a sibling group, and 3) for whom a reasonable but unsuccessful effort was made to place the child without providing a maintenance subsidy (except when the child is adopted by the child's foster parents or relative caregiver). s. 409.166(2)(d), F.S.
[19] S. 409.1664(2), F.S.
[20] S. 409.1664(2)(b), F.S.
[21] S. 409.1664(2)(c) and (3), F.S.
[22] Emails from the Florida Department of Children and Families on file with the Health & Human Services Committee (Feb. 6-7, 2024).

Fiscal Year	Child Welfare Adoptions	Number of Awards	Awards as a Percent of Child Welfare Adoptions	Appropriations[23]	Expenditures
2019-20	4,548	275	6%	$2,750,000	$2,732,000
2020-21	3,904	263	7%	$2,750,000	$2,674,370
2021-22	3,888	323	8%	$3,233,700	$3,225,000
2022-23	3,602	412	11%	$8,377,470	$4,345,000

The Florida Department of Children and Families (DCF) holds an annual open enrollment period to receive applications for the adoption monetary benefit between the first business day in January and the last business day of March. For multiple adoptions, the applicant must submit a separate application for each child. DCF must review all timely applications and determine who is eligible to receive the benefit. Applications[24] must be processed in the order they were received during the open enrollment period.[25]

Applicants must include in their application packets a certified copy of the final order of adoption naming the applicant as the adoptive parent. While the Chief Financial Officer of DCF transfers the funds to award recipients, not every applicant can apply for the adoption monetary benefit directly to DCF. Current law requires veterans and servicemembers to apply directly to DCF to receive the benefit; however, state employees must apply to their own agency head, state employees at a charter school[26] or the Florida Virtual School[27] must apply to their respective school director, and a law enforcement officer must apply to the Florida Department of Law Enforcement.[28]

When the demand for the adoption benefit exceeds the supply of appropriated funds, denied applicants do not have to submit a new application during the next open enrollment period. Instead, DCF will automatically consider this pool of eligible applicants for future appropriations.[29]

Instruction in Motor Vehicle Operation

Each school district is responsible for providing a course of study and instruction in the safe and lawful operation of a motor vehicle is available to students in secondary schools.[30] The course may use instructional personnel employed by the school district or contract with a commercial driving school or instructor certified under chapter 488.[31] The courses are financed by a $0.50 annual fee charged to each driver as part of the driver license fee.[32]

[23] The general revenue appropriation increased in FY 2022-23 because the state changed the law to make law enforcement officers eligible. All remaining funds not spent each year revert to the Legislature. Email from the Florida Department of Children and Families on file with the Health & Human Services Committee (Feb. 7, 2024).
[24] Florida Department of Children and Families, *CF-FSP 5327 Adoption Benefits For State Employees And Other Eligible Applicants*, (Oct. 21, 2022) https://www.flrules.org/Gateway/reference.asp?No=Ref-14887 (last visited Feb. 7, 2024).
[25] R. 65C-16.021; see s. 409.1664(6), F.S.
[26] All charter schools in Florida are public schools and part of the state's program of public education. s. 1002.33 (1), F.S.
[27] The Florida Virtual School provides online and distance learning education. The school is governed by a board of trustees appointed by the Governor, and the board of trustees is a public agency. Current law advises that all employees except temporary, seasonal, and student employees may be classified as state employees for purposes of benefits. s. 1002.37, F.S.
[28] Ss. 409.1664(3), (7), F.S.
[29] R. 65C-16.021; see s. 409.1664(6), F.S.
[30] S. 1003.48(1), F.S.
[31] S. 1003.48(2), F.S.
[32] S. 1003.48(4), F.s.

Effect of Proposed Changes

Compensation of County Officials and Public Employee Bonuses

CS/HB 505 increases the base salary for tax collectors in each population group by $5,000. If this base salary had been in effect during the 2022-23 fiscal year, the total salary of each county tax collector would have increased by approximately $26,703 relative to current law. The bill authorizes tax collectors, notwithstanding any other law to the contrary, to budget for and pay a hiring or retention bonus to employees if the expenditure is approved of by the Department of Revenue in the respective tax collector's budget or by the board of county commissioners after the budget is submitted to the Department of Revenue.

Adoption Benefits

The bill adds tax collector employees to the list of individuals who may qualify for a lump-sum monetary benefit of $10,000 for adopting a difficult to place child in the welfare system, or $5,000 for other children. The tax collector employee must be domiciled in the state and may only receive the benefit if they adopt the child on or after July 1, 2024. A tax collector employee must apply to the Department of Children and Families to receive the benefit.

It is unknown what the FY 2024-25 appropriation will be to account for the inclusion of tax collectors in the adoption monetary benefit program. When Chapter 2022-23, Laws of Fla., made law enforcement officers eligible for the benefit, the Legislature appropriated more than $8.3 million to the adoption monetary benefit program for FY 2022-23; however, DCF awarded about $4.3 million in benefits to eligible applicants. Therefore, DCF reverted over $4 million to the Legislature at the end of FY 2022-23. While this reversion was disproportionately greater than the average reversion for the preceding three years (about $34,000), the Legislature appropriated sufficient funds to ensure no eligible applicant was denied. It is unknown how many tax collector employees will adopt children from the child welfare system or apply for the adoption benefit.

Instruction in Motor Vehicle Operation

Lastly, the bill allows district school boards to contract with the county tax collector to authorize a tax collector employee to administer road test on school grounds at one or more secondary schools in the district.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 145.11, F.S., relating to tax collector salaries.
Section 2: Amends s. 409.1664, F.S., relating to adoption benefits.
Section 3: Creates s. 445.09, F.S., relating to bonuses for tax collector employees.
Section 4: Amends s. 1003.48, F.S., relating to instruction in operation of motor vehicles.
Section 5: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None. Benefits are awarded on a first-come, first-served basis and subject to appropriation.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

The bill may have an indeterminate negative fiscal impact on counties due to an increase in the base salary rate for tax collectors and the extent to which each county provides bonuses for tax collector employees.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The county/municipality mandates provision of Art. VII, section 18, of the Florida Constitution may apply because this bill increases the salary of tax collectors. However, an exception may apply, as laws having an insignificant fiscal impact are exempt from the requirements of Art. VII, s. 18 of the Florida Constitution.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 25, 2024, the Local Administration, Federal Affairs & Special Districts Subcommittee adopted a proposed committee substitute (PCS) and reported the bill favorably as a committee substitute. The bill removed a provision that would have increased the base salary for school superintendents.

This analysis is drafted to the committee substitute as passed by the Local Administration, Federal Affairs & Special Districts Subcommittee.

A bill to be entitled

An act relating to tax collectors; amending s. 145.11, F.S.; revising tax collector base salaries; amending s. 409.1664, F.S.; defining the term "tax collector employee"; providing that tax collector employees are eligible to receive certain adoption benefits; specifying monetary benefit amounts to be paid under specified conditions; requiring such employees to apply to the Department of Children and Families to obtain the benefit; authorizing the department to adopt specified rules; creating s. 445.09, F.S.; authorizing county tax collectors to budget for and pay hiring and retention bonuses to employees under specified conditions; amending s. 1003.48, F.S.; authorizing a district school board to contract with a county tax collector to authorize a tax collector employee to administer road tests on school grounds at one or more secondary schools within the district; providing an effective date.

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

Section 1. Subsection (1) of section 145.11, Florida Statutes, is amended to read:

145.11 Tax collector.—

(1) Each tax collector shall receive as salary the amount indicated, based on the population of his or her county. In addition, a compensation shall be made for population increments over the minimum for each population group, which shall be determined by multiplying the population in excess of the minimum for the group times the group rate.

Pop. Group	County Pop. Range		Base Salary	Group Rate
	Minimum	Maximum		
I			$26,250 ~~$21,250~~	$0.07875
	-0-	49,999		
II			29,400 ~~24,400~~	0.06300
	50,000	99,999		
III			32,550 ~~27,550~~	0.02625
	100,000	199,999		
IV			35,175 ~~30,175~~	0.01575
	200,000	399,999		
V	400,000	999,999	38,325	0.00525

		~~33,325~~	
VI		41,475	
	1,000,000	~~36,475~~	0.00400

Section 2. Paragraph (f) of subsection (1) of section 409.1664, Florida Statutes, is redesignated as paragraph (g), subsections (2), (3), (4), and (6) are amended, and a new paragraph (f) is added to subsection (1) of that section, to read:

409.1664 Adoption benefits for qualifying adoptive employees of state agencies, veterans, servicemembers, ~~and~~ law enforcement officers, and tax collector employees.—

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

(f) "Tax collector employee" means an employee or a deputy tax collector, provided in s. 197.103, of an office of a county tax collector.

(2) A qualifying adoptive employee, veteran, ~~or~~ servicemember, or tax collector employee who adopts a child within the child welfare system who is difficult to place as described in s. 409.166(2)(d)2. is eligible to receive a lump-sum monetary benefit in the amount of $10,000 per such child, subject to applicable taxes. A law enforcement officer who adopts a child within the child welfare system who is difficult to place as described in s. 409.166(2)(d)2. is eligible to

receive a lump-sum monetary benefit in the amount of $25,000 per such child, subject to applicable taxes. A qualifying adoptive employee, veteran, ~~or~~ servicemember, or tax collector employee who adopts a child within the child welfare system who is not difficult to place as described in s. 409.166(2)(d)2. is eligible to receive a lump-sum monetary benefit in the amount of $5,000 per such child, subject to applicable taxes. A law enforcement officer who adopts a child within the child welfare system who is not difficult to place as described in s. 409.166(2)(d)2. is eligible to receive a lump-sum monetary benefit in the amount of $10,000 per each such child, subject to applicable taxes. A qualifying adoptive employee of a charter school or the Florida Virtual School may retroactively apply for the monetary benefit provided in this subsection if such employee was employed by a charter school or the Florida Virtual School when he or she adopted a child within the child welfare system pursuant to chapter 63 on or after July 1, 2015. A veteran, ~~or~~ servicemember, or tax collector employee may apply for the monetary benefit provided in this subsection if he or she is domiciled in this state and adopts a child within the child welfare system pursuant to chapter 63 on or after July 1, 2020. A law enforcement officer may apply for the monetary benefit provided in this subsection if he or she is domiciled in this state and adopts a child within the child welfare system pursuant to chapter 63 on or after July 1, 2022. A tax collector

employee may apply for the monetary benefit provided in this subsection if he or she is domiciled in this state and adopts a child within the child welfare system under chapter 63 on or after July 1, 2024.

(a) Benefits paid to a qualifying adoptive employee who is a part-time employee must be prorated based on the qualifying adoptive employee's full-time equivalency at the time of applying for the benefits.

(b) Monetary benefits awarded under this subsection are limited to one award per adopted child within the child welfare system.

(c) The payment of a lump-sum monetary benefit for adopting a child within the child welfare system under this section is subject to a specific appropriation to the department for such purpose.

(3) A qualifying adoptive employee must apply to his or her agency head, or to his or her school director in the case of a qualifying adoptive employee of a charter school or the Florida Virtual School, to obtain the monetary benefit provided in subsection (2). A veteran, ~~or~~ servicemember, or tax collector employee must apply to the department to obtain the benefit. A law enforcement officer must apply to the Department of Law Enforcement to obtain the benefit. Applications must be on forms approved by the department and must include a certified copy of the final order of adoption naming the applicant as the adoptive

parent. Monetary benefits shall be approved on a first-come, first-served basis based upon the date that each fully completed application is received by the department.

(4) This section does not preclude a qualifying adoptive employee, veteran, servicemember, tax collector employee, or law enforcement officer from receiving adoption assistance for which he or she may qualify under s. 409.166 or any other statute that provides financial incentives for the adoption of children.

(6) The department may adopt rules to administer this section. The rules may provide for an application process such as, but not limited to, an open enrollment period during which qualifying adoptive employees, veterans, servicemembers, tax collector employees, or law enforcement officers may apply for monetary benefits under this section.

Section 3. Section 445.09, Florida Statutes, is created to read:

445.09 Bonuses for tax collector employees.—Notwithstanding any other law to the contrary, a county tax collector may budget for and pay a hiring or retention bonus to an employee if the expenditure is approved by the Department of Revenue in the respective tax collector's budget or approved by the respective board of county commissioners after the budget is submitted to the Department of Revenue as set forth in s. 195.087(2).

Section 4. Subsection (6) is added to section 1003.48, Florida Statutes, to read:

1003.48 Instruction in operation of motor vehicles.—

(6) The district school board may contract with the county tax collector to authorize a tax collector employee, as defined in s. 409.1664(1), to administer road tests on school grounds at one or more secondary schools within the district.

Section 5. This act shall take effect July 1, 2024.

CS/HB 591

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 591 Hot Car Death Prevention
SPONSOR(S): Children, Families & Seniors Subcommittee, Brannan
TIED BILLS: **IDEN./SIM. BILLS:** SB 554

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	DesRochers	Brazzell
2) Transportation & Modals Subcommittee	14 Y, 0 N	Hinshelwood	Hinshelwood
3) Health & Human Services Committee		DesRochers	Calamas

SUMMARY ANALYSIS

Heatstroke is a debilitating illness characterized by severe hyperthermia, profound central nervous system dysfunction, and additional organ and tissue damage. Vehicular heatstroke occurs when a person experiencing heatstroke cannot escape the vehicle in which the person is trapped.

Since 1998, Florida has lost 110 children to vehicular heatstroke, of which 7 died in 2023. Florida's Uniform Traffic Control Law (ch. 316, F.S.) provides penalties if a child under the age of 6 is left unattended or unsupervised in a motor vehicle. The Florida Department of Highway Safety and Motor Vehicles (FLHSMV) reports that law enforcement cited 1,282 people statewide for leaving a child under the age of 6 unattended or unsupervised from 2012 to 2022.

Any law enforcement officer who observes a child left unattended or unsupervised in a motor vehicle may use whatever means reasonably necessary to protect the minor child and to remove the child from the vehicle. Current law advises a law enforcement officer to attach written notification to the vehicle when the officer removes a child from the immediate area. If the law enforcement officer cannot locate the child's parents, legal guardian, or other person responsible for the child, the officer must deliver physical custody of the child to the Florida Department of Children and Families (DCF) for the purposes of a dependency court shelter hearing. In addition, current law authorizes the general public to rescue a vulnerable person by removing that person from a vehicle.

CS/HB 591 is named "Ariya's Act" in memoriam of 10-month-old Ariya Paige who died of a heatstroke after being left in a vehicle. The bill designates April as "Hot Car Death Prevention Month" to raise the public's awareness of the dangers of leaving children unattended in motor vehicles and to educate the public on how to prevent children from dying of vehicular heatstroke.

The bill encourages DCF, the Florida Department of Health, FLHSMV, local governments, and other agencies to sponsor events that promote awareness on the dangers of leaving a child unattended in a motor vehicle and methods to prevent hot car deaths of children. Specifically, these campaigns must address proper motor vehicle safety for children, the criminal penalties associated with leaving a child in a motor vehicle unattended or unsupervised, and the steps a bystander can take to rescue a vulnerable child in imminent danger.

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

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Vehicular Heatstroke and Child Mortality

Heat illness occurs when the elevation of the core body temperature surpasses the compensatory limits of thermoregulation. Heat illness is the result of environmental heat stress or exertion, or both, and represents a set of conditions that exist along a continuum from less severe (heat exhaustion) to potentially life threatening (heatstroke). [1]

Heatstroke is a debilitating illness characterized clinically by the following conditions:

- Severe hyperthermia (i.e., a core body temperature of 104°F or greater),
- Profound central nervous system dysfunction (e.g., delirium, seizures, or coma), and
- Additional organ and tissue damage.

Even with medical intervention, heatstroke may have lasting effects, including damage to the nervous system and other vital organs and decreased heat tolerance, making an individual more susceptible to subsequent episodes of heat illness. Furthermore, the continued manifestation of multiorgan system dysfunction after heatstroke increases patients' risk of mortality during the ensuing months and years. Multiorgan system failure is the ultimate cause of mortality from heatstroke.[2]

Vehicular heatstroke occurs when a person experiencing heatstroke cannot escape the vehicle in which the person is trapped. Vehicular heatstroke can become fatal when the internal body core temperature reaches 107°F – the point when the body cannot cool itself down. A child's body temperature rises three to five times faster than an adult's body temperature.[3]

Since 1998, 969 children have died nationwide due to vehicular heatstroke: 505 of these children (52.17%) were forgotten by a caregiver, and another 237 children were knowingly left behind by a caregiver (20.66%). More than half of these deaths are children under 2 years of age. Since 1998, Florida has lost 110 children to vehicular heatstroke,[4] 7 of which occurred in 2023.[5]

In July 2023, 10-month-old Ariya Paige of Baker County died after her babysitter left her in a car for five hours during 95-degree weather. The Baker County Sheriff's Office subsequently arrested the babysitter and charged her with aggravated manslaughter of a child in violation of s. 782.07, F.S.[6]

