The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	PCS/SB 7078 (192902)
INTRODUCER:	Appropriations Committee (Recommended by Appropriations Subcommittee on Health and Human Services) and Health Policy Committee
SUBJECT:	Health Care
DATE:	April 17, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	Williams, et al	Brown		**HP Submitted as Committee Bill**
1.	Loe	Kidd	AHS	**Recommend: Fav/CS**
2.	Loe	Kynoch	AP	**Pre-meeting**

I. Summary:

PCS/SB 7078 addresses a variety of health care and health insurance issues, including:

- Access to medical records;
- Transparency of hospital quality information;
- Access to primary and specialist care in a hospital setting;
- Patient notification of hospital observation status;
- Expansion of the duties of the Pediatric Cardiac Technical Advisory Panel;
- Expansion of direct health care agreements;
- Consumer-friendly protections to prescription drug step-therapy protocols;
- Price transparency for services covered by health insurance; and
- Authorization for Florida to participate in the Interstate Medical License Compact.

The bill has an indeterminate fiscal impact on state revenues and state expenditures. The increase in state expenditures related to the expanded duties of the Pediatric Cardiac Technical Advisory Panel is addressed in SB 2500, First Engrossed, the Senate's proposed General Appropriations Bill for the 2019-2020 fiscal year.

The bill has an effective date of July 1, 2019, except as otherwise provided in the bill.

II. Present Situation:

Access to Medical and Clinical Records

Federal Law

The Health Insurance Portability and Accountability Act

The federal Health Insurance Portability and Accountability Act (HIPAA) Health Insurance Portability and Accountability Act establishes standards to protect an individual's medical and clinical records and other personal health information (PHI).[1] The HIPAA provides that, except in certain circumstances,[2] individuals have the right to view and inspect – at no charge – or request to obtain a copy of their protected health information [3] in a covered entity's[4] designated record set.[5] If an individual requests a copy of his or her PHI, or a summary or explanation of such information, covered entities may impose reasonable, cost-based fees for the cost of labor, supplies, copying, postage, and preparation of the summary or explanation of the PHI.[6] A covered entity must disclose the approximate amount of a fee to be assessed to an individual or other requesting entity prior to completing a request for medical and clinical records.[7] The HIPAA prohibits certain costs from being included in the fee charged by the covered entity, even if such costs are authorized by state law.[8] A covered entity may charge a fee on a per-page basis when the PHI is maintained in paper format and the individual requests a paper copy of the PHI or asks that the paper PHI be scanned into electronic format.[9] A covered entity may charge individuals a flat fee – not to exceed $6.50 – for all requests for electronic copies of PHI maintained electronically, inclusive of all labor, supplies, and postage, if applicable.[10]

A covered entity must provide access – within 30 days of a request – to an individual's medical and clinical records and other PHI in the format requested by the individual or requesting entity

---

[1] Pub. L. No. 104-191 (1996). *See also* U.S. Department of Health and Human Services, Office for Civil Rights, Summary of the HIPAA Privacy Rule, (last rev. May 2003), available at: https://www.hhs.gov/sites/default/files/privacysummary.pdf. (last visited March 28, 2019).

[2] *Id.* The HIPAA excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. Additionally, a covered entity may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion.

[3] *Id.* "Protected Health Information" includes all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

[4] *Id.* "Covered entities" include health plans, health care providers, health care clearinghouses, and business associates of any of the aforementioned covered entities.

[5] *Id.* The "designated record set" is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider's medical and billing records about individuals or a health plan's enrollment, payment, claims adjudication, and case or medical management record systems.

[6] U.S. Department of Health and Human Services, Individuals' Right under HIPAA to Access their Health Information 45 C.F.R. § 164.524, available at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/#maximumflatfee (last visited March 28, 2019).

[7] *Id.*

[8] *Id.*

[9] *Id.* Per page fees for copies of PHI maintained electronically are not considered reasonable under HIPAA.

[10] *Id.*

if such records are readily producible in the requested format.[11] An individual must provide written authorization to a covered entity when requesting the disclosure of PHI; however, a covered entity may release records without such authorization under certain circumstances.[12]

HIPAA privacy rules typically preempt any state law that is contrary to its provisions; however, the state law applies if it is more stringent than, and not contrary to, HIPAA privacy rules.[13]

Florida Law

In addition to federal HIPAA requirements, Florida law establishes requirements for the disclosure, production, and inspection of a patient's or resident's medical and clinical records in various health care facility licensure acts;[14] however, these requirements vary amongst facility types.

Mental Health Records

Any facility[15] or private mental health practitioner providing mental health services authorized by the Baker Act[16] is required to maintain clinical records for a patient that includes specific information deemed confidential and exempt from the provisions of section 119.07(1), Florida Statutes, unless:

- Waived by express and informed consent by the patient or the patient's guardian or guardian advocate; or
- If the patient is deceased, by the patient's personal representative or the family member who stands next in line of intestate succession.[17]

The confidential status of a patient's clinical record must be maintained in circumstances where release of such records to a person, organization, or agency is either mandatory or permissive.[18] Any facility or private mental health practitioner who acts in good faith when lawfully releasing information from a patient's clinical record is not subject to civil or criminal liability for such release.[19]

The aforementioned requirements pertaining to the confidentiality of a patient's clinical record does not prohibit the parent or next of kin of a patient who is held in, or treated under a mental health facility or program, from requesting and receiving information limited to a summary of

[11] *Id.*
[12] *Supra* Note 1. PHI may be released without a patient's written authorization for certain public health activities, law enforcement purposes, or for certain victims of abuse, neglect, or domestic violence.
[13] 45 C.F.R. § 160.203.
[14] *See* ss. 394.4615, F.S. (mental health facilities); 395.3025 (hospitals and ambulatory surgical centers); 397.501 (substance abuse service providers); and 400.145 (nursing homes), F.S.
[15] *See* section 394.455(16), F.S. A "facility" is defined as any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have or who have been diagnosed as having a mental illness or substance abuse impairment. The term "facility" does not include a program or an entity licensed under chapters 400 or 429, F.S.
[16] Chapter 71-131, Laws of Fla.; the Baker Act is contained in ch. 394, F.S.
[17] Section 394.4615(1), F.S.
[18] Section 394.4615(2)-(7), F.S.
[19] Section 394.4615(8), F.S.

such patient's treatment plan and current physical and mental condition.[20] Patients are entitled to reasonable access to their mental health clinical records unless such access is determined by the patient's physician to be harmful to the patient.[21] A decision by a facility to restrict a patient's right to inspect his or her mental health clinical record expires after seven days, but may be renewed for a subsequent seven days.[22]

A facility or private mental health practitioner is not required under state law to release requested clinical records within a certain timeframe. There is no standardized fee structure established in statute to limit the amount a facility or private mental health practitioner may charge to produce requested records.

Hospital and Ambulatory Surgical Center Records

Hospitals and ambulatory surgical centers (ASCs) are required to furnish records in a timely manner, without delays for legal review, to a patient or the patient's representative[23] but only after the patient has been discharged from the hospital or ASC.[24] A hospital or ASC may charge up to $1 per page of paper records or up to $2 in total for non-paper records regardless if the records are furnished by the hospital, the ASC, or a copy service. A hospital or ASC may also charge a fee of up to $1 per year of records requested. Records copied for the purpose of continuing medical care are not subject to a charge and a hospital or ASC must allow any person who is authorized to receive copies of records to examine the original records, or suitable reproductions, with reasonable terms to ensure that such records are not damaged, destroyed, or altered.[25]

Patient records from hospitals and ASCs are confidential, exempt from disclosure under public records laws, and may not be disclosed without the consent of the patient or his or her legal representative. A patient's records may be accessed without the consent of the patient by specific entities for purposes related to the treatment of the patient, licensure actions, investigations, audits, and quality assurance.[26]

Substance Abuse Records

A person's right to the confidentiality of their individual substance abuse records requires a substance abuse service provider to protect an individual's identity, diagnosis, prognosis, and service provided. Such records are confidential, in accordance with state and federal law, and are exempt from disclosure under state public records laws. Substance abuse records may not be disclosed without the written consent of the individual to whom they pertain, except under limited circumstances, such as a medical emergency.[27]

[20] Section 394.4615(9), F.S.
[21] Section 394.4615(10), F.S.
[22] *Id.*
[23] Specified as the patients guardian, curator, or personal representative, or in the absence of one of those persons, to the next of kin of a decedent or the parent of a minor, or to anyone designated by such person in writing.
[24] Section 395.3025, F.S. This section does apply to records maintained at a psychiatric hospital or at licensed facilities whereby such records are governed pursuant to ss. 394.4615 and 397.501(7), F.S.
[25] Section 395.3025(1), F.S.
[26] Section 395.3025(4)(a)-(l) and (5), F.S.
[27] Section 397.501(7)(a) and (e), F.S.

The Marchman Act[28] establishes various processes, notice requirements, and legal procedures whereby confidential information from an individual's records may be legally disclosed by court order, such as for the purpose of conducting a criminal investigation.[29] The restrictions on the disclosure and use of confidential records held by substance abuse program service providers do not apply to communications from personnel of the substance abuse provider to law enforcement officers relating to the commission of a crime or a threat to commit such a crime, or when reporting incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law.[30]

Substance abuse service providers are not required under state law to release requested clinical records within a certain timeframe. There is no standardized fee structure established in statute to limit the amount a substance abuse service provider may charge to produce requested records.

Nursing Home Records

Nursing homes are required to provide copies of certain medical records to a resident, or their authorized representative, within 14 days for a current resident and 30 days for a former resident when the nursing home receives a written request in compliance with the HIPAA.[31] A nursing home may refuse to furnish requested medical records directly to a resident under certain circumstances and limitations,[32] and is generally not required to provide such records more than once per month.[33]

A nursing home is authorized to charge a reasonable fee for copying resident records not to exceed $1 per page for the first 25 pages and 25 cents per page for each additional page. A facility must allow an authorized person to examine the original records, or suitable reproductions, and may impose reasonable terms to ensure the records are not damaged, destroyed, or altered;[34] however, a nursing facility is not required by law to provide such access within a specified timeframe.

Ownership and Control of Patients' Medical Records

Under Florida law, a patient's medical records are not the property of the patient. A patient's medical records belong to the records owner, which includes certain health care practitioners and their employer, but does not include certain health care facilities.[35]

---

[28] Chapter 93-39, Laws of Fla.; the Hal S. Marchman Alcohol and Other Drug Services Act (Marchman Act) is contained in ch. 397, F.S.

[29] Section 397.501(7)(f)-(i), F.S.

[30] Section 397.501(7)(b) and (c), F.S. However, the confidentiality restrictions continue to apply to the original substance abuse records maintained by the provider, including their disclosure and use for civil or criminal proceedings which may arise out of the report of suspected child abuse and neglect.