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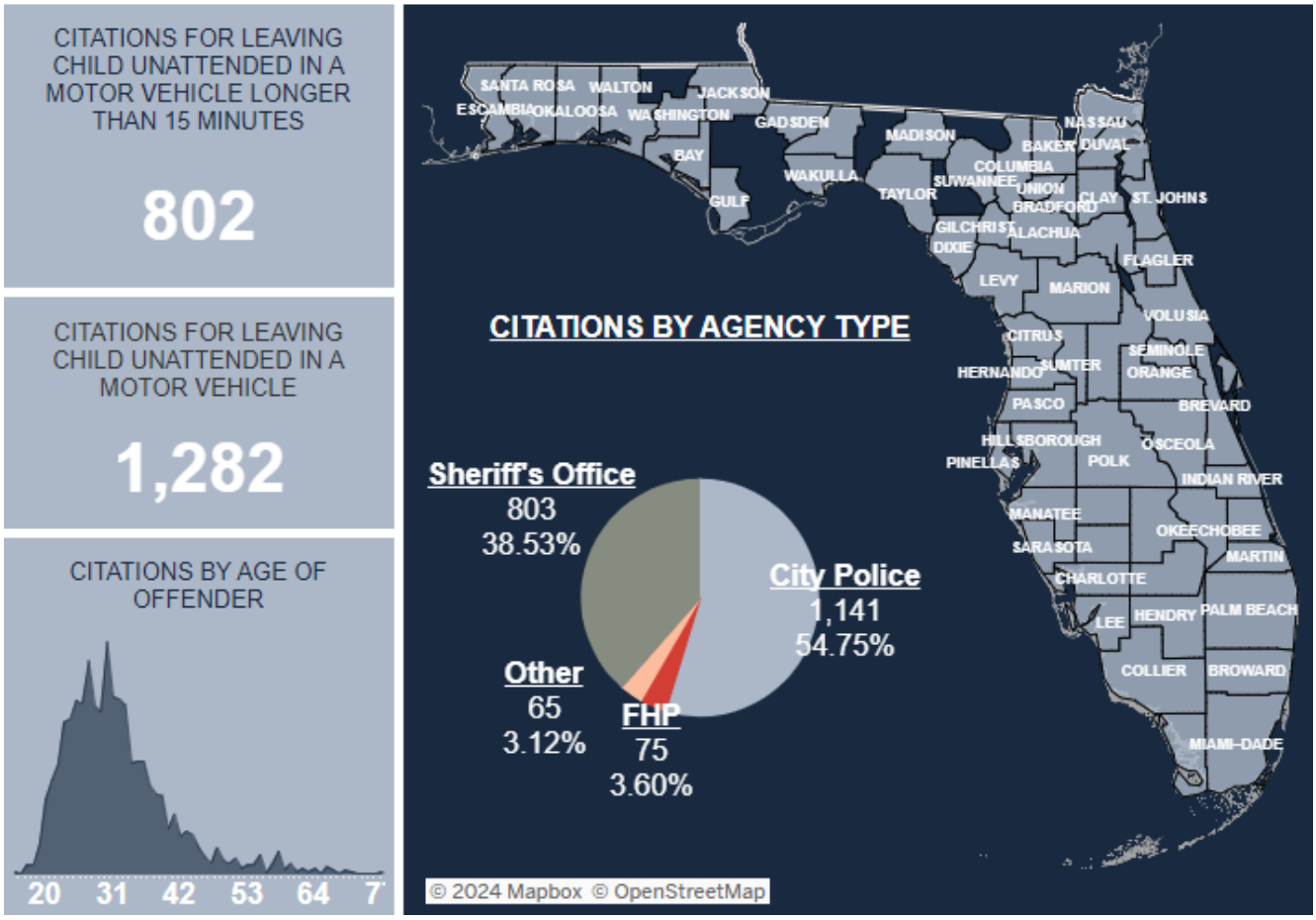
[1] Armed Forces Health Surveillance Division, *Heat Illness, Active Component, U.S. Armed Forces, 2021*, The Military Health System and Defense Health Agency (Apr. 1, 2022) https://health.mil/News/Articles/2022/04/01/Update-Ht-MSMR (last visited Jan. 29, 2024).
[2] *Id*.
[3] National Highway Traffic Safety Administration, *Child Heatstroke Prevention: Prevent Hot Car Deaths*, U.S. Department of Transportation, https://www.nhtsa.gov/campaign/heatstroke (last visited Jan. 29, 2024).
[4] National Safety Council, *Hot Car Deaths: Heatstroke deaths of children in vehicles*, https://injuryfacts.nsc.org/motor-vehicle/motor-vehicle-safety-issues/hotcars/ (last visited Jan 29, 2024).
[5] Jan Null, *Heatstroke Deaths of Children in Vehicles*, The San Jose State University Department of Meteorology & Climate Science (last updated Jan. 3, 2024) https://www.noheatstroke.org/ (last visited Jan. 29, 2024). The National Weather Service of the National Oceanic and Atmospheric Administration sources its data from Jan Null's research.
[6] Baker County Sheriff's Office, Arrest Report Number BCSO23CR00421S, (July 19, 2023) available at https://s3.documentcloud.org/documents/23883703/23-1585-arrest-jewell.pdf (last visited Jan. 29, 2024).

Certain Offenses, Corresponding Penalties, and Rescuer Actions

Florida's Uniform Traffic Control Law (ch. 316, F.S.) addresses children left unattended or unsupervised in motor vehicles by prohibiting a parent, legal guardian, or other person responsible for a child under 6 years of age from leaving that child unattended or unsupervised in a motor vehicle. As the following infographic illustrates, the Florida Department of Highway Safety and Motor Vehicles (FLHSMV) reports that law enforcement cited 1,282 people statewide for leaving a child under the age of 6 unattended or unsupervised in Florida from 2012 to 2022.[7]



[7] The Florida Department of Highway Safety and Motor Vehicles, *Child Safety: Car and Driveway Safety*, https://www.flhsmv.gov/safety-center/child-safety/car-driveway-safety/ (last visited Jan. 29, 2024).

If someone leaves a child under the age of 6 unattended or unsupervised in a motor vehicle in one of the three following situations, current law imposes corresponding penalties.[8]

Offending Situation	Penalty: No Serious Harm	Penalty: Great Bodily Harm, Permanent Disability, or Permanent Disfigurement
Child under the age of 6 left in vehicle in excess of 15 minutes	Second degree misdemeanor[9]	Third degree felony[10]
Child under the age of 6 left in running vehicle	Noncriminal traffic infraction ($500 maximum fine)	Third degree felony
Child under the age of 6 left in vehicle and the child's health is in danger or child appears to be in distress	Noncriminal traffic infraction ($500 maximum fine)	Third degree felony

Current law authorizes a law enforcement officer who observes a child left unattended or unsupervised in a motor vehicle to use whatever means reasonably necessary to protect the minor child and to remove the child from the vehicle.[11] Current law advises a law enforcement officer to attach written notification to the vehicle when the officer removes a child from the immediate area.[12] If the law enforcement officer cannot locate the child's parents, legal guardian, or other person responsible for the child, the officer must deliver physical custody of the child to the Florida Department of Children and Families (DCF) for the purposes of a dependency court shelter hearing.[13]

In addition, current law authorizes the general public to rescue a vulnerable person[14] by removing that person from a vehicle. The rescuer has immunity from civil liability for vehicle damage during the rescue effort if the rescuer:

- Determines the motor vehicle is locked or there is otherwise no reasonable method for the vulnerable person to exit the vehicle without assistance;
- Has a good faith and reasonable belief, based upon the known circumstances, that entry into a motor vehicle is necessary because the vulnerable person is in imminent danger of suffering harm;
- Ensures that law enforcement is notified or 911 called before entering the motor vehicle or immediately thereafter;
- Uses no more force than is necessary to enter the vehicle; and
- Remains with the vulnerable person in a safe location, in reasonable proximity to the motor vehicle, until law enforcement or other first responder arrives.[15]

[8] S. 316.6135(1)-(4), F.S.
[9] A second-degree misdemeanor conviction generally carries a term of imprisonment not exceeding 60 days and, or a $500 maximum fine. ss. 775.082(4)(b), 775.083(1)(e), F.S.
[10] A third-degree felony conviction generally carries a term of imprisonment not exceeding 5 years or a $5,000 maximum fine. ss. 775.082(3)(e), 755.083(1)(c), F.S. (However, ordinarily, a person who willfully or by culpable negligence neglects a child and in so doing causes great bodily harm, permanent disability, or permanent disfigurement to the child commits a felony of the second degree. s. 827.03(2)(b), F.S.).
[11] S. 316.6135(5), F.S.
[12] S. 316.6135(6), F.S.
[13] S. 316.6135(7), F.S.
[14] A vulnerable person means any person who has not attained the age of 18 or a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging. ss. 1.01(13), 415.102(28), 435.02(6), 768.139(1)(c), F.S.
[15] S. 768.139(2), F.S.

In the event of death, the prosecutor might choose to pursue criminal charges for, at the very least depending on the facts, aggravated manslaughter,[16] and the family of the decedent minor child might seek legal advice on whether to sue in civil court for wrongful death.[17]

Public Awareness Campaigns by the State of Florida

The Florida Department of Children and Families

The Florida Department of Children and Families (DCF) is responsible for providing services that support child and family well-being. DCF contracts with the Ounce of Prevention Fund of Florida, Inc. (Ounce)[18] for various situational awareness campaigns throughout the year. The Ounce raises awareness in April for Child Abuse Prevention Month, in May for Water Safety Month, and October for Safe Sleep Month. The activities for these awareness months include public service announcements, radio and television advertisements, social media campaigns, media tool kits, and more.[19]

DCF pays for this contract using federal Community-Based Child Abuse Prevention grant dollars. On August 21, 2023, DCF, the Florida Department of Health (DOH), the Agency for Persons with Disabilities, and the Ounce held an event that called for a greater awareness of children left in hot cars.[20]

The Florida Department of Health

The DOH Injury Prevention Section collaborates with Safe Kids Florida[21] to implement evidence-based programs that help parents and caregivers prevent childhood injuries.[22] As of June 2023, 15 local Safe Kids coalitions cover 42 counties throughout Florida. These coalitions promote prevention efforts by hosting educational events for parents and caregivers.[23]

The Florida Department of Highway Safety and Motor Vehicles

Current law authorizes FLHSMV to purchase educational items as part of the public information and educational campaigns promoting highway safety, awareness, and community-based initiatives.[24] FLHSMV's 2023 Safe Summer Travel campaign recently raised awareness of, among other topics, vehicular heatstroke prevention.[25]

[16] A person who causes the death of any person under the age of 18 by culpable negligence commits aggravated manslaughter of a child, a felony of the first degree. s. 782.07(3), F.S.

[17] Ss. 768.16 – 768.26, F.S. The Florida Wrongful Death Act creates a civil cause of action when the death of a person is caused by the wrongful act or negligence (although the death was caused under circumstances constituting a felony) and the event would have entitled the person injured to maintain an action and recover damages if the death had not occurred.

[18] The Ounce is a private, nonprofit corporation dedicated to shaping prevention policy and investing in innovative prevention programs that provide measurable benefits to Florida's children, families, and communities. The Ounce of Prevention of Florida, Home, http://www.ounce.org (last visited Jan. 29, 2024).

[19] Florida Department of Children and Families, Agency Analysis of 2024 House Bill 591, p. 2 (Dec. 27, 2023).

[20] *Id*.

[21] Safe Kids is a 501(c)(3) non-profit organization located in the Washington, D.C. area with a mission of preventing unintentional childhood injury. Safe Kids was founded by Children's National Hospital (Washington D.C.) in 1988. Safe Kids Worldwide, *Who We Are*, https://www.safekids.org/who-we-are (last visited Jan. 29, 2024).

[22] Safe Kids Worldwide, *Safe Kids Florida*, https://www.safekids.org/coalition/safe-kids-florida (last visited Jan. 29, 2024).

[23] Florida Department of Health, *Safe Kids Florida*, (last reviewed June 24, 2023) https://www.floridahealth.gov/programs-and-services/safe-kids-florida/index.html (last visited Jan. 29, 2024).

[24] Ss. 316.003(19), 316.6131, F.S.

[25] Florida Department of Highway Safety and Motor Vehicles, *Safe Summer Travel*, https://www.flhsmv.gov/safety-center/driving-safety/safe-summer-travel/ (last visited Jan. 29, 2024).

Effects of Proposed Changes

The bill creates s. 638.336, F.S., designating April as "Hot Car Death Prevention Month" to raise public awareness of the dangers of leaving children unattended in motor vehicles and educate the public on how to prevent children dying from vehicular heatstroke.

The bill encourages DCF, DOH, FLHSMV, local governments, and other agencies to sponsor events that promote awareness on the dangers of leaving a child unattended in a motor vehicle and methods to prevent hot car deaths of children. These efforts must include education in:

- Proper motor vehicle safety for children,
- The criminal penalties associated with leaving a child in a motor vehicle unattended or unsupervised, and
- The steps a bystander can take to rescue a vulnerable child in imminent danger, as set forth in s. 768.139, F.S.

Finally, the bill names the act "Ariya's Act" in memoriam of 10-month-old Ariya Paige who died of heatstroke after being left in a vehicle.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Provides that the act may be cited as "Ariya's Act".
Section 2: Creates s. 683.336, F.S., relating to Hot Car Death Prevention Month.
Section 3: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None. The bill does not mandate expenditures by state agencies but rather encourages expenditure of funds within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None. The bill encourages local governments to sponsor events, and any costs incurred are voluntary.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On January 24, 2024, the Children, Families, & Seniors Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment adds FLHSMV as a specific entity that is encouraged to sponsor public awareness and education events relating to the prevention of hot car deaths.

The analysis is drafted to the amended bill as passed by the Children, Families, & Seniors Subcommittee.

A bill to be entitled

An act relating to hot car death prevention; providing a short title; creating s. 683.336, F.S.; designating the month of April as "Hot Car Death Prevention Month"; encouraging specified entities to sponsor events to promote public awareness on the dangers of leaving a child unattended in a motor vehicle; providing methods to prevent hot car deaths; providing an effective date.

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

Section 1. This act may be cited as "Ariya's Act."

Section 2. Section 683.336, Florida Statutes, is created to read:

683.336 Hot Car Death Prevention Month.-

(1) The month of April is designated as "Hot Car Death Prevention Month," to raise awareness of the dangers of leaving children in motor vehicles unattended and to educate the public in preventing hot car deaths of children.

(2) The Department of Children and Families, the Department of Health, the Department of Highway Safety and Motor Vehicles, local governments, and other agencies are encouraged to sponsor events that promote public awareness on the dangers of leaving a child unattended in a motor vehicle and methods to

prevent hot car deaths of children, including educating the public relating to:

(a) Proper motor vehicle safety for children;

(b) The criminal penalties associated with leaving a child in a motor vehicle unattended or unsupervised; and

(c) Steps a bystander can take to rescue a vulnerable child in imminent danger, as set forth in s. 768.139.

Section 3. This act shall take effect July 1, 2024.

HB 725

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 725 Veterans' Long-term Care Facilities Admissions
SPONSOR(S): Woodson, Snyder & others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Local Administration, Federal Affairs & Special Districts Subcommittee	15 Y, 0 N	Mwakyanjala	Darden
2) Health Care Appropriations Subcommittee	12 Y, 0 N	Aderibigbe	Clark
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Florida Department of Veterans' Affairs (FDVA) operates a network of nine veterans' homes and provides statewide outreach to connect veterans with services, benefits, and support. State veterans' homes may be either nursing homes or domiciliary homes. Both veterans of wartime service and of peacetime service are eligible for admission.

The bill expands the eligibility for residency at a state veterans' home to include the spouse or surviving spouse of a qualifying veteran. The bill revises the priority of admittance to veterans' homes and places the spouse or surviving spouse of a veteran last in priority. These rankings preserve a higher priority of admittance to veterans over non-veterans.

The bill does not have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Veterans' Services

The U.S. Department of Veterans' Affairs (VA) is principally responsible for the delivery of health care services to veterans.[1] Eligibility for hospital, nursing home, and domiciliary care depends on a number of factors. Veterans qualify for specified health care services depending on disability status, time of service, active duty status during service, toxic exposure during service, annual income, and need for support.[2]

The Florida Department of Veterans' Affairs (FDVA) is a nearly 1,500-member constitutionally chartered[3] department with a budget of $201 million for FY 2023-2024.[4] FDVA operates a network of nine state veterans' homes and provides statewide outreach to connect veterans with services, benefits, and support.[5] FDVA offers benefits and services in the fields of health care, mental health and substance abuse, claims support, education, employment, housing, burial benefits, and legal assistance.[6]

Veterans Homes

The FDVA provides care for veterans' in both domiciliary homes[7] and nursing facilities.[8] Both veterans of wartime and peacetime service are eligible for admission.[9] Veterans are admitted to both types of facilities based on a priority ranking.[10] To be considered for admission to a veterans' home in Florida, a veteran must have been discharged from the military with either an honorable or an upgrade to an honorable discharge.[11]

Domiciliary Homes

Domiciliary care is shelter, sustenance, and incidental medical care on an ambulatory self-care basis for eligible veterans who are disabled by age or disease, but not in need of hospitalization or nursing home care.[12] A domiciliary home is a type of assisted living facility (ALF).[13]

To be eligible for admission, a veteran must:

- Have wartime service or peacetime service;
- Be a resident of the state at the time of application;
- Not be mentally ill, habitually inebriated, or addicted to drugs;
- Not owe money to FDVA for services rendered during a previous stay at a FDVA facility;

[1] Florida Dept. of Veterans Affairs, *Health Care*, https://www.floridavets.org/benefits-services/health-care/ (last visited Jan. 21, 2024).
[2] 38 U.S.C. § 1710.
[3] Art. IV, s. 11, Fla. Const.
[4] Ch. 2023-239, Laws of Florida.
[5] Florida Dept. of Veterans Affairs, *Florida Department of Veterans' Affairs – Our Vision and Mission*, https://www.floridavets.org/leadership/ (last visited Jan. 21, 2024).
[6] Florida Department of Veterans Affairs, *Benefits & Services*, https://www.floridavets.org/benefits-services/ (last visited Jan. 21, 2024).
[7] A Veterans' Domiciliary Home of Florida is a home for veterans established by the state. Ss. 296.02 (10), and 296.03, F.S.
[8] Ch. 296, F.S.
[9] Ss. 296.08 and 296.36, F.S. "Wartime service" is defined as is service in any of the following campaigns or expeditions: Spanish-American War (1898-1902); Mexican Border Period (1916-1917); World War I (1917-1918, with qualifying extensions until 1921); World War II (1941-1946); Korean War (1950-1955); Vietnam War, (1961-1975); Persian Gulf War (1990-1992); Operation Enduring Freedom (2001-date prescribed by presidential proclamation or by law); Operation Iraqi Freedom (2003-date prescribed by presidential proclamation or by law). Peacetime service is defined as any Army, Navy, Marines, Coast Guard, Air Force, or Space Force service that not in any of the campaigns or expeditions. S. 1.01(14), F.S.
[10] Ss. 296.08 and 296.36, F.S.
[11] Ss. 296.02(9) and 1.01(14), F.S.
[12] S. 296.02(4), F.S.
[13] *See* Florida Dept. of Veterans Affairs, *State Veterans' Homes*, https://floridavets.org/locations/state-veterans-nursing-homes/ (last visited Jan. 21, 2024) (describing care provided by the Robert H. Jenkins Jr. Veterans' Domiciliary Home).

- Have applied for all financial assistance reasonably available through governmental sources; and
- Have been approved as eligible for care and treatment by the VA.[14]

Residents are admitted in order of priority as follows:

- A veteran with wartime service who has a service-connected disability but is not in need of hospitalization or nursing home care.
- A veteran with wartime service who has a non-service-connected disability but is not in need of hospitalization or nursing home care.
- A veteran with wartime service and no disability.
- A veteran with peacetime service.[15]

An applicant must file with the facility administrator all information necessary for admission, including a certificate of eligibility, a certified copy of the veteran's discharge, and any other information the administrator determines is necessary.[16]

The FDVA currently operates one domiciliary home in Florida. The domiciliary home is located in Lake City.[17]

Nursing Homes

In addition to assisted-living facilities, Florida law provides for veterans' nursing homes.[18] Each nursing home is overseen by an administrator who is selected by the Executive Director (director) of FDVA.[19]

To be eligible for admission, a veteran must:

- Be in need of nursing care;
- Be a resident of the state at the time of application;
- Not owe money to the FDVA for services rendered during a previous stay at a FDVA facility;
- Have applied for all financial assistance reasonably available through governmental sources; and
- Have been approved as eligible for care and treatment by the VA.[20]

Eligible veterans are given priority for admission in the following order:

- Residents of the state.
- Those who have a service-connected disability as determined by the VA, or who were discharged or released from service for a disability incurred or aggravated in the line of duty and the disability is the condition for the nursing home need.
- Those who have a non-service-connected disability and are unable to defray the cost of nursing home care.[21]

The FDVA currently operates eight skilled nursing facilities throughout the state. The nursing homes are located in Daytona Beach, Orlando, Land O'Lakes, Pembroke Pines, Panama City, Port Charlotte, Port St. Lucie, and St. Augustine, Florida.[22]

Cost and Funding of Resident Care

[14] S. 296.06(2), F.S.,
[15] S. 296.08, F.S.
[16] S. 296.08(2), F.S.
[17] Florida Dept. of Veterans Affairs, State Veterans' Homes, https://floridavets.org/locations/state-veterans-nursing-homes/ (last visited Jan. 21, 2024).
[18] Ch. 296, Part II, F.S.
[19] S. 296.34, F.S.
[20] S. 296.36(1), F.S.
[21] S. 296.36(3), F.S.
[22] *Supra* note 17.