[31] Section 400.145(1), F.S. A nursing home is required to provide medical records and records concerning the care and treatment of a resident, but is not required to provide progress notes and consultation report sections of a psychiatric nature.

[32] Section 400.145(5), F.S. Disclosure of records is not required if deemed by the facility to be detrimental to the physical or mental health of the resident; however, such records must be provided to any other medical provider designated by, and at the written request of, the resident.

[33] Section 400.145(7), F.S. Copies of physician reports in the resident's records must be provided as often as necessary to allow the effective monitoring of the resident's condition.

[34] Section 400.145(4), F.S.

[35] Section 456.057, F.S. The term "records owner" means any health care practitioner who generates a medical record after making a physical or mental examination of, or administering treatment or dispensing legend drugs to, any person; any health

Certain health care practitioners and entities not considered to be records owners, or any person or entity that obtains medical records from a record owner, are considered records custodians and must maintain records or documents under the same confidentiality and disclosure requirements as any health care practitioner, or their employer, who is a records owner.[36]

Health Care Practitioners' Records

Any health care practitioner licensed by the Department of Health (DOH), or a board within the DOH,[37] who makes an examination of a patient, administers treatment or dispenses legend drugs, must, in a timely manner, furnish to the patient, or his or her legal representative, without delays for legal review or conditioned upon payment of a fee for services rendered, copies of all reports and records relating to the examination, treatment, X-rays, and insurance information.[38]

A health care practitioner or records owner who furnishes copies of reports or records, or makes the reports or records available for digital scanning, is authorized to charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate board, or the DOH when there is no board.[39] The Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) have adopted rules related to the fees its licensees may charge for copying patient medical records.

Florida Board of Medicine Rule

The BOM encourages allopathic physicians to provide patients with a copy of their medical records free of charge, especially if the patient is disadvantaged.[40] However, an allopathic physician is authorized to charge a patient or governmental entity a fee of $1 per page for the

---

care practitioner who receives records transferred by a previous records owner; or any health care practitioner's employer, but does not include health care practitioners or entities regulated under part II of ch. 464, F.S., (certified nursing assistants) or part V of ch. 468, F.S., (respiratory therapists); licensed under ch. 465, F.S., (pharmacists and pharmacies), s. 466.023, F.S., (dental hygienists), part II (nursing home administrators) and part XIII (athletic trainers) of ch. 468, F.S., ch. 478, F.S., (electrologists), and part II (clinical laboratory personnel) and part III (medical physicists) of ch. 483, F.S.; licensed or permitted under part I of chapter 484, F.S., (opticians and optical establishments); or persons or entities performing personal injury protection (PIP) examinations for insurance carriers under s. 627.736(7), F.S. The aforementioned excluded health care practitioners and entities are not authorized to acquire or own medical records, but are authorized to maintain documents required by their respective practice acts under the same confidentiality and disclosure requirements of records owners. Additionally, the term "records owner," and the requirements of s. 456.057, F.S., does not apply to hospitals and ambulatory surgical centers licensed pursuant to ch. 395, F.S.

[36] Section 456.057(3) and (4), F.S.

[37] A health care practitioner is any person licensed under ch. 457, F.S., (acupuncture); ch. 458, F.S., (medical practice); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathy); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry, dental hygiene, and dental laboratories); ch. 467, F.S., (midwifery); part I, part II, part III, part V, part X, part XIII, or part XIV of ch. 468, F.S., (speech language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrolysis); ch. 480, F.S., (massage practice); part III or part IV of ch. 483, F.S., (clinical laboratory personnel or medical physicists); ch. 484, F.S., (dispensers of optical devices and hearing aids); ch. 486, F.S., (physical therapy practice); ch. 490, F.S., (psychological services); or ch. 491, F.S., (clinical, counseling, and psychotherapy services).

[38] Section 456.057(6), F.S. In lieu of copies of certain medical records related to psychiatric or psychological treatment, a practitioner may release a report of examination and treatment.

[39] Section 456.057(17), F.S.

[40] Fla. Admin Code R. 64B8-10.003 (2019).

first 25 pages, and no more than 25 cents for each subsequent page.[41] For all other entities, an allopathic physician may charge up to $1 per page. An allopathic physician may charge the actual cost for reproducing certain documents, such as X-rays and other special kinds of records.[42] Actual costs include the materials, supplies, labor, and overhead costs associated with such duplication.[43] No timeline is specified for the provision of these records.

Florida Board of Osteopathic Medicine Rule

An osteopathic physician may charge up to $1 per page for the first 25 pages, and no more than 25 cents for each subsequent page, regardless of the requestor.[44] An osteopathic physician must comply with a patient's written request for records within 30 days of such request unless there are circumstances beyond the osteopathic physician's control that prevents such compliance.[45] An osteopathic physician may charge the actual cost for reproducing certain documents, such as X-rays and other special kinds of records.[46] Actual costs include the materials, supplies, labor, and overhead costs associated with such duplication.[47]

Transparency of Health Care Quality Information

Patient Safety Plan

Hospitals and ASCs are required to adopt a patient safety plan in accordance with state and federal laws and regulations.[48] Hospitals and ASCs designate an employee to serve as a patient safety officer, and establish a patient safety committee, to promote the health and safety of patients, evaluate the quality of patient safety measures utilized by the facility, and ensure the accountability of, and fidelity to, the facility's patient safety plan.[49]