A resident of a state veterans' home must contribute to the cost of his or her care if the resident receives a pension, compensation, gratuity from the federal government, or income from any other source of more than $100 per month for domiciliary homes and $160 per month for nursing homes.[23]

In addition to the resident's portion of payment, the VA provides a reimbursement care subsidy to domiciliary homes and nursing homes based on a per diem rate.[24] The current VA per diem for domiciliary homes is $59.69 a day.[25] The current VA per diem for basic care in a nursing home is set at $138.29 a day, while per diem for disabled veterans who are determined to be at least 70 percent disabled is set at $474.45 a day.[26] To qualify for reimbursement, federal law requires at least 75 percent of the population of the facility to be veterans. This threshold drops to 50 percent if the facility was constructed or renovated solely by the state.

Federal law authorizes a state veterans' home to house non-veteran residents who are spouses of veterans or parents whose children died while in military service.[27] These residents are required to pay for the full cost of their care. However, Florida law does not allow the spouses of veterans to be admitted to state veterans' homes.

Effect of Proposed Changes

The bill expands the eligibility for residency at state veterans' homes to include the spouse or surviving spouse of a qualifying veteran. The bill updates the priority order of admission to reflect this change, placing the spouse or surviving spouse last in the admission priority list, ensuring that higher priority of admittance will be given to veterans over non-veterans.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 296.02, F.S., relating to definitions.
Section 2: Amends s. 296.03, F.S., relating to Veterans' Domiciliary Home of Florida.
Section 3: Amends s. 296.08, F.S., relating to priority of admittance.
Section 4: Amends s. 296.32, F.S, relating to purpose.
Section 5: Amends s. 296.33, F.S., relating to definitions.
Section 6: Amends s. 296.36, F.S., relating to eligibility and priority of admittance.
Section 7: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has no fiscal impact on FDVA or the state Medicaid program. While the VA does not cover the cost of care for spouses, FDVA will be reimbursed for services through private pay, Medicare, and the state Medicaid program. [28]

[23] S. 296.10, F.S., and s. 296.37, F.S. This contribution for care may be 100 percent of the cost if an otherwise eligible veteran is able to fund his or her own support.
[24] 38 C.F.R. § 51.390 and 38 C.F.R. § 51.210.
[25] U.S. Department of Veterans Affairs, Geriatric and Extended Care, State Home Per Diem Program, *State Home Per Diem Basic Rates for FYs 200-2024*, available at https://www.va.gov/geriatrics/pages/State_Veterans_Home_Program_per_diem.asp (last visited January 21, 2024).
[26] Florida Dept. of Veterans' Affairs, *2023 Agency Legislative Bill Analysis*, *SB 174* (Nov. 7, 2023) (on file with the House Local Administration, Federal Affairs, & Special Districts Subcommittee).
[27] 38 C.F.R. § 51.210(d).
[28] *Supra* note 8

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill neither authorizes nor requires administrative rulemaking by executive branch agencies.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to veterans' long-term care facilities admissions; amending s. 296.02, F.S.; revising definitions; amending s. 296.03, F.S.; revising eligibility for residency in the Veterans' Domiciliary Home of Florida to include specified individuals; amending s. 296.08, F.S.; adding such individuals to the priority of admittance schedule; amending s. 296.32, F.S.; conforming provisions to changes made by the act; amending s. 296.33, F.S.; revising the definition of the term "resident"; amending s. 296.36, F.S.; revising the admission eligibility for veterans' nursing homes to include specified persons; revising the priority of admittance to include such persons; providing an effective date.

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

Section 1. Subsections (1), (4), (8), and (10) of section 296.02, Florida Statutes, are amended to read:

296.02 Definitions.—For the purposes of this part, except where the context clearly indicates otherwise:

(1) "Applicant" means a veteran with wartime service or peacetime service, as defined in this section, or the spouse or surviving spouse of such veteran, who is not in need of

hospitalization or nursing home care.

(4) "Domiciliary care" means shelter, sustenance, and incidental medical care provided on an ambulatory self-care basis to assist eligible applicants ~~veterans~~ who are disabled by age or disease~~,~~ but who are not in need of hospitalization or nursing home care services.

(8) "Resident" means any eligible applicant ~~veteran~~ admitted to residency in the home.

(10) "Veterans' Domiciliary Home of Florida," hereinafter referred to as the "home," means a home established by the state for veterans who served in wartime service or in peacetime service, as defined in this section, or the spouses or surviving spouses of such veterans.

Section 2. Section 296.03, Florida Statutes, is amended to read:

296.03 Veterans' Domiciliary Home of Florida.—The Veterans' Domiciliary Home of Florida is for veterans who served in wartime service or peacetime service, as defined in s. 296.02, or the spouses or surviving spouses of such veterans, and is maintained for the use of those individuals ~~veterans~~ who are not in need of hospitalization or nursing home care and who can attend to their personal needs, dress themselves, and attend a general dining facility, or who are in need of extended congregate care.

Section 3. Paragraph (e) is added to subsection (1) of

section 296.08, Florida Statutes, to read:

296.08 Priority of admittance.—

(1) In determining the eligibility of applicants to the home, the administrator shall give admittance priority in accordance with the following schedule:

(e) The spouses or surviving spouses of veterans described in this subsection.

Section 4. Section 296.32, Florida Statutes, is amended to read:

296.32 Purpose.—The purpose of this part is to provide for the establishment of basic standards for the operation of veterans' nursing homes for eligible veterans and the spouses or surviving spouses of such veterans who are in need of such services.

Section 5. Subsection (5) of section 296.33, Florida Statutes, is amended to read:

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

(5) "Resident" means any eligible veteran, or the spouse or surviving spouse of such veteran, who is admitted to the home.

Section 6. Subsections (1) and (3) of section 296.36, Florida Statutes, are amended to read:

296.36 Eligibility and priority of admittance.—

(1) To be eligible for admittance to the home, the person must be a veteran as provided in s. 1.01(14) or have eligible

peacetime service as defined in s. 296.02, or be the spouse or surviving spouse of a veteran, and must:

(a) Be in need of nursing home care.

(b) Be a resident of the state at the time of application for admission to the home.

(c) Not owe money to the department for services rendered during any previous stay at a department facility.

(d) Have applied for all financial assistance reasonably available through governmental sources.

(e) Have been approved as eligible for care and treatment by the United States Department of Veterans Affairs.

(3) Admittance priority must be given to eligible persons ~~veterans~~ in the following order of priority:

(a) An eligible veteran who is a resident of the State of Florida.

(b) An eligible veteran who has a service-connected disability as determined by the United States Department of Veterans Affairs, or was discharged or released from military service for disability incurred or aggravated in the line of duty and the disability is the condition for which nursing home care is needed.

(c) An eligible veteran who has a non-service-connected disability and is unable to defray the expense of nursing home care and so states under oath before a notary public or other officer authorized to administer an oath.

(d) The spouse or surviving spouse of a veteran described in this subsection.

Section 7. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 827 Mental Health Professionals
SPONSOR(S): Healthcare Regulation Subcommittee, Koster
TIED BILLS: **IDEN./SIM. BILLS:** SB 210

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N, As CS	Osborne	McElroy
2) Health & Human Services Committee		Osborne	Calamas

SUMMARY ANALYSIS

Marriage and family therapists are trained mental health professionals who diagnose and treat mental health and emotional disorders within the context of marriage and family systems. A mental health counselor is an individual who uses scientific and applied behavioral science theories, methods, and techniques to describe, prevent, and treat undesired behavior and enhance mental health and human development. Clinical social workers use scientific and applied knowledge to prevent and treat undesired behavior and the decline of an individual's mental health. The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling within the Department of Health (DOH) regulates the practice of clinical social work, marriage and family therapy, and mental health counseling.

To be licensed as a clinical social worker, marriage and family therapist, or mental health counselor, an applicant must meet educational requirements, complete at least two years of postgraduate or postmaster's clinical practice supervised by a licensed practitioner, and pass a theory and practice examination. During the time in which an applicant is completing the required supervised clinical experience, he or she must register with the Department of Health (DOH) as an intern. The supervised clinical experience may be met by providing at least 1,500 hours of face-to-face psychotherapy with clients, which may not be accrued in fewer than 100 weeks.

CS/HB 827 changes the title under which a post-master's licensure candidate for clinical social work, marriage and family therapy, and mental health counseling practices for the two years of required supervised clinical practice before the candidate is eligible for full licensure. Under current law, this class of practitioner are referred to as "registered…interns," the bill changes this title to "registered associates." The bill makes conforming changes to statutory references to this class of practitioner.

The bill eliminates the express requirement that a fully licensed mental health professional be on the premises when clinical services are provided by a registered intern in a private practice setting.

The bill also revises the title for interns who are providing services while currently enrolled as students in a course of study leading to a degree relevant to the professions of clinical social work, marriage and family therapy, and mental health counseling. For students providing services and exempt from licensure under s. 491.014, F.S., the bill changes their title from "student intern," to "student associate."

The bill has an indeterminant, negative fiscal impact on DOH, and no fiscal impact on local governments.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Health Professions

Florida licenses three distinct mental health professions: marriage and family therapists, clinical social workers, and mental health counselors.[1] All three of these professions are overseen by the Board of Social Work, Marriage and Family Therapy, and Mental Health Counseling within the Department of Health (DOH).

Marriage and Family Therapists

The practice of marriage and family therapy incorporates psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis intervention, and the provision of needed information and education to clients.[2]

To qualify for licensure as a marriage and family therapist, an applicant must:[3]

- Possess a master's degree from a program accredited by either:
  - The Commission on Accreditation for Marriage and Family Therapy Education;
  - The Council on Accreditation of Counseling and Related Educational Programs (CACREP) with coursework with an emphasis in marriage and family therapy and approved by the board; or
  - For master's degrees conferred before September 1, 2027, programs may be institutionally accredited with graduate courses approved by the board.
- Pass a board-approved examination;[4] and
- Demonstrate knowledge of laws and rules governing the practice.[5]

DOH may also issue a dual license in marriage and family therapy to anyone who meets the following requirements:[6]

- Holds a valid, active license as a psychologist,[7] a clinical social worker or mental health counselor,[8] or is a licensed advanced practice registered nurse with a specialty in psychiatric nursing;[9]
- Has held a valid, active license for at least three years; and
- Has passed the examination required for licensure as a marriage and family therapist.

There are approximately 2,990 marriage and family therapists with active licenses to practice in Florida.[10]

[1] Ch. 491, F.S.
[2] S. 491.003(9), F.S.
[3] S. 491.005(3), F.S. An individual may qualify for a dual license in marriage and family therapy if he or she passes an examination in marriage and family therapy and has held an active license for at least three years as a psychologist, clinical social worker, mental health counselor, or advanced registered nurse practitioner who is determined by the Board of Nursing to be a specialist in psychiatric mental health (s. 491.0057, F.S.)
[4] Rule 64B4-3.003, F.A.C., establishes the examination developed by the Examination Advisory Committee of the Association of Marital and Family Therapy Regulatory Board as the approved exam.
[5] Rule 64B4-3.0035, F.A.C., requires licensure applicants complete a course on the laws and rules of Florida as they pertain to the relevant profession. The course must include a testing mechanism on which the applicant must obtain a passing score of at least 80 percent.
[6] S. 491.0057, F.S.
[7] Psychologists are licensed under ch. 490, F.S.
[8] Clinical social workers and mental health counselors are licensed under ch. 491, F.S.
[9] Advanced practice registered nurses are licensed under s. 464.012, F.S.

Mental Health Counselors

A mental health counselor is an individual who uses scientific and applied behavioral science theories, methods, and techniques to describe, prevent, and treat undesired behavior and enhance mental health and human development and is based on research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation.[11]

To qualify for licensure as a mental health counselor, an applicant must:[12]

- Possess a master's degree from a mental health counseling program accredited by CACREP, or a program related to the practice of mental health counseling that meets specific coursework and experiential learning requirements;
- Pass a board-approved examination;[13] and
- Demonstrate knowledge of laws and rules governing the practice.[14]

There are approximately 16,499 licensed mental health counselors with active licenses to practice in Florida.[15]

Clinical Social Workers

The practice of clinical social work is use of scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering.[16]

To qualify for licensure as a clinical social worker, an applicant must:

- Possess a master's degree in social work from an institution which, at the time the applicant graduated, was:
  - Accredited by the Council on Social Work Education;
  - Accredited by the Canadian Association for Social Work Education;
  - Has been determined to have been a program equivalent to programs approved by the Council on Social Work Education by the Foreign Equivalency Determination Service of the Council on Social Work Education; or
  - Otherwise met coursework requirements outlined in statute.
- Pass a board-approved examination;[17] and
- Demonstrate knowledge of laws and rules governing the practice.[18]

There are approximately 12,785 clinical social workers with active licenses to practice in Florida.[19]

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[10] Department of Health, *Division of Medical Quality Assurance Annual Report for Fiscal Year 2022-23*. Available at https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/2023.11.01.MQAAR-FINAL.pdf (last visited February 5, 2024).
[11] Ss. 491.003(6) and (9), F.S.
[12] S. 491.005(4), F.S.
[13] Rule 64B4-3.003, F.A.C., establishes the National Clinical Mental Health Counseling Examination (NCMHCE) developed by the National Board for Certified Counselors (NBCC) as the approved exam.
[14] *Supra*, note 5.
[15] *Supra*, note 10.
[16] S. 491.003(8), F.S.
[17] Rule 64B4-3.003, F.A.C., establishes the Clinical Level objective multiple choice examination developed by the Association of Social Work Boards (ASWB) as the approved exam.
[18] *Supra*, note 5.
[19] *Supra*, note 10.

In addition to the requirements described above, an individual seeking licensure as a clinical social worker, marriage and family therapist, or mental health counselor must register with DOH as an intern and complete at least two years of post-graduate or post-master's clinical practice supervised by a licensed practitioner before they are eligible for full licensure.[20] The supervised clinical experience may be met by providing at least 1,500 hours of face-to-face psychotherapy with clients, which may not be accrued in fewer than 100 weeks.[21]

To become a registered intern, an applicant must:[22]

- Submit a completed application form and the nonrefundable fee to DOH;
- Complete education requirements necessary for licensure in the relevant profession;
- Submit an acceptable supervision plan for meeting the practicum, internship, or field work required for licensure that was not satisfied by graduate studies; and
- Identify a qualified supervisor.

An intern registration expires 60 months after the date of issue and may only be renewed if the candidate has passed the theory and practice examination required for full licensure.[23]

There are approximately 9,765 registered interns in the state: 4,294 Registered Clinical Social Worker Interns, 709 Registered Marriage and Family Therapy Interns, and 4,762 Registered Mental Health Counselor Interns.[24]

Current law requires that a licensed mental health professional be on the premises when a registered intern is providing clinical services in a private practice setting.[25] There is not a comparable requirement for registered interns providing clinical services at a public facility.[26]

Effect of the Bill

CS/HB 827 changes the title under which a post-master's licensure candidate for clinical social work, marriage and family therapy, and mental health counseling practices for the two years of required supervised clinical practice before the candidate is eligible for full licensure.

The bill revises the titles of the following practitioners as described:

- "Registered clinical social worker *intern*" becomes "registered *associate* clinical social worker;"
- "Registered marriage and family therapist intern" becomes "registered associate marriage and family therapist;" and
- "Registered mental health counselor intern" becomes "Registered associate mental health counselor."

The bill makes conforming changes to other statutory references to this class of practitioner.

The bill also eliminates the express requirement that a fully licensed mental health professional be on the premises when clinical services are provided by a registered intern[27] in a private practice setting.

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[20] Ss. 491.005 and 491.0045, F.S.
[21] Rule 64B4-2.001, F.A.C.; The 1,500 hours of face-to-face psychotherapy with clients are not required to be directly supervised. The requirement for "supervision" may be met through at least 1 hour of face-to-face contact with the supervisor every two weeks wherein the supervision focuses on the raw data from the intern's face-to-face psychotherapy with clients.
[22] S. 491.0045(2), F.S.
[23] S. 491.0045(6), F.S.
[24] *Supra*, note 10.
[25] S. 491.005(1)(c), 491.005(3)(c), and 491.005(4)(c), F.S.
[26] Public facilities include county health departments, social services agencies (such as the Department of Children & Families or the Department of Elder Affairs), or public hospitals. These entities may have their own policies regarding the on-site supervision of practitioners who are not fully licensed, but it is not expressly required by statute. For more information on where mental health professionals are employed, see U.S. Bureau of Labor Statistics, Occupational Employment and Wage Statistics (2022). Available at https://www.bls.gov/oes/current/oes211019.htm (last visited January 17, 2024).

The bill revises the title for interns who are providing services while currently enrolled as students in a course of study leading to a degree relevant to the professions of clinical social work, marriage and family therapy, and mental health counseling. For students providing services and exempt from licensure under s. 491.014, F.S., the bill changes their title from "student intern," to "student associate."

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 491.003, F.S., relating to definitions.
Section 2: Amends s. 491.0045, F.S., relating to intern registration; requirements.
Section 3: Amends s. 491.005, F.S., relating to licensure by examination.
Section 4: Amends s. 491.007, F.S., relating to renewal of license, registration, or certificate.
Section 5: Amends s. 491.009, F.S., relating to discipline.
Section 6: Amends s. 491.012, F.S., relating to violations; penalty; injunction.
Section 7: Amends s. 491.014, F.S., relating to exemptions.
Section 8: Amends s. 491.0149, F.S., relating to display of license; use of professional title on promotional materials.
Section 9: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has a indeterminant, negative fiscal impact on DOH which can be absorbed within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

[27] "*Registered associate*," under the bill.

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Sufficient rule-making authority exists to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to mental health professionals; amending s. 491.003, F.S.; revising definitions; amending s. 491.0045, F.S.; reclassifying intern registrations as associate registrations for the professions of clinical social work, marriage and family therapy, and mental health counseling; amending s. 491.005, F.S.; deleting the requirement that a licensed mental health professional be present on the premises when registered associates, formerly classified as registered interns, are providing clinical services in a private practice setting; amending ss. 491.007, 491.009, 491.012, 491.014, and 491.0149, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsections (15), (16), and (17) of section 491.003, Florida Statutes, are amended to read:

491.003 Definitions.—As used in this chapter:

(15) "Registered <u>associate</u> clinical social worker ~~intern~~" means a person registered under this chapter who is completing the postgraduate clinical social work experience requirement specified in s. 491.005(1)(c).

(16) "Registered associate marriage and family therapist ~~intern~~" means a person registered under this chapter who is completing the post-master's clinical experience requirement specified in s. 491.005(3)(c).

(17) "Registered associate mental health counselor ~~intern~~" means a person registered under this chapter who is completing the post-master's clinical experience requirement specified in s. 491.005(4)(c).

Section 2. Section 491.0045, Florida Statutes, is amended to read:

491.0045 Associate ~~Intern~~ registration; requirements.—

(1) An individual who has not satisfied the postgraduate or post-master's level experience requirements, as specified in s. 491.005(1)(c), (3)(c), or (4)(c), must register as an associate ~~intern~~ in the profession for which he or she is seeking full licensure before commencing the post-master's experience requirement or an individual who intends to satisfy part of the required graduate-level practicum, internship, or field experience, outside the academic arena for any profession, and must register as an associate ~~intern~~ in the profession for which he or she is seeking full licensure before commencing the practicum, internship, or field experience.

(2) The department shall register as an associate ~~a~~ clinical social worker ~~intern~~, an associate marriage and family therapist ~~intern~~, or an associate mental health counselor ~~intern~~

each applicant whom ~~who~~ the board certifies has:

(a) Completed the application form and remitted a nonrefundable application fee not to exceed $200, as set by board rule;

(b)1. Completed the education requirements as specified in s. 491.005(1)(c), (3)(c), or (4)(c) for the profession for which he or she is applying for licensure, if needed; and

2. Submitted an acceptable supervision plan, as determined by the board, for meeting the practicum, internship, or field work required for licensure that was not satisfied in his or her graduate program.

(c) Identified a qualified supervisor.

(3) An individual registered under this section must remain under supervision while practicing under registered associate ~~intern~~ status.

(4) An individual who fails to comply with this section may not be granted a full license under this chapter, and any time spent by the individual completing the experience requirement as specified in s. 491.005(1)(c), (3)(c), or (4)(c) before registering as an associate ~~intern~~ does not count toward completion of the requirement.

(5) An associate ~~intern~~ registration is valid for 5 years.

(6) Any registration issued after March 31, 2017, expires 60 months after the date it is issued. The board may make a one-time exception to the requirements of this subsection in

emergency or hardship cases, as defined by board rule, if the candidate has passed the theory and practice examination described in s. 491.005(1)(d), (3)(d), and (4)(d).

(7) An individual who has held a provisional license issued by the board may not apply for an associate ~~intern~~ registration in the same profession.

Section 3. Paragraph (c) of subsection (1), paragraph (c) of subsection (3), and paragraphs (b) and (c) of subsection (4) of section 491.005, Florida Statutes, are amended to read:

491.005 Licensure by examination.—

(1) CLINICAL SOCIAL WORK.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, the department shall issue a license as a clinical social worker to an applicant whom the board certifies has met all of the following criteria:

(c) Completed at least 2 years of clinical social work experience, which took place subsequent to completion of a graduate degree in social work at an institution meeting the accreditation requirements of this section, under the supervision of a licensed clinical social worker or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If the applicant's graduate program was not a program which emphasized direct

clinical patient or client health care services as described in subparagraph (b)2., the supervised experience requirement must take place after the applicant has completed a minimum of 15 semester hours or 22 quarter hours of the coursework required. A doctoral internship may be applied toward the clinical social work experience requirement. ~~A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.~~

(3) MARRIAGE AND FAMILY THERAPY.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, the department shall issue a license as a marriage and family therapist to an applicant whom the board certifies has met all of the following criteria:

(c) Completed at least 2 years of clinical experience during which 50 percent of the applicant's clients were receiving marriage and family therapy services, which must be at the post-master's level under the supervision of a licensed marriage and family therapist with at least 5 years of experience, or the equivalent, who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major emphasis in marriage and family therapy or a closely related field which did not include all of the coursework required by paragraph (b),

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

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

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, the department shall issue a license as a mental health counselor to an applicant whom the board certifies has met all of the following criteria:

(b)1. Attained a minimum of an earned master's degree from

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

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

b. A minimum of 3 semester hours or 4 quarter hours of

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

c. The equivalent, as determined by the board, of at least 700 hours of university-sponsored supervised clinical practicum, internship, or field experience that includes at least 280 hours of direct client services, as required in the accrediting standards of the Council for Accreditation of Counseling and Related Educational Programs for mental health counseling programs. This experience may not be used to satisfy the post-master's clinical experience requirement.

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

Education and training in mental health counseling must have been received in an institution of higher education that, at the time the applicant graduated, was fully accredited by an institutional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization or

was a member in good standing with Universities Canada, or an institution of higher education located outside the United States and Canada which, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training substantially equivalent to the standards of training of those institutions in the United States which are accredited by an institutional accrediting body recognized by the Council for Higher Education Accreditation or its successor organization. Such foreign education and training must have been received in an institution or program of higher education officially recognized by the government of the country in which it is located as an institution or program to train students to practice as mental health counselors. The applicant has the burden of establishing that the requirements of this provision have been met, and the board shall require documentation, such as an evaluation by a foreign equivalency determination service, as evidence that the applicant's graduate degree program and education were equivalent to an accredited program in this country. Beginning July 1, 2025, an applicant must have a master's degree from a program that is accredited by the Council for Accreditation of Counseling and Related Educational Programs, the Masters in Psychology and Counseling Accreditation Council, or an equivalent accrediting body which consists of at least 60 semester hours or 80 quarter hours to apply for licensure under this paragraph.

(c) Completed at least 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling which did not include all the coursework required under sub-subparagraphs (b)1.a. and b., credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. ~~A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.~~

Section 4. Section 491.007, Florida Statutes, is amended to read:

491.007 Renewal of license, registration, or certificate.—

(1) The board or department shall prescribe by rule a method for the biennial renewal of licenses or certificates at a fee set by rule, not to exceed $250.

(2) Each applicant for renewal must ~~shall~~ present satisfactory evidence that, in the period since the license or certificate was issued, the applicant has completed continuing education requirements set by rule of the board or department. No ~~Not~~ more than 25 classroom hours of continuing education per year may ~~shall~~ be required. A certified master social worker is exempt from the continuing education requirements for the first renewal of the certificate.

Section 5. Paragraphs (f), (n), (o), (p), (r), (s), and (u) of subsection (1) of section 491.009, Florida Statutes, are 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:

(f) Maintaining a professional association with any person who the applicant, licensee, registered associate ~~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.

(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 associate ~~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 associate's ~~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 associate ~~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 associate ~~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 associate ~~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 associate ~~intern~~, or certificateholder resides or does business. The licensee, registered associate ~~intern~~, or certificateholder against whom the petition is filed may not be named or identified by initials in any public court records or documents, and the proceedings must ~~shall~~ be closed to the public. The department is ~~shall be~~ entitled to the summary procedure provided in s. 51.011. A licensee, registered associate ~~intern~~, or certificateholder affected under this paragraph must, ~~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.

(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 associate ~~intern~~, or certificateholder is not qualified by training or experience.

(s) Delegating professional responsibilities to a person who the licensee, registered associate ~~intern~~, or certificateholder knows or has reason to know is not qualified by training or experience to perform such responsibilities.

(u) Failure of the licensee, registered associate ~~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.

Section 6. Paragraphs (i) through (l) of subsection (1) of section 491.012, Florida Statutes, are amended to read:

491.012 Violations; penalty; injunction.—

(1) It is unlawful and a violation of this chapter for any person to:

(i) Practice clinical social work in this state for compensation, unless the person holds a valid, active license to practice clinical social work issued under ~~pursuant to~~ this chapter or is an associate ~~intern~~ registered pursuant to s. 491.0045.

(j) Practice marriage and family therapy in this state for compensation, unless the person holds a valid, active license to practice marriage and family therapy issued under ~~pursuant to~~ this chapter or is an associate ~~intern~~ registered pursuant to s. 491.0045.

(k) Practice mental health counseling in this state for compensation, unless the person holds a valid, active license to practice mental health counseling issued under ~~pursuant to~~ this chapter or is an associate ~~intern~~ registered pursuant to s. 491.0045.

(l) Use the following titles or any combination thereof, unless he or she holds a valid registration as an associate ~~intern~~ issued under ~~pursuant to~~ this chapter:

1. "Registered associate clinical social worker ~~intern~~."

2. "Registered associate marriage and family therapist

~~intern~~."

3. "Registered associate mental health counselor ~~intern~~."

Section 7. Paragraph (c) of subsection (4) of section 491.014, Florida Statutes, is amended to read:

(4) No person shall be required to be licensed, provisionally licensed, registered, or certified under this chapter who:

(c) Is a student providing services regulated under this chapter who is pursuing a course of study which leads to a degree in a profession regulated by this chapter, is providing services in a training setting, provided such services and associated activities constitute part of a supervised course of study, and is designated by the title "student associate ~~intern~~."

Section 8. Subsection (2) of section 491.0149, Florida Statutes, is amended to read:

491.0149 Display of license; use of professional title on promotional materials.—

(2)(a) A person registered under this chapter as an associate ~~a~~ clinical social worker ~~intern~~, an associate marriage and family therapist ~~intern~~, or an associate mental health counselor ~~intern~~ shall conspicuously display the valid registration issued by the department or a true copy thereof at each location at which the registered associate ~~intern~~ is completing the experience requirements.

(b) A registered associate clinical social worker ~~intern~~ shall include the words "registered associate clinical social worker ~~intern~~," a registered associate marriage and family therapist ~~intern~~ shall include the words "registered associate marriage and family therapist ~~intern~~," and a registered associate mental health counselor ~~intern~~ shall include the words "registered associate mental health counselor ~~intern~~" on all promotional materials, including cards, brochures, stationery, advertisements, and signs, naming the registered associate ~~intern~~.

Section 9. This act shall take effect July 1, 2024.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 855 Dental Services
SPONSOR(S): McClure and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 302

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	16 Y, 0 N	Osborne	McElroy
2) Health & Human Services Committee		Osborne	Calamas

SUMMARY ANALYSIS

The Board of Dentistry, within the Department of Health (DOH), regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants under the Dental Practice Act. A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures. A dental hygienist provides education, preventive and delegated therapeutic dental services. There are approximately 17,193 dentists, 17,681 dental hygienists, and 8,371 dental radiographers with active licenses to practice in Florida. There are 41 out-of-state registered telehealth dentists.

Telehealth is the use of synchronous or asynchronous telecommunications technology by a health care practitioner to provide health care services. Current law sets the standard of care for telehealth providers at the same standard of care for health care practitioners providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care practitioner to deliver the services. Current law does not contain health care practitioner-specific regulations for the use of telehealth. Health care practitioners must adhere to the applicable standard of care when providing services through telehealth and are subject to disciplinary action if they fail to do so.

HB 855 revises existing standards for the practice of dentistry and establishes new requirements that specifically apply to providers using telehealth to provide dental services to patients.

Under current law, a dentist of record who is primarily responsible for all dental treatments received by the patient must be specified in the patient records of every dental patient. The bill establishes a separate provision restating this requirement in the context of telehealth.

The bill requires every dentist to provide each patient with the dentist's name, contact telephone number, after-hours contact information for emergencies, and, upon the patient's request, license information.

The bill also requires telehealth providers make available the name, telephone number, practice address, and the state license number for the dentist of record and any other dentist providing services to a patient before such services are rendered. The bill requires that an advertisement for certain dental services provided through telehealth to include a disclaimer.

The bill expands grounds for the denial of a dental license or disciplinary action against a dentist to include failure to conduct an in-person examination in certain circumstances and failure by an individual providing service through telehealth to provide patients with contact information or to designate a dentist of record.

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

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Dental Practice in Florida

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

There are currently 17,193 dentists, 17,681 dental hygienists, and 8,371 dental radiographers with active licenses to practice in Florida. There are 41 out-of-state registered telehealth dentists.[4]

Dental Licensure

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

- The National Board of Dental Examiners dental examiner (NBDE);
- A written examination on Florida laws and rules regulating the practice of dentistry; and
- A practical examination, which is the American Dental Licensing Examination (ADEX) developed by the American Board of Dental Examiners, Inc.[5]

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

Dental Practice

Dentists must maintain professional liability insurance or provide proof of financial responsibility. If the dentist obtains professional liability insurance, the coverage must be at least $100,000 per claim, with a minimum annual aggregate of at least $300,000.[6] Alternatively, a dentist may maintain an unexpired, irrevocable letter of credit in the amount of $100,000 per claim, with a minimum aggregate availability of credit of at least $300,000.[7] The professional liability insurance must provide coverage for the actions of any dental hygienist supervised by the dentist.[8] However, a dentist may be exempt from maintaining professional liability insurance if he or she:[9]

- Practices exclusively for the federal government or the State of Florida or its agencies or subdivisions;

[1] S. 466.004, F.S.
[2] S. 466.003(3), F.S.
[3] S. 466.003(4)-(5), F.S.
[4] *See*, Department of Health *License Verification* web search. Available at https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders (last visited January 14, 2023).
[5] A passing score is valid for 365 days after the date the official examination results are published. A passing score on an examination obtained in another jurisdiction must be completed on or after October 1, 2011.
[6] Rule 64B5-17.011(1), F.A.C.
[7] Rule 64B5-17.011(2), F.A.C.
[8] Rule 64B5-17.011(4), F.A.C.
[9] Rule 64B5-17.011(3), F.A.C.

- Is not practicing in this state;
- Practices only in conjunction with his or her teaching duties at an accredited school of dentistry or in its main teaching hospitals; or
- Demonstrates to the BOD that he or she has no malpractice exposure in this state.

Current law requires that a dentist of record be established in the patient record for each dental patient. The dentist of record assumes primary responsibility for all dental treatment for the patient, regardless of whether the treatment is rendered by the dentist of record, or another dentist, dental hygienist, or dental assistant in conjunction with, at the direction or request of, or under the supervision of the dentist of record.[10]

The dentist of record is the dentist identified and noted in the patient record as the dentist of record, or who provides a specific treatment or service and is noted in the patient record as the dentist of record for that treatment or service.[11] For instances where a dentist of record is not identified in the patient's record, it is assumed that the dentist of record is the owner of the dental practice in which the patient is treated.[12]

By rule, every dentist is required to provide, either personally, through another licensed dentist, or through a reciprocal agreement with another agency, reasonable 24-hour emergency services for all patients under his or her continuing care.[13]

Every dentist licensed in Florida must post and keep conspicuously displayed his or her license in the office wherein she or he practices and in plain sight of patients.[14]

Dental Hygienists

A dental hygienist provides education, preventive and delegated therapeutic dental services under varying levels of supervision by a licensed dentist.[15] Any person wishing to be licensed as a dental hygienist must apply to DOH and meet the following qualifications:[16]

- Be 18 years of age or older;
- Be a graduate of an accredited dental hygiene college or school;[17] and
- Obtain a passing score on the:
    - Dental Hygiene National Board Examination;
    - Dental Hygiene Licensing Examination developed by the American Board of Dental Examiners, Inc., which is graded by a Florida-licensed dentist or dental hygienist employed by DOH for such purpose; and
    - A written examination on Florida laws and rules regulating the practice of dental hygiene.

A dental hygienist is not required to maintain professional liability insurance and must be covered by supervising dentist's liability insurance.[18]

A supervising dentist may delegate certain tasks to a dental hygienist, such as removing calculus deposits, accretions, and stains from exposed surfaces of the teeth and from the gingival sulcus and

[10] S. 466.018, F.S.
[11] Rule 64B5-17.002, F.A.C.
[12] S. 466.018(1)-(2), F.S.; see also, rule 64B5-17.002, F.A.C.; *see also*, 466.0285, F.S., no person other than a licensed dentist, or an entity composed of dentists, may employ a dentist in the operation of a dental office.
[13] Rule 64B5-17.004, F.A.C.
[14] S. 466.016, F.S.
[15] S. 466.003(4)-(5), F.S.
[16] S. 466.007, F.S.
[17] If the school is not accredited, the applicant must have completed a minimum of 4 years of postsecondary dental education and received a dental school diploma which is comparable to a D.D.S. or D.M.
[18] *Supra,* note 8.

the task of performing root planning and curettage.[19] A dental hygienist may also expose dental X-ray films, apply topical preventive or prophylactic agents, and delegated remediable tasks.[20] Remediable tasks are intra-oral tasks which do not create an unalterable change in the oral cavity or contiguous structures, are reversible, and do not expose a risk to the patient, including but not limited to:

- Fabricating temporary crowns or bridges inter-orally;
- Selecting and pre-sizing orthodontic bands;
- Preparing a tooth service by applying conditioning agents for orthodontic appliances;
- Removing and re-cementing properly contoured and fitting loose bands that are not permanently attached to any appliance;
- Applying bleaching solution, activating light source, and monitoring and removing in-office bleaching solution;
- Placing or removing rubber dams;
- Making impressions for study casts which are not being made for the purpose of fabricating any intra-oral appliances, restorations, or orthodontic appliances;
- Taking impressions for passive appliances, occlusal guards, space maintainers, and protective mouth guards; and
- Cementing temporary crowns and bridges with temporary cement.

A dental hygienist may perform additional remediable tasks as delegated by the supervising dentist if they have received additional training in a pre-licensure course, other formal training, or on-the-job training.[21] To administer local anesthesia, a dental hygienist obtain certification which requires the dental hygienist completes an accredited course of 30 hours of didactic training and 30 hours of clinical training and is certified in basic or advanced cardiac life support. Once certified, the dental hygienist may only administer local anesthesia to a non-sedated, adult patient.[22]

Every dental hygienist licensed in Florida must post and keep conspicuously displayed his or her license in the office wherein she or he practices, in plain sight of patients.[23]

Dental Advertising

Florida regulates dental advertising[24] to ensure that the public has access to information which provides a sufficient basis to make an informed selection of dentists and protect it from false or misleading advertisements.[25]

A licensed dentist's advertisements may not contain any false, fraudulent, misleading, or deceptive statement or claim or any statement or claim which:[26]

- Contains misrepresentations of fact;
- Is likely to mislead or deceive because, in context, it makes only a partial disclosure of relevant facts;
- Contains laudatory statements about the dentist or group of dentists;
- Is intended or is likely to create false, unjustified expectations of favorable results;
- Relates to the quality of dental services provided as compared to other available dental services;
- Is intended or is likely to appeal primarily to a layperson's fears;

[19] S. 466.023, F.S.
[20] Ss. 466.023 and 466.024, F.S.
[21] *See*, ss. 466.023, 466.0235, and 466.024, F.S.; and Rule 64B5-16, F.A.C.
[22] S. 466.017(5), F.S.
[23] S. 466.016, F.S.
[24] Rule 64B5-4.002, F.A.C., defines advertising to mean any statements, oral or written, disseminated to or before the public or any portion thereof with the intent of furthering the purpose, either directly or indirectly, of selling professional services, or offering to perform professional services, or inducing members of the public to enter into any obligation relating to such professional services. The provisions of this rule shall apply to media exposure of any nature regardless of whether it is in the form of paid advertising.
[25] S. 468.019, F.S.
[26] *Id.*

- Contains fee information without a disclaimer that such is a minimum fee only; or
- Contains other representations or implications that in reasonable probability will cause an ordinary, prudent person to misunderstand or to be deceived.