Hospital Compare

The federal Centers for Medicare & Medicaid Services (CMS) maintains the Hospital Compare website,[50] which provides consumers with data about the quality of care at over 4,000 Medicare-certified hospitals.[51] Hospital Compare allows consumers to select multiple hospitals and directly compare performance measure information related to heart attack, heart failure, pneumonia, surgery and other conditions.[52] Performance measures are derived from consumers' responses to

[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] Fla. Admin. Code R. 64B15-15.003, (2019).
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] Section 395.1012, F.S., and 42 C.F.R. § 482.21.
[49] Section 395.1012(2), F.S. At least one member of the patient safety committee must be a person who is neither employed by nor practicing in the hospital or ASC.
[50] Centers for Medicare & Medicaid Services, Hospital Compare, available at https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html (last visited on March 12, 2019)
[51] Medicare.gov, What is Hospital Compare? available at https://www.medicare.gov/hospitalcompare/About/What-Is-HOS.html (last visited March 12, 2019).
[52] *Id.*

the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey[53] which collects data on patient satisfaction and readmission, hospital-acquired infection, and mortality rates.[54] Overall hospital performance is presented to consumers through a star rating of one to five stars.[55]

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center) provides a comprehensive health information system that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data. The Florida Center is housed within the Agency for Health Care Administration (AHCA).[56] The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ASC, emergency department, and comprehensive rehabilitation hospital on a quarterly basis.[57]

The Florida Center maintains www.FloridaHealthFinder.gov, which assists consumers in making informed health care decisions and leads to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public that allows easy access to information on hospitals, ASCs, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator; hospital and ASCs performance data; data on mortality, complication, readmission, and acquired infection rates for hospitals; and a facility/provider locator.

Access to Primary and Specialist Care in a Hospital Setting

Continuity of Care

'Continuity of care' generally refers to a patient's care over time by a single individual or team of health professionals but can also include effective and timely communication of health information at different levels of care between the patient, the primary care provider, and other treating specialists.[58] This long-term patient-physician relationship in which the physician knows the patient's history from experience allows the physician to integrate new information and decisions from a holistic perspective efficiently without extensive investigation or record review.[59]

---

[53] The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is a national survey that asks patients about their experiences during a recent hospital stay. The HCAHPS is endorsed by the National Quality Forum as a measure of hospital quality. Available at: http://www.hcahpsonline.org/ (last visited March 29, 2019).
[54] Medicare.gov, Measures and current data collection periods, available at: https://www.medicare.gov/hospitalcompare/Data/Data-Updated.html# (last visited March 12, 2019).
[55] Medicare.gov, Hospital Compare overall hospital rating, available athttps://www.medicare.gov/hospitalcompare/About/Hospital-overall-ratings.html (last viewed March 12, 2019).
[56] Section 408.05, F.S.
[57] Section 408.061, F.S., and chs. 59B-9 and 59E-7, F.A.C.
[58] Institute of Medicine Committee on the Future of Primary Care; M.S. Donaldson et. al., *Primary Care: America's Health in a New Era*, 27-51 (National Academies Press, 1996), available at: https://www.ncbi.nlm.nih.gov/books/NBK232643/pdf/Bookshelf_NBK232643.pdf (last visited Mar. 29, 2019).
[59] *Id.* at 52-75; *See also*, American Academy of Family Physicians, Continuity of Care, https://www.aafp.org/about/policies/all/definition-care.html (last visited Mar. 29, 2019).

When a patient's various healthcare providers do not communicate with one another, the lack of coordination results in fragmented care. Fragmented care can have an adverse impact on the quality of care, and is associated with increased healthcare costs, medical errors,[60] and risk of re-hospitalization.[61]

Patient handoff – when the patient care responsibility is transferred from one health care professional to another – is a critical moment in the continuum of care. This is especially significant during transition from an inpatient to an outpatient setting. Based on reports and studies, it is not common practice for a treating physician at a hospital to communicate with the patient's primary care provider during a patient's admission or even at discharge.[62] Primary care providers are often wholly unaware of the hospitalization or do not receive a discharge summary or information from the hospital.

A growing body of research and articles recommend that a primary care provider be informed of the patient's admission to, or discharge from, a hospital, with the most effective care being provided when information is shared between the primary care provider and treating physician throughout the course of the admission.[63] In an effort to better coordinate care, some hospitals

[60] "Medical error" generally refers to failure of a planned action to be completed as intended or a preventable adverse effect of care, and can range from documentation errors to improper diagnosis or failure to test or treat as required.

[61] Study of 86 patients seen by their primary care physicians two months after hospital discharge found 49% experienced medical errors and patients with a work-up error were 6.2 times more likely to be re-hospitalized within three months after the first outpatient visit. Carlton Moore et. al., *Medical Errors Related to Discontinuity of Care from an Inpatient to an Outpatient Setting*, 18:8 J. Gen. Internal Med. 646-51 (Aug. 2013), available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494907/ (last visited Mar. 29, 2019).

[62] Sunil Kripalani, M.D., M.Sc., et. al., *Deficits in Communication and Information Transfer Between Hospital-Based and Primary Care Physicians: Implications for Patient Safety and Continuity of Care*, 297:8 JAMA 831-41 (Feb. 2007), available at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.522.2320&rep=rep1&type=pdf (last visited Mar. 29, 2019); extracted and synthesized data from existing body of research and found that direct communication between the hospital and primary care physician occurred less than 20 percent of the time, the availability of the discharge summary at the first post-discharge visit was less than 34 percent and remained poor even four weeks after discharge and affected the quality of care in 25 percent of follow-up visits.