Direct-To-Consumer Teeth Alignment

The direct-to-consumer teeth alignment business model consists of dental impressions being taken by the consumer using a dental impression kit provided by the aligner company. The impression is then reviewed by a dentist to create custom aligners, which are shipped back to the consumer for use. This model generally does not include an in-person examination by a licensed dentist or include direct supervision by a dentist when digital scanning is performed.[27]

Telehealth

Telehealth is the delivery of health care services using information and communication technologies to exchange valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation.[28] Telehealth connects individuals and their health care providers when in-person care is not possible. Current law broadly defines 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.

Florida-licensed health care practitioners, registered out-of-state health practitioners, and those licensed under a multistate health care licensure compact of which Florida is a member, are authorized to use telehealth to deliver health care services to patients within the state according to the practitioners' respective scopes of practice. Providers treating Florida patients via telehealth must comply with the applicable practitioner scope of practice under Florida law; not the scope of practice of the state where the practitioner is physically located.[29]

Florida-licensed telehealth providers, as well as those licensed under a multistate health care licensure compact of which Florida is a member, include:[30]

- Behavioral Analyst
- Acupuncturist
- Allopathic physician
- Osteopathic physician
- Chiropractor
- Podiatrist
- Optometrist
- Nurse
- Pharmacist
- Dentist
- Dental hygienist
- Midwife
- Occupational therapist
- Radiology technician
- Electrologist
- Orthotist
- Pedorthist
- Prosthetist
- Medical physicist
- Emergency Medical Technician
- Paramedic
- Massage therapist
- Optician
- Clinical laboratory personnel
- Respiratory therapist
- Physical therapist
- Psychologist
- Psychotherapist
- Dietician/Nutritionist
- Athletic trainer
- Clinical social worker
- Marriage and family therapist
- Mental health counselor

[27] Department of Health, *Agency Bill Analysis for HB 855* (2024). On file with the Health and Human Services Committee.
[28] U.S. Department of Health and Human Services, *Report to Congress: E-Health and Telemedicine* (August 2016). Available at https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf (last visited January 14, 2024).
[29] S. 456.47, F.S.
[30] 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.

- Speech therapist
- Hearing aid specialist
- Genetic counselor

Out-of-state telehealth providers must register biennially with DOH or the applicable board to provide telehealth services, within the relevant scope of practice established by Florida law and rule, to patients in this state. To register or renew registration as an out-of-state telehealth provider, the health care professional must:

- Hold an active and unencumbered license, which is substantially similar to a license issued to a Florida practitioner in the same profession, in a U.S. state or jurisdiction and
- Not have been subject to licensure disciplinary action during the five years before submission of the registration application;[31]
- Not be subject to a pending licensure disciplinary investigation or action;
- Not have had license revoked in any state or jurisdiction;
- Designate a registered agent in this state for the service of process;
- Maintain professional liability coverage or financial responsibility, which covers services provided to patients not located in the provider's home state, in the same amount as required for Florida-licensed practitioners;[32] and
- Prominently display a link to the DOH website, described below, which provides public information on registered telehealth providers.[33]

Telehealth Standards of Practice

A patient receiving telehealth services may be in any location at the time services are rendered and a telehealth provider may be in any location when providing telehealth services to a patient. However, the same standard of care applies regardless of physical location; current law sets the standard of care for telehealth providers at the same level as the standard of care for health care practitioners providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care practitioner to deliver the services.[34]

Practitioners may perform a patient evaluation using telehealth. A practitioner using telehealth is not required to research a patient's medical history or conduct a physical examination of the patient before providing telehealth services to the patient if the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth.

Current law does not contain health care practitioner-specific regulations for the use of telehealth. Health care practitioners must adhere to the existing standard of care when providing services through telehealth[35] and are subject to disciplinary action if they fail to do so.[36]

Effect of the Bill

HB 855 revises existing standards for the practice of dentistry and establishes new requirements that specifically apply to providers using telehealth to provide dental services to patients.

Dental Practice

[31] The bill requires DOH to consult the National Practitioner Data Bank to verify whether adverse information is available for the registrant.
[32] Florida law requires physicians, acupuncturists, chiropractic physicians, dentists, anesthesiologist assistants, advanced practice registered nurses, and licensed midwives to demonstrate $100,000 per claim and an annual aggregate of $300,000 of professional responsibility (*see* ss. 458.320 and 459.0085, F.S.; r. 64B1-12.001. F.A.C; r. 64B2-17.009, F.A.C.; 64B5-17.0105, F.A.C.; rr. 64B8-31.006 and 64B15-7.006, F.A.C.; r. 64B9-4.002, F.A.C.; and r. 64B24-7.013, F.A.C.; respectively). Podiatric physicians must demonstrate professional responsibility in the amount of $100,000 (*see* r. 64B18-14.0072, F.A.C.).
[33] S. 456.47(4), F.S.
[34] S. 456.47(2), F.S.
[35] S. 456.47(2), F.S.
[36] S. 456.47(4)(i), F.S.

The bill requires every dentist, including individuals or entities providing services through telehealth (telehealth provider), to provide each of his or her patients with the dentist's name, contact telephone number, after-hours contact information for emergencies, and, upon the patient's request, license information. A dentist who fails to provide each patient with the name, contact telephone number, after-hours contact information for emergencies, and, upon the patient's request, the license information of each dentist who is providing dental services, is subject to discipline.

Under current law, a dentist of record who is primarily responsible for all dental treatments received by the patient must be specified in the patient records of every dental patient.[37] The bill separately restates that this requirement applies to patients receiving dental services through telehealth, and makes the failure of a telehealth provider to designate a dentist of record grounds for discipline. A dentist providing in-person services is not subject to discipline for failing to designate a dentist of record.

The bill requires that any individual, partnership, corporation, or other entity that provides dental services through telehealth *make available* the name, telephone number, practice address, and the state license number for the dentist of record and any other dentist providing services to a patient before such services are rendered. This requirement applies exclusively to telehealth providers, and conflicts with the bill's requirement that all dentists, including telehealth providers, are required only to make available their license number *upon the patient's request*.

The bill also makes failure by the dentist of record to perform an in-person examination of the patient or obtain records from an in-person examination within the last six months and review such records prior to making an initial diagnosis, correction of a malposition of teeth, or initial use of an orthodontic appliance grounds for discipline. The bill does not, however, make this an affirmative requirement for dentists. This requirement would have the effect of eliminating direct-to-consumer alignment business models, unless such businesses are able to incorporate in-person visits that satisfy this requirement.

Dental Advertising

The bill regulates advertisements for certain dental services provided via telehealth, including:

- The taking of an impression or the digital scanning[38] of the human tooth, teeth, or jaws by any means or method, directly or indirectly;
- Furnishing, supplying, constructing, reproducing, or repairing any prosthetic denture, bridge, or appliance or any other structure designed to be worn in the human mouth;
- Placing an appliance or a structure in the human mouth or adjusting or attempting to adjust the appliance or structure; and
- Correcting or attempting to correct malformations of teeth or jaws.

Advertisements for these services provided via telehealth must include a disclaimer that reads, in a clearly legible font and size:

> "An in-person examination with a dentist licensed under chapter 466, Florida Statutes, is recommended before beginning telehealth treatment in order to prevent injury or harm."

This requirement applies to advertisements intended to solicit patients including, but not limited to, business cards, circulars, pamphlets, newspapers, websites, and social media.

The provisions of the bill represent a significant departure from Florida's current policies regarding telehealth. Since telehealth was first recognized in statute in 2019,[39] Florida law has treated health care services as equivalent, regardless of whether they are rendered in person or via telehealth. By

[37] S. 466.018, F.S.
[38] The bill defines "digital scanning" as the use of digital technology that creates a computer-generated replica of the hard and soft tissue of the oral cavity using enhanced digital photography, lasers, or other optical scanning devices.
[39] *See*, ch. 2019-137, L.O.F.

establishing requirements that apply exclusively to telehealth services, the bill creates a separate, more stringent, regulatory standard for services provided via telehealth.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 466.003, F.S., relating to definitions.
Section 2: Amends s. 466.016, F.S., relating to license to be displayed.
Section 3: Amends s. 466.018, F.S., relating to dentist of record; patient records.
Section 4: Amends s. 466.019, F.S., relating to advertising by dentists
Section 5: Amends s. 466.028, F.S., relating to grounds for disciplinary action; action by the board.
Section 6: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   According to DOH, they will experience an increase in workload associated with additional complaints, investigations, and prosecutions due to the provisions of this bill. DOH estimates a need for an additional three full-time equivalent (FTE) positions in order to implement the provisions of the bill.[40] The total estimated annual FTE cost of $386,117 consists of the following:[41]

   - Salary and Benefits - $338,435/Recurring
   - Salary Rate – 237,580 Units of Rate/Recurring
   - Expense category - $26,625/Recurring + $19,977/Non-Recurring
   - Human Resources - $1,080/Recurring

   DOH will also incur non-recurring costs associated with rulemaking and IT system updates, which current budget authority is adequate to absorb.[42]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Businesses operating under the direct-to-consumer teeth aligner business model may experience a significant negative economic impact due to the regulatory provisions of the bill.

D. FISCAL COMMENTS:

None.

[40] *Supra*, note 27.
[41] *Supra*, note 27.
[42] *Supra*, note 27.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

DOH and the Board of Dentistry have sufficient rulemaking authority to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to dental services; amending s. 466.003, F.S.; revising and providing definitions; amending s. 466.016, F.S.; requiring every dentist and certain individuals, partnerships, corporations, or other entities to provide specified information to certain patients; amending s. 466.018, F.S.; requiring a dentist of record to remain primarily responsible for all dental treatments for a patient treated through telehealth; requiring any individual, partnership, corporation, or other entity that provides dental services through telehealth to make available specified information; providing construction; amending s. 466.019, F.S.; defining the term "advertisement"; requiring advertisements of dental services provided through telehealth to include a specified disclaimer for certain dental services; amending s. 466.028, F.S.; providing penalties for specified acts; providing an effective date.

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

Section 1. Subsections (8) through (15) of section 466.003, Florida Statutes, are renumbered as subsections (9) through (16) respectively, present subsection (15) is amended,

and a new subsection (8) is created, to read:

466.003 Definitions.—As used in this chapter:

(8) "Digital scanning" means the use of digital technology that creates a computer-generated replica of the hard and soft tissue of the oral cavity using enhanced digital photography, lasers, or other optical scanning devices.

(16) ~~(15)~~ "School-based prevention program" means preventive oral health services offered at a school by one of the entities defined in subsection (15) ~~(14)~~ or by a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c)(3) of the Internal Revenue Code.

Section 2. Section 466.016, Florida Statutes, is amended to read:

466.016 License to be displayed.—

(1) Every practitioner of dentistry or dental hygiene within the meaning of this chapter shall post and keep conspicuously displayed her or his license in the office wherein she or he practices, in plain sight of the practitioner's patients. Any dentist or dental hygienist who practices at more than one location must ~~shall be required to~~ display a copy of her or his license in each office where she or he practices.

(2) Every dentist shall provide each of her or his patients with her or his name, contact telephone number, after-hours contact information for emergencies, and, upon the

patient's request, license information.

(3) Any individual, partnership, corporation, or other entity that provides dental services through telehealth as defined in s. 456.47(1) shall provide each patient with the name, contact telephone number, after-hours contact information for emergencies, and, upon the patient's request, license information of each dentist who provides dental services through telehealth to the patient.

Section 3. Subsection (6) is added to section 466.018, Florida Statutes, to read:

466.018 Dentist of record; patient records.—

(6) For any patient treated through telehealth as defined in s. 456.47(1), there must be a dentist of record who remains primarily responsible for all dental treatments on the patient regardless of whether the treatment is rendered by the dentist of record or by another dentist, dental hygienist, or dental assistant rendering such treatment in conjunction with, at the direction or request of, or under the supervision of, such dentist of record. A dentist of record for a patient treated through telehealth is subject to all of the requirements of this section applicable to dentists of record.

(a) Any individual, partnership, corporation, or other entity that provides dental services through telehealth shall make available the name, telephone number, practice address, and state license number for the dentist of record and any other

dentist who provides dental services to a patient before the rendering of such services and at any time requested by a patient.

(b) This subsection may not be construed to assign any responsibility to a dentist of record for treatment rendered pursuant to a proper referral to another dentist who is not in the same practice with the dentist of record or to prohibit a patient from voluntarily selecting a new dentist without permission of the dentist of record.

Section 4. Section 466.019, Florida Statutes, is amended to read:

466.019 Advertising by dentists.—

(1) As used in this section, the term "advertisement" means a representation disseminated in any manner or by any means to solicit patients including, but not limited to, business cards, circulars, pamphlets, newspapers, websites, and social media.

(2)~~(1)~~ The purpose of this section is to ensure that the public has access to information which provides a sufficient basis upon which to make an informed selection of dentists while also ensuring that the public is protected from false or misleading advertisements which would detract from a fair and rational selection process. The board shall adopt rules to carry out the intent of this section, the purpose of which shall be to regulate the manner of such advertising in keeping with the

provisions hereof.

(3) ~~(2)~~ An ~~No~~ advertisement by a licensed dentist may not ~~shall~~ contain any false, fraudulent, misleading, or deceptive statement or claim or any statement or claim which:

(a) Contains misrepresentations of fact;

(b) Is likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts;

(c) Contains laudatory statements about the dentist or group of dentists;

(d) Is intended or is likely to create false, unjustified expectations of favorable results;

(e) Relates to the quality of dental services provided as compared to other available dental services;

(f) Is intended or is likely to appeal primarily to a layperson's fears;

(g) Contains fee information without a disclaimer that such is a minimum fee only; or

(h) Contains other representations or implications that in reasonable probability will cause an ordinary, prudent person to misunderstand or to be deceived.

(4) An advertisement of dental services provided through telehealth as defined in s. 456.47(1) must include a disclaimer that reads, in a clearly legible font and size, "An in-person examination with a dentist licensed under chapter 466, Florida Statutes, is recommended before beginning telehealth treatment

in order to prevent injury or harm" for each of the following services, if advertised:

(a) The taking of an impression or the digital scanning of the human tooth, teeth, or jaws, directly or indirectly and by any means or method.

(b) Furnishing, supplying, constructing, reproducing, or repairing any prosthetic denture, bridge, or appliance or any other structure designed to be worn in the human mouth.

(c) Placing an appliance or a structure in the human mouth or adjusting or attempting to adjust the appliance or structure.

(d) Correcting or attempting to correct malformations of teeth or jaws.

(5)~~(3)~~ For purposes of this section, D.D.S. or D.M.D. are synonymous and may be used interchangeably by licensed dentists who have graduated from an accredited American dental school with a D.D.S. or D.M.D. degree, when advertising dental services.

Section 5. Paragraph (mm) of subsection (1) of section 466.028, Florida Statutes, is redesignated as paragraph (pp) and a new paragraph (mm) and paragraphs (nn) and (oo) are added to subsection (1) of that section, to read:

466.028 Grounds for disciplinary action; action by the board.—

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

(mm) Failure by the dentist of record, before the initial diagnosis and correction of a malposition of human teeth or initial use of an orthodontic appliance, to perform an in-person examination of the patient or obtain records from an in-person examination within the last 6 months and to perform a review of the patient's most recent diagnostic digital or conventional radiographs or other equivalent bone imaging suitable for orthodontia. This subsection does not apply to providing emergent care, to care provided in connection with a public health program, or to make an initial diagnosis of a malposition of teeth and a determination of the need for an orthodontic appliance. Such an initial diagnosis and determination must be confirmed through an in-person examination and review of the patient's most recent diagnostic digital or conventional radiographs before the patient begins using the orthodontic appliance.

(nn) For dental services provided in person or through telehealth by an individual, a partnership, a corporation, or any other entity, failing to provide each patient with the name, contact telephone number, after-hours contact information for emergencies, and, upon the patient's request, the license information of each dentist who is providing dental services to the patient.

(oo) For dental services provided through telehealth by an individual, a partnership, a corporation, or any other entity,

failing to designate a dentist of record and make available, before the rendering of such services and upon the patient's request, the name, telephone number, practice address, and state license number for the dentist of record and any other dentist who will provide dental services to the patient through telehealth.

Section 6. This act shall take effect July 1, 2024.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative McClure offered the following:

Amendment (with title amendment)

Remove lines 50-181 and insert:

hours contact information for emergencies, and license information.

(3) Any partnership, corporation, or other business entity that advertises dental services shall designate with the board a dentist of record and provide each patient with the name, contact telephone number, after-hours contact information for emergencies, and, upon the patient's request, license information of the dentist record. The designated dentist shall have a full, active, and unencumbered license under this chapter or a registration pursuant to s.456.47.

Section 3. Section 466.019, Florida Statutes, is amended to read:

466.019 Advertising by dentists.—

(1) As used in this section, the term "advertisement" means a representation disseminated in any manner or by any means to solicit patients including, but not limited to, business cards, circulars, pamphlets, newspapers, websites, and social media.

(2) ~~(1)~~ The purpose of this section is to ensure that the public has access to information which provides a sufficient basis upon which to make an informed selection of dentists while also ensuring that the public is protected from false or misleading advertisements which would detract from a fair and rational selection process. The board shall adopt rules to carry out the intent of this section, the purpose of which shall be to regulate the manner of such advertising in keeping with the provisions hereof.

(3) ~~(2)~~ An ~~No~~ advertisement by a licensed dentist may not ~~shall~~ contain any false, fraudulent, misleading, or deceptive statement or claim or any statement or claim which:

(a) Contains misrepresentations of fact;

(b) Is likely to mislead or deceive because in context it makes only a partial disclosure of relevant facts;

(c) Contains laudatory statements about the dentist or group of dentists;

(d) Is intended or is likely to create false, unjustified expectations of favorable results;

(e) Relates to the quality of dental services provided as compared to other available dental services;

(f) Is intended or is likely to appeal primarily to a layperson's fears;

(g) Contains fee information without a disclaimer that such is a minimum fee only; or

(h) Contains other representations or implications that in reasonable probability will cause an ordinary, prudent person to misunderstand or to be deceived.

(4) An advertisement of dental services provided through telehealth as defined in s. 456.47(1) must include a disclaimer that reads, in a clearly legible font and size, "An in-person examination with a dentist licensed under chapter 466, Florida Statutes, is recommended before beginning telehealth treatment in order to prevent injury or harm" for each of the following services, if advertised:

(a) The taking of an impression or the digital scanning of the human tooth, teeth, or jaws, directly or indirectly and by any means or method.

(b) Furnishing, supplying, constructing, reproducing, or repairing any prosthetic denture, bridge, or appliance or any other structure designed to be worn in the human mouth.

(c) Placing an appliance or a structure in the human mouth

or adjusting or attempting to adjust the appliance or structure.

(d) Correcting or attempting to correct malformations of teeth or jaws.

(5)~~(3)~~ For purposes of this section, D.D.S. or D.M.D. are synonymous and may be used interchangeably by licensed dentists who have graduated from an accredited American dental school with a D.D.S. or D.M.D. degree, when advertising dental services.

Section 4. Paragraph (mm) of subsection (1) of section 466.028, Florida Statutes, is redesignated as paragraph (pp) and a new paragraph (mm) and paragraph (nn) ia added to subsection (1) of that section, to read:

466.028 Grounds for disciplinary action; action by the board.—

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

(mm) Failure by the dentist of record, before the initial diagnosis and correction of a malposition of human teeth or initial use of an orthodontic appliance, to perform an in-person examination of the patient or obtain records from an in-person examination within the last 12 months and to perform a review of the patient's most recent diagnostic digital or conventional radiographs or other equivalent bone imaging suitable for orthodontia.

(nn) Failing to provide each patient with the name,

contact telephone number, after-hours contact information for emergencies, and the license information of each dentist who is providing dental services to the patient.

Section 5. Section 466.0281, Florida Statutes, is created to read:

466.0281 Initial Examination for Orthodontic Appliance.—

Before the initial diagnosis and correction of a malposition of human teeth or initial use of an orthodontic appliance, a dentist must perform an in-person examination of the patient or obtain records from an in-person examination within the last 12 months and to perform a review of the patient's most recent diagnostic digital or conventional radiographs or other equivalent bone imaging suitable for orthodontia. The term “in-person examination” means an examination conducted by a dentist while the dentist is physically present in the same room as the patient.

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

Remove lines 5-19 and insert:

certain partnerships, corporations, or other entities to provide specified information to certain patients; amending s. 466.019, F.S.; defining the term "advertisement"; requiring advertisements of dental services provided through telehealth to include a specified disclaimer for certain dental services;

amending s. 466.028, F.S.; providing penalties for specified acts; creating s. 466.0281, F.S.; establishing requirements for initial examination for orthodontic appliances; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 935 Home Health Care Services
SPONSOR(S): Select Committee on Health Innovation, Franklin
TIED BILLS: **IDEN./SIM. BILLS:** SB 1798

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	11 Y, 0 N, As CS	Guzzo	Calamas
2) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons and is administered by the AHCA. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include home health care services.

Florida Medicaid pays for home health services necessary to assist a recipient living at home, including home health visits, nursing and home health aide services, supplies, appliances, and durable medical equipment. Under current law, Medicaid reimbursement is not available for home health services ordered by any practitioner other than a physician, such as a nurse.

The bill allows Medicaid to pay for home health services ordered by advanced practice registered nurses.

The bill has an indeterminate, likely insignificant negative fiscal impact on state government and no fiscal impact on local government.

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the AHCA and financed by federal and state funds.

The structure of each state's Medicaid program varies and what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include home health care services.[2]

Medicaid Home Health Coverage

Medicaid pays for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home.[3] Under current law, AHCA may not pay for these services unless they are medically necessary and:[4]

- The services are ordered by a physician.
- The written prescription for the services is signed and dated by the recipient's physician before the development of a plan of care and before any request requiring prior authorization.
- The physician ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services.
- The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.
- The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health services required, and for skilled nursing services, the frequency and duration of the services.
- The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

Under current law, reimbursement is not available for home health services ordered by any practitioner other than a physician, such as a nurse.

[1] Title 42 U.S.C. §§ 1396-1396w-5; Title 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).
[2] *Id.*
[3] S. 409.905(4), F.S.
[4] *Id.*

The SMMC program covers home health services that are medically necessary and can be safely provided to the recipient in their home or in the community, including home health visits (skilled nursing and home health aide services), private duty nursing (PDN) services, and personal care services.[5]

Home Health Visits – Children and Adults

Florida Medicaid covers home health visits, which may include any combination of skilled nursing or home health aide services visits, for recipients who have a medical condition or disability that substantially limits their ability to perform activities of daily living or instrumental activities of daily living.[6] The home health visit coverage policy includes up to four hours of intermittent home health visits per day for recipients under the age of 21 and pregnant recipients over the age of 21.[7] The home visit coverage policy also includes up to three hours of intermittent home health visits per day for non-pregnant recipients over the age of 21.

Personal Care Services – Children

Personal care services are for Medicaid recipients who require more extensive care than can be provided through a home health visit. They are provided by unlicensed HHA personnel to assist Medicaid recipients under the age of 21 with activities of daily living and instrumental activities of daily living to enable recipients to accomplish tasks they would be able to do for themselves if they did not have a medical condition or a disability. A recipient may receive up to 24 hours of personal care services per day that have been determined to be medically necessary and that can be safely provided in the recipient's home or in the community.[8]

Private Duty Nursing Services – Children

PDN services are skilled nursing services provided to recipients under the age of 21 by a registered nurse or licensed practical nurse. A recipient may receive up to 24 hours of private duty nursing services per day if they have a physician's order for PDN services that are medically necessary and can be safely provided in their home or their community. The PDN coverage policy also allows for reimbursement of up to 40 hours per week of a HHA provider for PDN services provided by the parent or legal guardian of a recipient.[9] The parent or legal guardian must be employed by an HHA and have a valid license as a registered nurse or licensed practical nurse.

The Coronavirus Aid, Relief, and Economic Security Act

The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act provided fast and direct economic assistance for American workers, families, small businesses, and industries through the implementation of a variety of programs[10] to address issues related to the onset of the COVID-19

[5] Florida Medicaid Home Health Visit Services Coverages Policy (November 2016), available at https://ahca.myflorida.com/content/download/7034/file/59G-4-130_Home_Health_Visit_Services_Coverage_Policy.pdf (last visited January 31, 2023).
[6] Activities of daily living include bathing, dressing, eating, maintaining continence, toileting, and transferring. Instrumental activities of daily living include grocery shopping, laundry, light housework, meal preparation, medication management, money management, personal hygiene, transportation, and using the telephone to take care of essential tasks.
[7] *Florida Medicaid Home Health Visit Services Coverages Policy* (November 2016), available at https://ahca.myflorida.com/content/download/7034/file/59G-4-130_Home_Health_Visit_Services_Coverage_Policy.pdf (last visited January 31, 2024).
[8] *Florida Medicaid Personal Care Services Coverage Policy* (November 2016), available at https://ahca.myflorida.com/content/download/7035/file/59G-4-215_Personal_Care_Services_Coverage_Policy.pdf (last visited January 31, 2024).
[9] *Florida Medicaid Private Duty Nursing Services Coverage Policy* (November 2016), available at https://ahca.myflorida.com/content/download/7036/file/59G-4-261_Private_Duty_Nursing_Services_Coverage_Policy.pdf (last visited January 31, 2024).
[10] Centers for Medicare & Medicaid Services, *Home Health Agencies: CMS Flexibilities to Fight COVID-19, available at* https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf (last visited January 31, 2024).

pandemic. The CARES Act was passed by Congress on March 25, 2020, and signed into law on March 27, 2020.[11]

Prior to the CARES Act, federal law only allowed a physician to order home health services for Medicare and Medicaid recipients.[12] The CARES Act[13] authorized nurse practitioners, clinical nurse specialists, and physician assistants to order home health services.[14]

Effect of the Bill

The bill allows Medicaid to pay for home health services ordered by an advanced practice registered nurse (APRN) who is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. The APRN must have examined the recipient within the 30 days preceding the request for home health services. When ordering home health services, the APRN must also include their national provider identifier, Medicaid identification number, or medical practitioner license number on the written prescription for the services. The APRN must also include such information on all claims for home health reimbursement, and prior authorization requests.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 409.905, F.S., relating to mandatory Medicaid services.
Section 2: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has an indeterminate, likely insignificant, negative fiscal impact on the state Medicaid program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

[11] U.S. Department of the Treasury, *About the CARES Act and the Consolidated Appropriations Act, available at* https://home.treasury.gov/policy-issues/coronavirus/about-the-cares-act (last visited January 31, 2024).
[12] Congress.gov, *H.R.748 – CARES Act, Summary, available at* https://www.congress.gov/bill/116th-congress/house-bill/748 (last visited January 31, 2024).
[13] Kaiser Family Foundation, *The Coronavirus Aid, Relief, and Economic Security Act: Summary of Key Health Provisions, available at* https://www.kff.org/coronavirus-covid-19/issue-brief/the-coronavirus-aid-relief-and-economic-security-act-summary-of-key-health-provisions/ (last visited January 31, 2024).
[14] Congress.gov, *H.R.748 – CARES Act, Text, available at* https://www.congress.gov/bill/116th-congress/house-bill/748/text (last visited January 31, 2024).

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to impact county or municipal government.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 2, 2024, the Select Committee on Health Innovation adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Removed a provision that allowed home health agency contracted staff to conduct initial admission visits, service evaluation visits, and discharge visits.
- Removed a provision that subjected home health services to Certificate of Need laws.

The analysis is drafted to the committee substitute as passed by the Select Committee on Health Innovation.

A bill to be entitled

An act relating to home health care services; amending s. 409.905, F.S.; authorizing an advanced practice registered nurse to order or write prescriptions for certain Medicaid services; providing an effective date.

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

Section 1. Paragraph (c) of subsection (4) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted 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, number of services, or 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.

(4) HOME HEALTH CARE SERVICES.—The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides such services must be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(c) The agency may not pay for home health services unless the services are medically necessary and:

1. The services are ordered by a physician or an advanced practice registered nurse.

2. The written prescription for the services is signed and dated by the recipient's physician or an advanced practice registered nurse before the development of a plan of care and before any request requiring prior authorization.

3. The physician or advanced practice registered nurse ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. However, this subparagraph does not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss.

1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living. For purposes of this subparagraph, the agency may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.

4. The physician or advanced practice registered nurse ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for skilled nursing services, the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician or advanced practice registered nurse ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

Section 2. This act shall take effect July 1, 2024.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Franklin offered the following:

Amendment (with title amendment)

Remove lines 38-66 and insert:

1. The services are ordered by a physician, an advanced practice registered nurse, or a physician assistant.

2. The written prescription for the services is signed and dated by the recipient's physician, advanced practice registered nurse, or physician assistant before the development of a plan of care and before any request requiring prior authorization.

3. The physician, advanced practice registered nurse, or physician assistant ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. However, this subparagraph does

not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living. For purposes of this subparagraph, the agency may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.

4. The physician, advanced practice registered nurse, or physician assistant ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for skilled nursing services, the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician, advanced practice registered nurse, or physician assistant ordering the

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

Remove lines 3-4 and insert:

s. 409.905, F.S.; authorizing advanced practice registered nurses and physician assistants to order or write prescriptions for

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1269 Potency for Adult Personal Use of Marijuana
SPONSOR(S): Healthcare Regulation Subcommittee, Massullo and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Healthcare Regulation Subcommittee	13 Y, 4 N, As CS	McElroy	McElroy
2) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

Delta-9-tetrahydrocannabinol (THC) is the psychoactive chemical in marijuana. The full extent of the health impact of consuming products with high concentration of THC is unknown; however, research indicates that such use significantly increases the risk of marijuana-associated psychosis. Studies have found daily use, especially of high-potency marijuana (over 10 percent THC), is strongly associated with earlier onset of psychosis and the development of schizophrenia in marijuana users. Some studies have also shown that marijuana with a THC concentration of 10 percent or less is effective for medical treatment, including the relief of neuropathic pain and pain caused by conditions such as HIV/AIDS, multiple sclerosis, and post-traumatic surgical pain.

Currently, 24 states and the District of Columbia have legalized the adult use of marijuana. Two states, Connecticut and Vermont, currently have potency limits for adult use marijuana products. Both states prohibit cannabis flower with a total THC concentration greater than 30% and solid or liquid concentrate cannabis products with a total THC concentration of greater than 60% from being cultivated, produced or sold in the adult use market.

Adult personal use of marijuana is not legal in Florida; however, there is a pending ballot initiative to legalize adult personal use. Although Florida does not have an adult personal use program it does have a well-established medical marijuana program, including 25 licensed Medical Marijuana Treatment Centers (MMTC). Currently licensed MMTCs would be eligible to acquire, cultivate, process, manufacture, sell, and distribute adult personal use marijuana products if the ballot initiative were to pass. The THC concentration of the products currently offered by MMTCs varies by the route of administration from .4 percent to 90 percent THC.

CS/HB 1269 establishes THC potency limits for various adult personal use marijuana products. Marijuana in the form for smoking cannot have a THC potency of greater than 30 percent and all other marijuana products, excluding edibles, cannot have a THC potency of greater than 60 percent. Identical to the potency limits in the medical marijuana program, the bill prohibits multi-serving edibles from containing more than 200 mg of THC and a single serving edible from containing more than 10 mg of THC.

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

The bill provides an effective date of 30 days after passage of an amendment to the State Constitution authorizing adult personal use of marijuana.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Research on the Health Effects of THC

Although there are more than 100 cannabinoids in a marijuana plant, the two main cannabinoids are Delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD).[1] THC is a mind-altering chemical that increases appetite and reduces nausea and may also decrease pain, anxiety, and muscle control problems.[2] Though CBD may also have an effect on the mind, it does not produce the high or sense of euphoria associated with THC. CBD has been shown to help with anxiety, depression, reducing pain and inflammation, controlling epileptic seizures, and possibly treating psychosis or mental disorders.[3]

Marijuana has changed over time. The THC concentration in commonly cultivated marijuana plants increased three-fold between 1995 and 2014 (4% and 12% respectively).[4] Conversely, the CBD content decreased from .28% in 2001 to .15% in 2014. In 1995, the level of THC was 14 times higher than its CBD level. In 2014, the THC level was 80 times the CBD level.[5] The marijuana available today is much stronger than previous versions.

Some studies have shown that marijuana with a THC concentration of 10% or less is effective for medical treatment, including the relief of neuropathic pain and pain caused by conditions such as HIV/AIDS, multiple sclerosis, post-traumatic surgical pain.[6] Studies on the use of marijuana for pain relief found that marijuana cigarettes with a THC concentration between 2% and 10% THC provided sufficient pain relief,[7] with one study finding that medium-dose marijuana cigarettes with 3.5% THC were as effective as higher dosed marijuana cigarettes at 7% THC.[8]

A 2014 New England Journal of Medicine study warned that long-term marijuana use can lead to addiction and that adolescents are more vulnerable to adverse long-term outcomes from marijuana use.[9] Specifically, the study found that, as compared with persons who begin to use marijuana in adulthood, those who begin in adolescence are approximately 2 to 4 times as likely to have symptoms

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[1] U.S. Department of Health & Human Services, National Center for Complementary and Integrative Health, *Cannabis (Marijuana) and Cannabinoids: What You Need To Know*, available at https://www.nccih.nih.gov/health/cannabis-marijuana-and-cannabinoids-what-you-need-to-know (last visited January 30, 2024).
[2] Healthline, *CBD vs. THC: What's the Difference?*, https://www.healthline.com/health/cbd-vs-thc (last visited January 30, 2024).
[3] *Id*.
[4] *U.S. Surgeon General's Advisory: Marijuana Use and the Developing Brain*, https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/advisory-on-marijuana-use-and-developing-brain/index.html (last visited January 30, 2024).
[5] ElSohly, M.A., Mehmedic, Z., Foster, S., Gon, C., Chandra, S. and Church, J.C. *Changes in Cannabis Potency Over the Last 2 Decades (1995-2014): Analysis of Current Data in the United States,* Biological Psychiatry. April 1, 2016; 79(7):613-619.
[6] Igor Grant,1 J. Hampton Atkinson, Ben Gouaux, and Barth Wilsey. *Medical Marijuana: Clearing Away the Smoke.* Open Neurol J. 2012; 6: 18–25. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3358713/; Ellis RJ, Toperoff W, Vaida F, et al. *Smoked Medicinal Cannabis for Neuropathic Pain in HIV: A Randomized, Crossover Clinical Trial,* Neuropsychopharmacology, 2009; 34(3):672-680, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3066045/ (last viewed on January 30, 2024); Abrams DI, Jay CA, Shade SB, et al. *Cannabis in Painful HIV-associated Sensory Neuropathy: A Randomized Placebo-controlled Trial.* Neurology. 2007; 68(7):515-521 available at https://pubmed.ncbi.nlm.nih.gov/17296917/ (last viewed on January 30, 2024); Wilsey B, Marcotte T, Tsodikov A, et al. *A Randomized, Placebo-controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain,* J Pain. 2008;9(6):506-521, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4968043/ (last viewed on January 30, 2024); Wallace M, Schulteis G, Atkinson JH, et al. *Dose-dependent Effects of Smoked Cannabis on Capsaicin-induced Pain and Hyperalgesia in Healthy Volunteers.* Anesthesiology. 2007; 107(5):785–96, available at https://pubs.asahq.org/anesthesiology/article/107/5/785/7080/Dose-dependent-Effects-of-Smoked-Cannabis-on (last viewed on January 30, 2024).
[7] *Id*.
[8] Wilsey B, Marcotte T, Tsodikov A, et al. *A Randomized, Placebo-controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain*. J Pain. 2008; 9(6):506–21, available at https://pubmed.ncbi.nlm.nih.gov/18403272/ (last viewed on January 30, 2024).
[9] Volkow, N.D., Baler, R.D., Compton, W.M. and Weiss, S.R., *Adverse Health Effects of Marijuana Use,* NEW ENG. J. MED., June 5, 2014, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4827335/ (last viewed on January 30, 2024).

of marijuana dependence within 2 years after first use.[10] The study also found that marijuana-based treatments with THC may have irreversible effects on brain development in adolescents as the brain's endocannabinoid system undergoes development in childhood and adolescence.[11]

Heavy use of marijuana by adolescents is associated with impairments in attention, learning, memory, poor grades, high drop rates and I.Q. reduction.[12] Though the full extent of the health impact of consuming products with high concentration of THC is unknown, research indicates that use of such products significantly increases the risk of marijuana-associated psychosis,[13] regardless of age at first use or the type of marijuana used.[14] A 2019 European study showed that the use of high-potency marijuana (over 10% THC) only modestly increased the odds of a psychotic disorder compared to never using it; however, individuals who started using high-potency marijuana by age 15 showed a doubling of risk.[15] The European study also found that daily use of high-potency cannabis increased the risk of psychotic disorder nearly five times compared with never having used marijuana.[16]

Another study found that frequent use of marijuana or use of marijuana with high THC potency increased the risk of schizophrenia six-fold.[17] According to a literature review of studies on the impact of marijuana use on mental health published in the Journal of the American Medical Association Psychiatry, there is strong physiological and epidemiological evidence supporting a link between marijuana use and schizophrenia. High doses of THC can cause acute, transient, dose-dependent psychosis, which are schizophrenia-like symptoms. Additionally, prospective, longitudinal, and epidemiological studies have consistently found an association between marijuana use and schizophrenia in which marijuana use precedes psychosis, independent of alcohol consumption, and even after removing or controlling for those individuals who had used other drugs.[18]