[63] Diane Shannon, M.D., M.P.H, Effective Physician-to-Physician Communication: An Essential Ingredient for Care Coordination, 38(1) Physician Exec. J. 16-21 (Jan.-Feb. 2012), available at: http://www.mdwriter.com/uploads/1/8/0/3/18033585/md_to_md_communication_pej.pdf (last visited Mar. 29, 2019); *See also*, Stacey S. Brener, M.Sc., *Association Between In-Hospital Supportive Visits by Primary Care Physicians and Patient Outcomes: A Population-Based Cohort Study*, 11:6 J. Hosp. Med. 418-24 (June 2016), a retrospective cohort study of 164,059 patients, the 12 percent of patients who received visits from their primary care physicians had lower risks of adverse patient outcomes, fewer emergency room visits, and increased utilization of community health services; Carl van Walraven, M.D., M.Sc., *Effect of Discharge Summary Availability During Post-Discharge Visits on Hospital Readmission*, 17:3 J. Gen. Intern. Med. 186-92 (Mar. 2002), available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495026/ (last visited Mar. 29, 2019), studied 888 patients discharged from a single hospital after treatment for an acute illness and found that the discharge summary was only given to the primary physician in 25 percent of cases and in those cases, the patients had a decreased risk of re-hospitalization compared to their counterparts; *See generally*, Gregory A. Harlan, et. al., *Improving Transitions of Care at Hospital Discharge—Implications for Pediatric Hospitalists and Primary Care Providers*, 32:5 J. Healthcare Quality 51-60 (Sept.-Oct. 2010); Vicenza Snow, M.D., et. al., *Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine*, 4:6 J. Hosp. Med. 364-370 (July 2009), available at: https://pdfs.semanticscholar.org/4d62/22d8eadfdb0e3dc7edad34cc86b1290afbd5.pdf (last visited Mar. 29, 2019).

have implemented continuity visits or increased communication procedures so the primary care provider can be consulted in the patient's care.[64]

Regulation of Hospitals

Hospitals are regulated by the AHCA.[65] Hospitals are not required to coordinate care with patients' primary care providers or to comply with patients' request for such coordination. There is no statutory requirement that a treating physician at a hospital consult with a patient's primary care provider during the admission, or notify such provider after a patient is discharged.

Patient Notification of Hospital Observation Status

When a patient enters a hospital, the physician or other practitioner responsible for a patient's care must decide whether the patient should be admitted for inpatient care. The factors considered include:

- The severity of signs and symptoms exhibited by the patient;
- The medical probability of something adverse happening to the patient;
- The need for diagnostic studies to assist in the admitting decision; and
- The availability of diagnostic procedures at the time when, and the location where, the patient presents.[66]

Observation status is commonly ordered for a person who presents to the emergency department and requires treatment or monitoring to determine if he or she should be admitted or discharged.[67] A patient receives observation services when on observation status and can spend one or more nights in the hospital. These services can occur in the hospital's emergency department or in another area of the hospital.[68]

Observation services are covered under Medicare Part B, rather than Part A, so some patients with Medicare will experience an increase in out-of-pocket costs for observation services versus being admitted to the hospital.[69] For example, hospital inpatient services are covered under Medicare Part A and require the patient to pay a one-time deductible ($1,364) for the first 60 days of his or her stay. Alternately, hospital outpatient services, including observation services, are covered under Medicare Part B and require the patient to pay a deductible ($185) as

---

[64] Allan H. Goroll, M.D. and Daniel P. Hunt, M.D., *Bridging the Hospitalist-Primary Care Divide Through Collaborative Care*, 372:4 N. Engl. J. Med. 308-309 (Jan. 2015), available at: https://www.researchgate.net/publication/271222735_Bridging_the_HospitalistPrimary_Care_Divide_through_Collaborative_Care (last visited Mar. 29, 2019); *See also*, Larry Beresford, *Continuity Visits by Primary Care Physicians Could Benefit Inpatients*, The Hospitalist (Apr. 2015), https://www.the-hospitalist.org/hospitalist/article/122479/continuity-visits-primary-care-physicians-could-benefit-inpatients (last visited Mar. 29, 2019).

[65] Ch. 395, F.S.

[66] Medicare Benefit Policy Manual, ch. 1 § 10, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html (last visited Mar. 13, 2019).

[67] *Id* at ch. 6 § 20.6.

[68] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Product No. 11435, *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* (May 2014) available at https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf (last visited Mar. 12, 2019).

[69] AARP Public Policy Institute, *Rapid Growth in Medicare Hospital Observation Services: What's Going On?*, p. 1 (September 2013), available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf (last visited Mar. 12, 2019).

well as 20 percent of the Medicare-approved amount for doctor services.[70] A person who is treated for an extended period of time as a hospital outpatient receiving services may incur greater financial liability. However, it can be difficult for a person to determine his or her status based purely on the type of care provided at the hospital.[71]

Once a person is discharged from a hospital, additional rehabilitation in a nursing home is often necessary. Hospital admission can affect a person's eligibility for other services.[72] When a person is admitted and has a three-night inpatient stay in a hospital[73] and needs rehabilitative care, Medicare Part A will pay for up to 60 days in a skilled nursing facility. However, if a person is not admitted to the hospital – such as when a patient is under observation status for the duration of the hospital stay – and subsequently goes into a nursing home, the patient will have not met the requirements of a qualifying inpatient hospital stay, and Medicare will not pay for the skilled nursing facility care.[74]

The federal Notice of Observation Treatment and Implication for Care Eligibility Act requires hospitals to provide the Medicare Outpatient Observation Notice (MOON) to patients when observation status services last more than 24 hours.[75] The MOON must be provided to the patient if the patient is discharged, transferred, or admitted within 36 hours. The notice informs patients that observation status may affect their health care costs.

Florida law requires hospitals to notify patients or a patient's proxy of their observation status through documentation in the patient's discharge papers provided when leaving the hospital.[76] The documentation is not required to inform patients that observation status may affect their health care costs.

Pediatric Cardiac Standards of Care

Current Standards for Pediatric Cardiac Services

Hospital facilities are regulated by the Agency for Health Care Administration (AHCA) under ch. 395, F.S., and the general licensure provisions of ch. 408, F.S. Hospitals are also subject to the Certificate of Need (CON) provisions in Part I of ch. 408, F.S.

A CON is a written statement issued by the AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service. Certain specialty programs offered within a hospital may also be subject to a CON process as prescribed by statute. All health-care-related projects are subject to review and must file a CON

[70] Medicare.gov., *Medicare 2015 costs at a glance*, available at http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html (last visited Mar. 12, 2019) and 42 CFR s. 419.40.
[71] *See* Amanda Cassidy, *The Two-Midnight Rule*, Health Affairs, Health Policy Briefs (Jan. 22, 2015) available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=133 (last visited Mar. 12, 2019).
[72] *Id.*
[73] *See* 42 C.F.R. § 409.30. A patient must have a qualifying inpatient hospital stay, defined as three consecutive days of inpatient care, to be covered by Medicare Part A.
[74] *Id.*
[75] Centers for Medicare and Medicaid Services, Medicare Outpatient Observation Status, available at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html (last viewed Mar. 29, 2019).
[76] Section 395.301, F.S.

application with the AHCA, unless specifically exempt from the process.[77] Examples of covered health-care-related projects include hospice services, skilled nursing facilities, intermediate care facilities for the developmentally disabled, organ transplantation, and level II and level III neonatal intensive care units. Additionally, programs for pediatric cardiac catheterization and pediatric open heart surgery are considered health-care-related projects.[78]

Pediatric Surgery Programs

Pediatric Open Heart Surgery Programs

Pediatric open heart surgery programs are regulated through the CON process and governed by Rule 59C-1.033, F.A.C. The administrative rule establishes five service areas, defines the pediatric patient as those patients under 15 years of age, and specific services included in a pediatric open heart surgery program. To be considered for an open heart surgery program, a facility must meet certain minimum requirements and provide additional services in the event complications arise during the performance of pediatric open heart surgery.[79]

The pediatric open heart surgery team must be available for elective open heart surgery eight hours per day, five days per week and available for rapid mobilization of the surgical and medical support teams for emergency cases 24 hours a day, seven days per week.[80]

For pediatric open heart surgery, any CON applicant must document an adequate number of the following properly trained personnel that can perform during surgery:

- A cardiovascular surgeon, board certified by the American Board of Thoracic Surgery, or board eligible.
- A physician to assist the operating surgeon.
- A board certified or board eligible anesthesiologist trained in open heart surgery.
- A registered nurse or certified operating room technician trained to serve in open heart surgery operations and perform circulating duties.
- A perfusionist to perform extracorporeal perfusion, or a physician or specially trained nurse, technician, or physician assistant under the supervision of the operating surgeon to operate the heart-lung machine.[81]

Follow-up care after open heart surgery must be provided in an intensive care unit that provides 24 hour nursing coverage with a nurse-to-patient ratio of no less than one nurse for every two patients for the first hours of post-operative care. The facility must have at least one board-certified or board-eligible pediatric cardiac surgeon on the staff of the hospital seeking the CON

[77] Section 408.036, F.S.
[78] *See* s. 408.036(1)(f), F.S. (2018) and Rule 59C-1.004, F.A.C.
[79] Rule 59C-1.033, F.A.C., requires a facility be able to repair or replace heart valves; repair congenital heart defects; perform cardiac revascularization; repair or reconstruct intrathoracic vessels; and treat cardiac trauma, and provide the following additional services: cardiology, hematology, nephrology, pulmonary medicine, and treatment of infectious diseases; pathology, including anatomical, clinical blood bank and coagulation laboratory services; anesthesiology, including respiratory therapy; radiology, including diagnostic nuclear medicine and magnetic resonance imaging studies; neurology; inpatient cardiac catheterization; non-invasive cardiographics, including electrocardiography, exercise stress testing, transthoracic and transesophageal echocardiography; intensive care; emergency care available 24 hours per day for cardiac emergencies; and extracorporeal life support (ECLS).
[80] Rule 59C-1.033(4)(b), F.A.C.
[81] Rule 59C-1.033(5)(a), F.A.C.

for a pediatric open heart surgery.[82] Back-up personnel must be available for consultation to the surgical team, including a clinical cardiologist, cardiologist, anesthesiologist, pathologist, thoracic surgeon, and radiologist.