Even though marijuana use may have been discontinued long before the onset of psychosis, studies have found that the age at which marijuana use begins appears to correlate with the age of onset of psychosis, which suggests that early marijuana use plays a role in initiating psychosis that is independent of actual use.[19] Overall, studies have found that the association between marijuana use and chronic psychosis (including a schizophrenia diagnosis) is stronger in those individuals who have had heavy or frequent marijuana use, use marijuana during adolescence, or use marijuana with high THC potency.[20]

While studies have not shown that marijuana use alone is either necessary or sufficient for the development of schizophrenia, studies suggests that marijuana use may initiate the emergence of a lasting psychotic illness in some individuals, especially those with a genetic vulnerability to develop a psychotic illness.[21]

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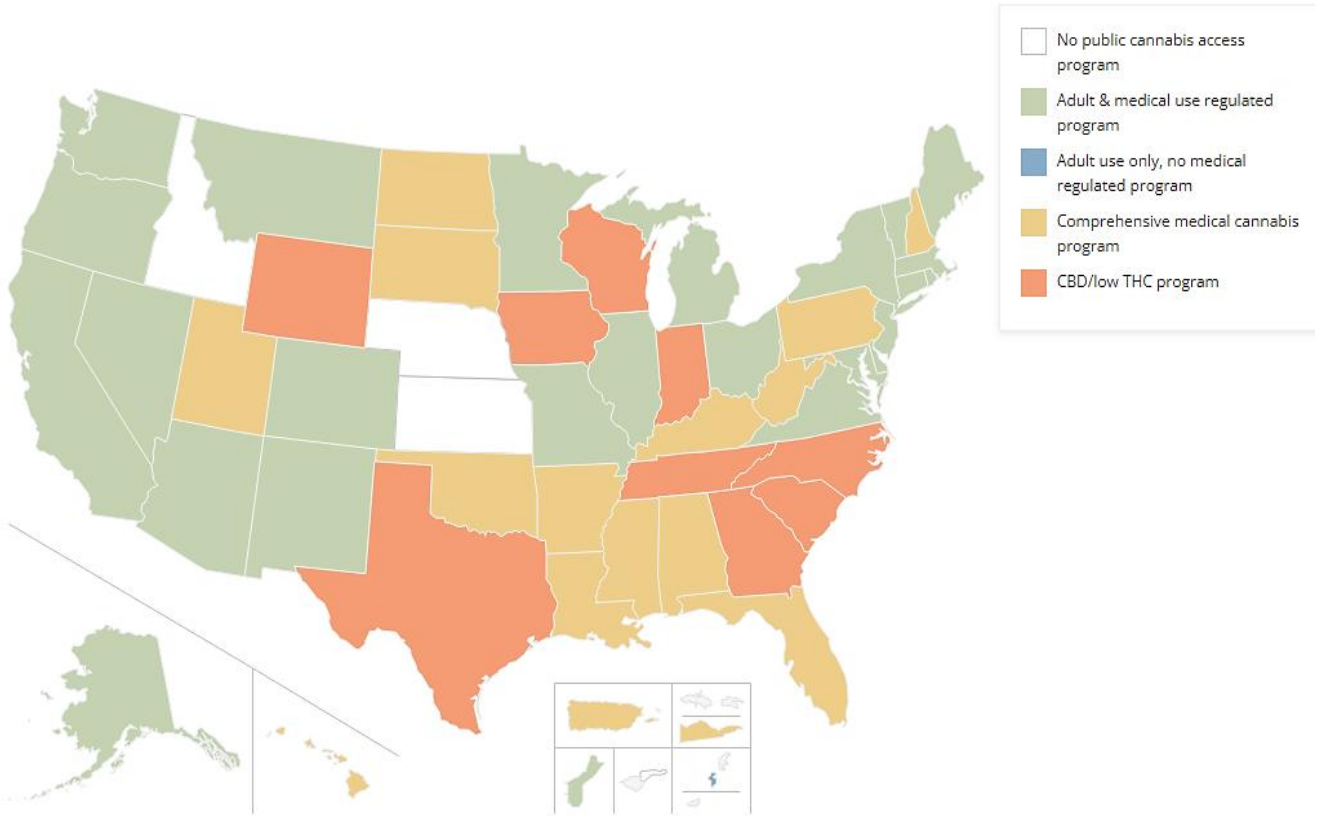
[10] *Id*.
[11] *Id*.
[12] *See* footnote 9; *see also The Influence of Marijuana Use on Neurocognitive Functioning in Adolescents*, Schweinsburg AD, Brown SA, Tapert SF, Curr Drug Abuse Rev. 2008;1(1):99-111, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2825218/ (last viewed on January 30, 2024).
[13] Robin Murray, Harriet Quigley, Diego Quattrone, Amir Englund and Marta Di Forti, *Traditional Marijuana, High-Potency Cannabis and Cannabinoids: Increasing Risk for Psychosis*, World Psychiatry, 2016 Oct; 15(3): 195–204, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5032490/ (last viewed January 30, 2024).
[14] Di Forti et al. *The Contribution of Cannabis Use to Variation in the Incidence of Psychotic Disorder Across Europe (EU-GEI): A Multicenter Case-control Study*. Lancet Psychiatry. 2019; 6:427-36, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7646282/ (last viewed on January 30, 2024); *High-Potency Cannabis and Incident Psychosis: Correcting the Causal Assumption*, The Lancet, Volume 6, Issue 6, June 2019, available at https://doi.org/10.1016/S2215-0366(19)30174-9 (last viewed January 30, 2024); *High-Potency Cannabis and Incident Psychosis: Correcting the Causal Assumption – Author's Reply*, The Lancet, Volume 6, Issue 6, June 2019 available at https://doi.org/10.1016/S2215-0366(19)30176-2 (last viewed January 30, 2024).
[15] *Id*. at 430.
[16] *Id*. at 431. The odds were lower for those who use low-potency marijuana daily.
[17] Nora D. Volkow, MD; James M. Swanson, PhD; A. Eden Evins, MD; Lynn E. DeLisi, MD; Madeline H. Meier, PhD; Raul Gonzalez, PhD; Michael A. P. Bloomfield, MRCPsych; H. Valerie Curran, PhD; Ruben Baler, PhD., *Effects of Cannabis Use on Human Behavior, Including Cognition, Motivation, and Psychosis: A Review.* JAMA Psychiatry. 2016; 73(3):292-297, available at https://core.ac.uk/reader/79505094?utm_source=linkout (last viewed January 30, 2024).
[18] *Id*.
[19] *Id*.
[20] *Id*.
[21] *Id*.

State Legalization of Adult Use of Marijuana

Currently, 24 states and the District of Columbia have legalized the adult use of marijuana, as indicated by the map below.[22]



State Potency Limits for Adult Use Marijuana

Two states, Connecticut and Vermont, currently have potency limits for adult use marijuana products. Both states prohibit cannabis flower with a total THC concentration greater than 30% and solid or liquid concentrate cannabis products with a total THC concentration of greater than 60% from being cultivated, produced or sold in the adult use market.[23] Both states provided an exception to these potency limits for pre-filled cartridges for vape pens.[24]

Florida - Adult Personal Use of Marijuana

Adult personal use of marijuana is not legal in Florida; however, there is a pending ballot initiative to legalize adult personal use. The proponents of the initiative were required to obtain 891,523 valid signatures to qualify the initiative for the ballot. The proponents have met this requirement as there are currently 1,033,770 valid signatures for the initiative.[25] The ballot summary of the initiative states:[26]

[22] *Map Monday: Nearly Every State Redefining Cannabis Access*, National Conference of State Legislatures available at https://www.ncsl.org/resources/map-monday-nearly-every-state-redefining-cannabis-access (last visited on February 7, 2024). States include: California, Alaska, Nevada, Oregon, Washington, Maine, Colorado, Montana, Vermont, Rhode Island, New Mexico, Michigan, Arizona, New Jersey, Delaware, Connecticut, Massachusetts, Illinois, Maryland, Minnesota, New York, Ohio, Missouri, Virginia.
[23] See CT ST s. 21a-421j and VT ST T.7 s. 868.
[24] *Id.*
[25] Adult Personal Use of Marijuana 22-05, Florida Division of Elections, available at https://dos.elections.myflorida.com/initiatives/initdetail.asp?account=83475&seqnum=2 (last viewed January 31, 2024).
[26] Constitutional Amendment Full Text, available at https://initiativepetitions.elections.myflorida.com/InitiativeForms/Fulltext/Fulltext_2205_EN.pdf (last viewed January 31, 2024).

Allows adults 21 years or older to possess, purchase, or use marijuana products and marijuana accessories for non-medical personal consumption by smoking, ingestion, or otherwise; allows Medical Marijuana Treatment Centers, and other state licensed entities, to acquire, cultivate, process, manufacture, sell, and distribute such products and accessories. Applies to Florida law; does not change, or immunize violations of, federal law. Establishes possession limits for personal use. Allows consistent legislation. Defines terms. Provides effective date.

The State of Florida requested an advisory opinion from the Florida Supreme Court as to the validity of the initiative specifically seeking guidance on whether the initiative and the ballot title and summary comply with applicable Florida law.[27] Oral arguments occurred in November 2023, and the issue remains pending before the court.[28]

Florida Potency of Medical Marijuana Products

Although Florida does not have an adult personal use program it does have a well-established medical marijuana program. Section 381.986, F.S., authorizes patients with any of the following debilitating medical conditions to obtain medical marijuana from Medical Marijuana Treatment Centers (MMTC):

- Cancer
- Epilepsy
- Glaucoma
- Positive status for human immunodeficiency virus
- Acquired immune deficiency syndrome
- Post-traumatic stress disorder
- Amyotrophic lateral sclerosis
- Crohn's disease
- Parkinson's disease
- Multiple sclerosis
- Medical conditions of the same kind or class as or comparable to those enumerated above

To obtain marijuana for medical use from a Medical Marijuana Treatment Center (MMTC), and maintain the immunity from criminal prosecution, the patient must obtain a physician certification from a qualified physician[29] and an identification card from the Department of Health.

As of January 26, 2024, there are 871,459 qualified patients, 2,781 qualified patients and 25 MMTCs with 618 dispensing locations.[30]

Currently licensed MMTCs would be eligible to acquire, cultivate, process, manufacture, sell, and distribute adult personal use marijuana products if the ballot initiative were to pass. The THC concentration of the products offered by MMTCs varies based on the route of administration, as evidenced by the table below.[31]

[27] *Advisory Opinion to the Attorney General Re: Adult Personal Use of Marijuana*, SC2023-0682, 2023, available at https://acis.flcourts.gov/portal/court/68f021c4-6a44-4735-9a76-5360b2e8af13/case/85dca015-d108-4595-8cdb-d4488890aa88 (last viewed January 31, 2024).
[28] *Id.*
[29] To certify patients for medical use of marijuana, a physician must hold an active, unrestricted license as an allopathic physician under chapter 458 or as an osteopathic physician under chapter 459 and comply with certain physician education requirements. See ss. 381.986(1)(m), F.S. and 381.986(3)(a), F.S.
[30] *Office of Medical Marijuana Use Weekly Updates, January 26, 2024,* DOH, Office of Medical Marijuana Use, available at https://knowthefactsmmj.com/wp-content/uploads/ommu_updates/2024/012624-OMMU-Update.pdf (last visited on January 29, 2024).
[31] *Florida's Medical Marijuana Program Update,* Office of Medical Marijuana Use, presented to the Health Care Regulation Subcommittee on December 13, 2023.

Route of Administration	Range in Potency Tetrahydrocannabinol (THC) Content as a Percentage of Volume	
	Lower Threshold	Upper Threshold
Inhalation	60.0%	90.0%
Oral	0.5%	4.0%
Smoking	10.0%	28.0%
Sublingual	0.5%	90.0%
Suppository	1.3%	3.0%
Topical	0.4%	90.0%
Edibles	A multi-serving edible may not contain more than 200 mg of THC, and a single-serving edible, or a single serving portion of a multi-serving edible, may not exceed 10 mg of THC.	

Edibles are the only medical marijuana products currently subject to THC potency limits.

Effect of the Bill

CS/HB 1269 establishes THC potency limits for various adult personal use marijuana products. Marijuana in the form for smoking cannot have a THC potency of greater than 30 percent and all other marijuana products, excluding edibles, cannot have a THC potency of greater than 60 percent. Identical to the potency limits in the medical marijuana program, the bill prohibits multi-serving edibles from containing more than 200 mg of THC and a single serving edible from containing more than 10 mg of THC.

The bill provides an effective date of 30 days after passage of an amendment to the State Constitution authorizing adult personal use of marijuana.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.9861, F.S., relating to the potency limits for adult personal use of marijuana.

Section 2: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

A. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

B. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

C. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 1, 2024, the Healthcare Regulation Subcommittee adopted an amendment and reported the bill favorable. The amendment established a THC potency limit for marijuana in the form for smoking in the adult personal use marijuana program. Such marijuana may not have a THC potency of greater than 30 percent.

This analysis is drafted to the committee substitute as passed by the Healthcare Regulation Subcommittee.

A bill to be entitled

An act relating to potency for adult personal use of marijuana; creating s. 381.9861, F.S.; providing definitions; specifying the authorized potency of tetrahydrocannabinol when consuming marijuana for personal use; providing a contingent effective date.

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

Section 1. Section 381.9861, Florida Statutes, is created to read:

381.9861 Potency limits for adult personal use of marijuana.—

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

(a) "Edibles" means commercially produced food items made with marijuana oil, but no other form of marijuana.

(b) "Marijuana" means all parts of any plant of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin, including low-THC cannabis.

(c) "Marijuana delivery device" means an object used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, or otherwise introducing marijuana into the human body.

(d) "Personal use" means possession, purchase, or use of marijuana or a marijuana delivery device by an adult 21 years of age or older for nonmedical consumption.

(e) "Potency" means the relative strength of cannabinoids, and the total amount, in milligrams, of tetrahydrocannabinol as the sum of delta-9-tetrahydrocannabinol, plus 0.877 multiplied by tetrahydrocannabinolic acid, plus delta-8-tetrahydrocannabinol and cannabidiol as the sum of cannabidiol, plus 0.877 multiplied by cannabidiolic acid in the final product.

(2) Marijuana for personal use may not have a tetrahydrocannabinol potency, by weight or volume, of greater than 30 percent for marijuana in a form for smoking or greater than 60 percent in the final product for all other forms of marijuana, excluding edibles. Edibles for personal use may not contain more than 200 milligrams of tetrahydrocannabinol and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol.

Section 2. This act shall take effect 30 days after passage of an amendment to the State Constitution authorizing adult personal use of marijuana.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Massullo offered the following:

Amendment

Remove lines 40-43 and insert:

marijuana, excluding edibles and marijuana products prepackaged for use in a vapor-generating electronic device, as defined in s. 386.203.

(a) Edibles for personal use may not contain more than 200 milligrams of tetrahydrocannabinol and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol. Edibles may have a potency variance of no greater than 15 percent.

(b) Marijuana products prepackaged for use in a vapor-generating electronic device, as defined in s. 386.203, may not

contain more than 1,000 milligrams of tetrahydrocannabinol per container.

Section 2. Section 1 of chapter 2017-232, Laws of Florida, is amended to read: Section 1. Legislative intent.—It is the intent of the Legislature to implement s. 29, Article X of the State Constitution by creating a unified regulatory structure. ~~If s. 29, Article X of the State Constitution is amended or a constitutional amendment related to cannabis or marijuana is adopted, this act shall expire 6 months after the effective date of such amendment.~~

CS/HB 1343

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1343 Health Care Patient Protection
SPONSOR(S): Select Committee on Health Innovation, Altman
TIED BILLS: **IDEN./SIM. BILLS:** SB 1418

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Health Innovation	11 Y, 0 N, As CS	Guzzo	Calamas
2) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

General hospital EDs (nonchildren's hospitals) primarily treat adults and may not be prepared to treat children because of low pediatric patient volume. More than 97 percent of EDs caring for children are general hospital EDs, accounting for 82 percent of pediatric ED visits. Currently, Florida laws do not require hospital EDs to meet minimum standards of care for pediatric patients.

The National Pediatric Readiness Project (NPRP) is a quality improvement initiative to empower all EDs to provide effective emergency care to children. The NPRP developed an assessment to measure a hospital ED's pediatric readiness. The NPRP Assessment is voluntary and is conducted every five years. Recent studies prove that hospital EDs with high pediatric readiness scores have lower mortality rates among children.

The bill requires all hospitals with EDs to develop and implement policies and procedures for pediatric patient care in the ED, which reflect evidence-based best practices related to, at a minimum: triage; measuring and recording vital signs; weighing and recording weights in kilograms; calculating medication dosages; and using pediatric instruments. Additionally, each hospital with an ED must conduct training on their policies and procedures, which must include, at a minimum: the use of pediatric instruments, as applicable to each licensure type, and using clinical simulation and drills that simulate emergency situations. Each ED must conduct drills at least annually and each clinical employee of the ED must receive training at least annually.

The bill requires each hospital with an ED to designate a physician or nurse to serve as the pediatric emergency care coordinator in the ED. The pediatric emergency care coordinator is responsible for implementation of, and ensuring fidelity to, the policies and procedures for pediatric patient care in the ED.

The bill requires AHCA, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, to adopt rules that establish minimum standards for pediatric patient care in hospital EDs, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies. The bill also requires AHCA to adopt rules to require a hospital's comprehensive emergency management plan to include components that address the needs of pediatric and neonatal patients.

The bill requires all hospital EDs to conduct the National Pediatric Readiness Assessment, in accordance with the timelines established by the National Pediatric Readiness Project. The next pediatric readiness assessment will be conducted in 2026 and every five years thereafter. Each hospital ED must submit the results of the assessment to AHCA by December 31, 2026. The bill requires AHCA to publish the results of the assessment score for each hospital ED and provide a comparison to the national average score. AHCA must publish the results of the 2026 assessment by April 1, 2027, and must publish the results of subsequent assessments by April 1 following a year in which the assessment is conducted.

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

The bill provides an effective date of July 1, 2024.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Hospital Licensure

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. In Florida, emergency departments (EDs) are either located in a hospital or on separate premises of a licensed hospital. Any licensed hospital which has a dedicated ED may provide emergency services in a location separate from the hospital's main premises, known as a hospital-based off-campus emergency department.[1]

Current law requires each hospital with an ED to screen, examine, and evaluate a patient who presents to the ED to determine if an emergency medical condition exists and, if it does, provide care, treatment, or surgery to relieve or eliminate the emergency medical condition.[2] Each hospital with an ED must provide emergency services and care[3] 24 hours a day and must have at least one physician on-call and available within 30 minutes.[4]

Inventory of Hospital Emergency Services

Each hospital offering emergency services and care must report to AHCA the services which are within the service capability of the hospital.[5] AHCA is required to maintain an inventory of hospitals with emergency services, including a list of the services within the service capability of the hospital, to assist emergency medical services providers and the general public in locating appropriate emergency medical care.[6] If a hospital determines it is unable to provide a service on a 24 hour per day, 7 day per week basis, either directly or indirectly through an arrangement with another hospital, the hospital must request a service exemption from AHCA.[7]

Policies and Procedures

Each hospital offering emergency services and care is required to maintain written policies and procedures specifying the scope and conduct of their emergency services. The policies and procedures must be approved by the organized medical staff, reviewed at least annually, and must include:[8]

- A process to designate a physician to serve as the director of the ED;
- A written description of the duties and responsibilities of all other health care personnel providing care within the ED;
- A planned formal training program on emergency access laws for all health care personnel working in the ED; and
- A control register to identify all persons seeking emergency care.