Pediatric Cardiac Catheterization and Angioplasty Institutional Health Services

As with the requirements for the pediatric open heart surgery program, the pediatric cardiac catheterization program requires a hospital to have a CON before it may operate its program. A cardiac catheterization is a medical procedure requiring the passage of a catheter into one or more cardiac chambers with or without coronary arteriograms, for the purpose of diagnosing congenital or acquired cardiovascular diseases, or for determining measurement of blood pressure flow. Cardiac catheterization also includes the selective catheterization of the coronary ostia with injection of contrast medium into the coronary arteries.[83]

A facility must demonstrate as part of the CON approval process that it is capable of providing immediate endocardiac catheter pacemaking in cases of cardiac arrest, and pressure recording to evaluate valvular disease or heart failure.[84] The facility must also ensure a range of additional services and equipment are available within the facility.[85]

The cardiac catheterization team must be capable of rapidly mobilizing within 30 minutes, 24 hours a day, seven days a week for emergency procedures.[86] The team must be capable of providing immediate endocardiac catheter pacemaking in cases of cardiac arrest, and pressure recording for monitoring and to evaluate valvular disease or heart failure.[87] The team must be able to document these standards.

In addition to documentation of the required staff[88] that is available to perform the pediatric cardiac catheterization and angiographic processes, the CON applicant facility is required to have a department, service, or other similar unit organized, directed, staffed, and integrated with the other units and departments of the hospital to assure the provision of quality of care.[89] A pediatric catheterization program must also be co-located at a facility where pediatric open heart surgeries are performed.[90]

[82] Rule 59C-1.033(5)(b), F.A.C.
[83] Rule 59C-1.032(2), F.A.C.
[84] Rule 59C-1.032(3)(a), F.A.C.
[85] Rules 59C-1.032(3)(b) and 59C-1.032(3)(b), F.A.C. Additional services and equipment include: hematology studies or coagulation studies; electrocardiography; chest x-ray; blood gas studies; clinical pathology studies and blood chemistry analysis; a special procedure x-ray room; a film storage and darkroom for proper processing of films; x-ray equipment with the capability in cineangiocardiography, or equipment with similar capabilities; an image intensifier; an automatic injector; a diagnostic x-ray examination table for special procedures; an electrocardiograph; a blood gas analyzer; a multi-channel polygraph; emergency equipment, including but not limited to, a temporary pacemaker unit with catheters, ventilatory assistance devices, and a DC defibrillator; biplane angiography, with framing rates of 30-60 fps and injection rates of up to 40mL/s; and one or more crash carts containing the necessary medication and equipment for ventilatory support, which must be located in each pediatric cardiac catheterization procedure room.
[86] Rule 59C-1.032(4)(a), F.A.C.
[87] Rule 59C-1.032(3)(a), F.A.C.
[88] The staff required for these programs are listed in Rule 59C-1.032(b), F.A.C.
[89] Rule 59C-1.032(5)(a), F.A.C.
[90] Rule 59C-1.032(6), F.A.C.

Pediatric cardiac facilities granted CONs under either program are required to provide the AHCA with quarterly utilization reports within 45 days of the end of each quarter showing the number of pediatric procedures under both programs.

Technical Advisory Panel for Pediatric Cardiac Programs

During the 2017 Legislative Session, a Technical Advisory Panel (panel) for Pediatric Cardiac Programs was established to develop procedures and standards for measuring outcomes of pediatric catheterization programs and pediatric cardiac cardiovascular programs, and make recommendations about regulatory guidelines for pediatric open heart surgery programs. The panel is housed administratively at the AHCA, and appointments to the panel are made by the AHCA Secretary in accordance with the statutory guidelines.

To be eligible as a voting member on the panel, a hospital must maintain its pediatric CON and the individual member must have technical expertise in pediatric cardiac medicine. Members serve without compensation and are not reimbursed for any travel costs or per diem.[91]

The AHCA Secretary appoints three at-large members, one of whom is a cardiologist who is board certified in caring for adults with congenital heart disease and two board-certified pediatric cardiologists. None of the three at-large members may be employed by any of the named facilities who have specific representation on the panel. The panel has 10 other members who are appointed by the chief executive officer of their respective hospitals, plus an alternate member. The named member, either the voting member or the alternate, must be a pediatric cardiologist or pediatric cardiovascular surgeon.

The panel membership comprises the following:

Cardiac Program Technical Advisory Panel Membership[92]			
Members\Type of Members:	**Voting**	**Alternate**	**Non-Voting**
Johns Hopkins All Children's Hospital in St. Petersburg	■	■	
Arnold Palmer Hospital for Children in Orlando	■	■	
Joe DiMaggio Children's Hospital in Hollywood			
Nicklaus Children's Hospital in Miami	■	■	
St. Joseph's Children's Hospital in Tampa	■	■	
University of Florida Health Shands Hospital in Gainesville	■	■	
University of Miami Holtz Children's Hospital in Miami	■	■	
Wolfson Children's Hospital in Jacksonville	■	■	
Florida Hospital for Children in Orlando	■	■	
Nemours Children's Hospital in Orlando	■	■	
AHCA Secretary may appoint following nonvoting members:			
Secretary, AHCA			■
Surgeon General, DOH			■
Deputy Secretary of Children's Medical Services, DOH			■
Any current or past Director of Children's Medical Services, DOH			■
A parent of a child with congenital heart disease			■
An adult with congenital heart disease			■
3- At Large Members			

[91] Section 395.1055(9)(a) and (b), F.S.
[92] Section 395.1055(9)(b) and (c), F.S.