[1] S. 395.002(13), F.S.
[2] S. 395.1041, F.S.
[3] S. 395.002(9), F.S., "emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.
[4] Rule 59A-3.255(6), F.A.C.
[5] S. 395.1041(2), F.S.
[6] Medical services listed in the inventory include: anesthesia; burn; cardiology; cardiovascular surgery; colon & rectal surgery; emergency medicine; endocrinology; gastroenterology; general surgery; gynecology; hematology; hyperbaric medicine; internal medicine; nephrology; neurology; neurosurgery; obstetrics; ophthalmology; oral/maxilla-facial surgery; orthopedics; otolaryngology; plastic surgery; podiatry; psychiatry; pulmonary medicine; radiology; thoracic surgery; urology; and vascular surgery.
[7] Rule 59A-3.255(4), F.A.C. AHCA Form 3000-1 Emergency Services Exemption Request available at https://www.flrules.org/Gateway/reference.asp?No=Ref-04607 (last visited December 22, 2023).
[8] Rule 59A-3.255(6)(e), F.A.C.

Current law does not require EDs to have pediatric-specific policies and procedures.

Equipment and Supplies

Each hospital ED is required to provide diagnostic radiology services and clinical laboratory services and must ensure that an adequate supply of blood is available at all times. Hospitals EDs are also required to have certain equipment available for immediate use at all times, including:[9]

- Oxygen and means of administration;
- Mechanical ventilatory assistance equipment, including airways, manual breathing bags, and ventilators;
- Cardiac defibrillators with synchronization capability;
- Respiratory and cardiac monitoring equipment;
- Thoracentises and closed thoracotomy sets;
- Tracheostomy or cricothyrotomy sets;
- Tourniquets;
- Vascular cutdown sets;
- Laryngoscopes and endotracheal tubes;
- Urinary catheters with closed volume urinary systems;
- Pleural and pericardial drainage sets;
- Minor surgical instruments;
- Splinting devices;
- Emergency obstetrical packs;
- Standard drugs as determined by the facility;
- Common poison antidotes;
- Syringes, needles, and surgical supplies;
- Parenteral fluids and infusion sets;
- Refrigerated storage for biologicals and other supplies; and
- Stable examination tables.

Currently, there are no pediatric-specific equipment or supply standards for EDs.

Comprehensive Emergency Management Plans

All hospitals are required to develop and adopt a comprehensive emergency management plan for emergency care during an internal or external disaster or an emergency.[10] Each hospital must review, update, and submit their plans annually to their county office of emergency management. A hospital's comprehensive emergency management plan must include the following:[11]

- Provisions for the management of staff, including the distribution and assignment of responsibilities and functions;
- Education and training of personnel in carrying out their responsibilities in accordance with the adopted plan;
- Information about how the hospital plans to implement specific procedures outlined in the plan;
- Precautionary measures, including voluntary cessation of hospital admissions, to be taken in preparation and response to warnings of inclement weather, or other potential emergency conditions;
- Provisions for the management of patients, including the discharge of patients in the event of an evacuation order;
- Provisions for coordinating with other hospitals;
- Provisions for the individual identification of patients, including the transfer of patient records;

[9] Rule 59A-3.255(6)(g), F.A.C.
[10] S. 395.1055(1)(c), F.S.
[11] Rule 59A-3.078, F.A.C.

- Provisions to ensure that relocated patients arrive at designated hospitals;
- Provisions to ensure that medication needs will be reviewed and advance medication for relocated patients will be forwarded to the appropriate hospitals;
- Provisions for essential care and services for patients who may be relocated to the facility during a disaster or an emergency, including staffing, supplies, and identification of patients;
- Provisions for the management of supplies, communications, power, emergency equipment, and security;
- Provisions for coordination with designated agencies including the Red Cross and the county emergency management office; and
- Plans for the recovery phase of the operation.

Current law does not require hospitals to include any pediatric-specific provisions in their comprehensive emergency management plans.

Pediatric Care in Hospital Emergency Departments

Children represent approximately 25 percent of all emergency department visits in the U.S. each year.[12] A recent analysis by the Wall Street Journal indicated that general hospital EDs are often unprepared to care for children, citing examples of failures to have pediatric equipment and supplies on hand, drug dosing errors, and lack of staff training on pediatric implements.[13]

According to a recent study conducted to evaluate the association between ED pediatric readiness and in-hospital mortality, pediatric patient deaths are 60 percent to 76 percent less likely to occur in an ED with high pediatric readiness.[14] The study included 796,937 pediatric patient visits in 983 EDs over a six-year period (January 1, 2012, through December 31, 2017). The study used the results of the 2013 National Pediatric Readiness Project Assessment to categorize each hospital ED in one of four levels of pediatric readiness (first quartile 0-58, second quartile 59-72, third quartile 73-87, and fourth quartile 88-100). Hospital EDs with an Assessment score of 88-100 were categorized as having high pediatric readiness. The study also concluded that if all 983 EDs had high pediatric readiness, an estimated 1,442 pediatric deaths may have been prevented.

General hospital EDs (nonchildren's hospitals) primarily treat adults and may not be prepared to treat children because of low pediatric patient volume. More than 97 percent of EDs caring for children are general hospital EDs, accounting for 82 percent of pediatric ED visits.[15] Most of these hospitals see less than 15 pediatric patients per day.[16] Therefore, according to a joint policy statement issued by the American Academy of pediatrics (AAP), the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA), "it is imperative that all hospital EDs have the appropriate resources (medications, equipment, policies, and education) and staff to provide effective emergency care for children."[17]

The 2009 joint policy statement by the AAP, ACEP, and ENA also included guidelines for care of children in the emergency department.[18] In 2012, the Emergency Medical Services for Children

[12] Remick KE, Hewes HA, Ely M, et al. *National Assessment of Pediatric Readiness of US Emergency Departments During the COVID-19 Pandemic.* JAMA Network (July, 2023) available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807059 (last visited December 22, 2023).
[13] Liz Essley Whyte and Melanie Evans, *Children are Dying in Ill-Prepared Emergency Rooms Across America*, Wall Street Journal (Oct. 2023), available at https://www.wsj.com/health/healthcare/hospitals-emergency-rooms-cost-childrens-lives-d6c9fc23 (last visited December 22, 2023).
[14] Newgard CD, Lin A, Malveau S, et al. *Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care*. JAMA Network (January, 2023) available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800400 (last visited December 22, 2023).
[15] *Id.*
[16] The National Pediatric Readiness Project, Pediatric Readiness Saves Lives, available at https://media.emscimprovement.center/documents/EMS220628_ReadinessByTheNumbers_220830_ZekNYVF.pdf (last visited December 22, 2023).
[17] American Academy of Pediatrics, Committee on Pediatric Emergency Medicine; American College of Emergency Physicians, Pediatric Committee; Emergency Nurses Association, Pediatric Committee. Joint policy statement--guidelines for care of children in the emergency department (Oct. 2009), available at https://doi.org/10.1542/peds.2009-1807 (last visited December 22, 2023).
[18] *Id.*

(EMSC) Program, under the U.S. Department of Health and Human Services, used the guidelines to launch the National Pediatric Readiness Project, in partnership with the AAP, ACEP, and ENA.

The National Pediatric Readiness Project

The National Pediatric Readiness Project (NPRP) is a quality improvement initiative offering state partnership grants to state governments and accredited schools of medicine to expand and improve emergency medical services for children in hospital EDs.[19] The NPRP measures the performance of hospital EDs based on the following 4 metrics and includes program goals for each.[20]

- Pediatric Readiness Recognition Programs – Program Goal: To increase the percent of hospitals with an ED recognized through a statewide, territorial, or regional standardized program that are able to stabilize and manage pediatric emergencies.
- Pediatric Emergency Care Coordinators – Program Goal: To increase the percent of hospitals with an ED that have a designated nurse, physician, or both who coordinates pediatric emergency care.
- Disaster Plan Resources – Program Goal: To increase the percent of hospitals with an ED that have a disaster plan that addresses the needs of children.
- Weigh and Record Children's Weight in Kilograms – Program Goal: To increase the percent of hospitals with an ED that weigh and record children in kilograms.

The NPRP particularly focuses on weighing and recording children's weight in kilograms to avoid medication errors. Product labeling for medications with weight-based dosing utilize the metric system. Converting from pounds to kilograms is an error-prone process and can double the number of dosing errors made. Pediatric and neonatal patients are at greater risk for adverse drug events, because they are more vulnerable to the effects of an error.[21]

ED performance is measured based on the NPRP Assessment,[22] a voluntary survey accessed via invitation from the NPRP. The NPRP has conducted two nationwide assessments. The first NPRP Assessment occurred in 2013 and the second was in 2021. According to current Program plans, the expectation is that the NPRP Assessment will occur every 5 years, so the next assessment will be in 2026.[23]

[19] The program is also used to improve emergency medical care for children in prehospital settings and to advance family partnerships and leadership in efforts to improve EMSC systems of care, *see* https://www.grants.gov/search-results-detail/340371 .
[20] EMSC Innovation and Improvement Center, Performance Measures, available at https://emscimprovement.center/programs/partnerships/performance-measures/ .
[21] Emergency Nurses Association, *Weighing all Patients in Kilograms* (2020), available at https://www.pedsnurses.org/assets/docs/Engage/Position-Statements/Weighing%20All%20Patients%20in%20Kilograms%20Final%20Web.pdf *see also* National Coordinating Council for Medication Error Reporting and Prevention, *Recommendations to Weigh Patients and Document Metric Weights to Ensure Accurate Medication Dosing* (Oct. 2018), available at https://www.nccmerp.org/recommendations-weigh-patients-and-document-metric-weights-ensure-accurate-medication-dosing-adopted (last visited December 22, 2023).
[22] National Pediatric Readiness Project, Pediatric Readiness Assessment, available at https://www.pedsready.org/docs/PedsReady%20Survey-QI%20Assessment.pdf (last visited December 22, 2023).
[23] Emergency Medical Services for Children, National Pediatric Readiness Project Assessment, available at https://emscdatacenter.org/sp/pediatric-readiness/national-pediatric-readiness-project-nprp-assessment/ (last visited December 22, 2023).

Not all hospitals choose to participate in the NPRP Assessment. Florida Participation rates are below the national average, and dropped from 2013[24] to 2021[25], as indicated by the tables below.

Florida Participation Rates	
2013 Rate	2021 Rate
61 % 126 of 209	58% 170 of 295

National Participation Rates	
2013 Rate	2021 Rate
83 % 4,150 of 5,017	71 % 3,647 of 5,150

The average score for participating hospitals in Florida dropped slightly from 2013[26] to 2021,[27] while the average national score saw a slight increase, as indicated by the tables below.

Florida Average Score	
2013 Score	2021 Score
78 %	75 %

National Average Score	
2013 Score	2021 Score
69 %	71%

Recent studies associate high pediatric readiness scores with:[28]

- 76 percent lower mortality rate in ill children;
- 60 percent lower mortality rate in injured children; and
- 1,400 children's lives saved across the U.S. each year.

Florida Emergency Medical Services for Children State Partnership Program

The Florida Emergency Medical Services for Children State Partnership Program[29] (program) is a quality improvement initiative administered by the University of Florida College of Medicine — Jacksonville, and is funded by a state partnership grant from the national EMSC Program.[30] The purpose of the program is to expand and improve emergency medical services for children who need treatment for trauma or critical care by partnering with EDs, emergency medical service agencies, and disaster preparedness organizations to enhance pediatric readiness. The program provides outreach and information to hospital EDs to help improve their pediatric readiness by, among other things, increasing awareness of, and participation in, the NPRP Assessment.

[24] Florida versus National Pediatric Readiness Project Results from 2013 Survey, available at https://www.floridahealth.gov/provider-and-partner-resources/emsc-program/_documents/fl-pediatricreadiness-summary091013.pdf (last visited December 22, 2023).
[25] Florida Versus National Pediatric Readiness Project Results from 2021 Survey, available at https://emlrc.org/wp-content/uploads/National-Pediatric-Readiness-Assessment-2021-Results_07.19.2023_Final.pdf (last visited December 22, 2023).
[26] *Supra* note 23.
[27] *Supra* note 24.
[28] Stefanie G. Ames, MD, MS; Billie S. Davis, PhD; Jennifer R. Marin, MD, MSc; Ericka L. Fink, MD, MS; Lenora M. Olson, PhD, MA; Marianne Gausche-Hill, MD; Jeremy M. Kahn, MD, MS, Emergency Department Pediatric Readiness and Mortality in Critically Ill Children, *American Academy of Pediatrics* (Sept. 2019), available at https://doi.org/10.1542/peds.2019-0568 and Newgard CD, Lin A, Malveau S, et al. Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care. JAMA Netw Open. 2023;6(1):e2250941. doi:10.1001/jamanetworkopen.2022.50941 (last visited December 22, 2023).
[29] Florida Emergency Medical Services for Children State Partnership Program (Florida PEDREADY), available at https://emlrc.org/flpedready/ (last visited December 22, 2023).
[30] EMSC Innovation and Improvement Center, EMSC State Partnership Grants Database, Florida – State Partnership, April 1, 2023 – March 31, 2027, available at https://emscimprovement.center/programs/grants/236/florida-state-partnership-20230401-20270331-emsc-state-partnership/ (last visited December 22, 2023).

Effect of the Bill

The bill requires all hospitals with EDs to develop and implement policies and procedures for pediatric patient care in the ED, which reflect evidence-based best practices related to, at a minimum:

- Triage;
- Measuring and recording vital signs;
- Weighing and recording weights in kilograms;
- Calculating medication dosages; and
- Using pediatric instruments.

Further, each hospital with an ED must conduct training on their policies and procedures, which must include, at a minimum: the use of pediatric instruments, as applicable to each licensure type, and using clinical simulation and drills that simulate emergency situations. Each ED must conduct drills at least annually and each clinical employee of the ED must receive training at least annually.

The bill requires each hospital with an ED to designate a physician or nurse to serve as the pediatric emergency care coordinator in the ED. The pediatric emergency care coordinator is responsible for implementation of, and ensuring fidelity to, the policies and procedures for pediatric patient care in the ED.

The bill requires AHCA, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, to adopt rules that establish minimum standards for pediatric patient care in hospital EDs, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies. The bill also requires AHCA to adopt rules to require a hospital's comprehensive emergency management plan to include components that address the needs of pediatric and neonatal patients.

The bill requires all hospital EDs to conduct the National Pediatric Readiness Assessment, in accordance with the timelines established by the National Pediatric Readiness Project. The next pediatric readiness assessment will be conducted in 2026 and every five years thereafter. Each hospital ED must submit the results of the assessment to AHCA by December 31, 2026. The bill requires AHCA to publish the results of the assessment score for each hospital ED and provide a comparison to the national average score. AHCA must publish the results of the 2026 assessment by April 1, 2027, and must publish the results of subsequent assessments by April 1 following a year in which the assessment is conducted.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.1012, F.S., relating to patient safety.
Section 2: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 3: Amends s. 408.05, F.S., relating to Florida Center for Health Information and Transparency.
Section 4: Provides an effective date of July 1, 2024.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Compliance with the operational requirements of the bill will have an indeterminate, yet likely insignificant, negative fiscal impact on hospitals.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to AHCA to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care patient protection; amending s. 395.1012, F.S.; requiring hospital emergency departments to develop and implement policies and procedures, conduct training, record weights in a certain manner, designate a pediatric emergency care coordinator, and conduct specified assessments; requiring each hospital emergency department to submit a specified report to the Agency for Health Care Administration by specified dates; amending s. 395.1055, F.S.; requiring the agency to adopt certain rules for comprehensive emergency management plans, and, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, establish minimum standards for pediatric patient care in hospital emergency departments; amending s. 408.05, F.S.; requiring the agency to collect and publish the results of specified assessments submitted by hospitals by specified dates; providing an effective date.

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

Section 1. Subsection (5) is added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

(5)(a) Each hospital with an emergency department must:

1. Develop and implement policies and procedures for pediatric patient care in the emergency department which reflect evidence-based best practices relating to, at a minimum:

a. Triage.

b. Measuring and recording vital signs.

c. Weighing and recording weights in kilograms.

d. Calculating medication dosages.

e. Use of pediatric instruments.

2. Conduct training at least annually on the policies and procedures developed under this subsection. The training must include, at a minimum:

a. The use of pediatric instruments, as applicable to each licensure type, using clinical simulation as defined in s. 464.003.

b. Drills that simulate emergency situations. Each emergency department must conduct drills at least annually.

(b) Each hospital emergency department must:

1. Designate a pediatric emergency care coordinator. The pediatric emergency care coordinator must be a physician licensed under chapter 458 or chapter 459, or a nurse licensed under chapter 464. The pediatric emergency care coordinator is responsible for implementation of and ensuring fidelity to the policies and procedures adopted under this subsection.

2. Conduct the National Pediatric Readiness Assessment developed by the National Pediatric Readiness Project, in accordance with timelines established by the National Pediatric Readiness Project. Each hospital emergency department shall submit the results of the assessment to the agency by December 31, 2026, and each December 31 during a year in which the National Pediatric Readiness Assessment is conducted thereafter.

Section 2. Subsections (4) through (19) of section 395.1055, Florida Statutes, are renumbered as subsections (5) through (20), respectively, paragraph (c) of subsection (1) is amended, and a new subsection (4) is added to that section to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(c) A comprehensive emergency management plan is prepared and updated annually. Such standards must be included in the rules adopted by the agency after consulting with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency

equipment; individual identification of residents and transfer of records, ~~and~~ responding to family inquiries, and the needs of pediatric and neonatal patients. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(4) The agency, in consultation with the Florida Emergency Medical Services for Children State Partnership Program, shall adopt rules that establish minimum standards for pediatric patient care in hospital emergency departments, including, but not limited to, availability and immediate access to pediatric specific equipment and supplies.

Section 3. Paragraph (n) is added to subsection (3) of section 408.05, Florida Statutes, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to

disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(n)1. Collect the results of National Pediatric Readiness Assessments submitted by hospitals pursuant to s. 395.1012(5).

2. By April 1, 2027, and each April 1 following a year in which the National Pediatric Readiness Assessment is conducted thereafter, publish the overall assessment score for each hospital emergency department, and provide a comparison to the national average score when it becomes available.

Section 4. This act shall take effect July 1, 2024.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Altman offered the following:

Amendment

Remove lines 47-48 and insert:

or physician assistant licensed under chapter 458 or chapter 459, a nurse licensed under chapter 464, or a paramedic licensed under chapter 401. The pediatric emergency care coordinator is