Cardiac Program Technical Advisory Panel Membership[92]			
Members\Type of Members:	**Voting**	**Alternate**	**Non-Voting**
1 Cardiologist - Board Certified in caring for adults with congenital health disease	■		
2 Pediatric Cardiologists – Board Certified	■		
A representative from each of the following organizations:			
Florida Chapter of the American Academy of Pediatrics			■
Florida Chapter of the American College of Cardiology			■
Greater Southeast Affiliate of the American Heart Association			■
Adult Congenital Heart Association			■
March of Dimes			■
Florida Association of Children's Hospitals			■
Florida Society of Thoracic and Cardiovascular Surgeons			■

The panel is required to meet at least biannually, or more frequently, upon the call of the AHCA Secretary. Meetings may be held telephonically or by other electronic means. The panel has held at least 26 meetings since its inception in 2017, and has been working toward proposed rules and policies on cardiology, surgery, public reporting and transparency, and facility standards.

At a minimum, the statute requires the panel to make recommendations for additional rules and standards for pediatric cardiac programs[93] which must include:

- Standards for pediatric cardiac catheterization services and pediatric cardiovascular surgery services, including quality of care, personnel, physical plant, equipment, emergency transportation, data reporting, and appropriate operating hours and timeframes for mobilization for emergency procedures.
- Outcome standards consistent with nationally established levels of performance in pediatric cardiac programs.
- Specific steps to be taken by the AHCA and licensed facilities when the facilities do not meet the outcome standards within a specified time, including time required for detailed case reviews and the development and implementation of corrective action plans.

By January 1, 2020, the panel is required to submit an annual report to the Governor, President of the Senate, the Speaker of the House of Representatives, the AHCA Secretary, and the Surgeon General which summarizes the panel's activities during the preceding fiscal year. The report must include data and performance measures on surgical morbidity and mortality for all pediatric cardiac programs.[94]

Once the panel has developed recommendations for pediatric cardiac care, the panel will forward such recommendations to the AHCA for adoption through the formal administrative rulemaking process.[95]

[93] Chapter 395, Florida Statutes, provides standards for cardiac programs. For example, a pediatric cardiac program must be affiliated with a hospital licensed under chapter 395; have a pediatric cardiac catheterization laboratory and pediatric cardiovascular surgical program located in the hospital; and have a risk-adjusted surgical procedure protocol which follows the guidelines established by the Society of Thoracic Surgeons. *Also see* The Society of Thoracic Surgeons, https://www.sts.org/about-sts (last visited March 13, 2019).
[94] Section 395.1055(9)(f), F.S.
[95] *See* s. 395.1055(10)(a-c) and (12), F.S.

Liability for Good Faith Actions

Currently, the volunteer physicians and other members of the panel are not covered by any liability or immunity clauses in the panel's implementing statute. During panel meetings, the members have held discussions relating to sovereign immunity for panel members when they are engaged in activities related to the panel.[96] Members on other panels, boards of directors, or volunteers in programs have been granted similar provisions of immunity for their official actions by the Legislature, such as individuals in the Division of Rehabilitation and Liquidation of the Department of Financial Services,[97] guardians ad litem,[98] and employees and board of directors of the Health Maintenance Organization Consumer Assistance Plan.[99]

Children's Medical Services

Children's Medical Services (CMS) is a group of programs administered by the Department of Health (DOH) that serve children with special health care needs.[100] One such program is the newborn screening program, which screens all newborns in Florida for 32 core disorders and 22 secondary disorders, unless a parent objects in writing.[101] The most recently added disorders to the newborn screening panel include critical congenital heart disease (CCHD), X-linked adrenoleukodystrophy (X-ALD), Pompe, Muccupolysachariidosis Type I (MPS I), and spinal muscular atrophy (SMA). The newborn screening program currently tests for CCHD and X-ALD,[102] and the program is expected to begin testing for Pompe, MPS I, and SMA in the 2019-2010 fiscal year.[103]

Direct Primary Care

Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the provider-patient relationship. A DPC contractual agreement is not considered insurance and is not subject to regulation under the Florida Insurance Code (Code).[104] The agreement, however, must meet certain requirements, such as being in writing and including the scope of services, duration of the agreement, amount of the fees, and specifying what the fees cover under the agreement. A primary care provider, which includes a primary care group practice, or his or her agent, is exempted from any certification or licensure requirements in the

[96] Agency for Health Care Administration, Pediatric Cardiology Technical Advisory Panel Meeting Minutes (October 2, 2018), pg. 3, http://ahca.myflorida.com/SCHS/PCTAP/docs/102518/PCTAPDraftMinutes100218.pdf (last visited March 13, 2019).
[97] *See* s. 631.391, F.S.
[98] *See* s. 61.405, F.S.
[99] *See* s. 631.825, F.S.
[100] *See* ss. 383.14 and 383.145, F.S., (newborn screening program); s. 391.301, F.S., (Early Steps Program); and ss. 391.055 and 409.974(4), F.S., (Children's Medical Services Managed Care Plan).
[101] Department of Health, *Newborn Screening* http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/index.html (last visited April 5, 2019).
[102] *Id.*
[103] The sum of $3.8 million is provided in SB 2500, First Engrossed, the Senate's proposed 2019-2020 General Appropriations Bill, for the program to begin testing for Pompe, MPS I, and SMA in the 2019-2020 fiscal year, *see* Section, 3, Specific Appropriations 467 and 469, at page 97; 474, at page 98; 480, at page 100; and 525, at page 106.
[104] Section 624.27, F.S.

Code for marketing, selling, or offering to sell an agreement, and establishes criteria for DPC agreements.[105]

A patient generally pays a monthly retainer fee– on average $77 per individual[106] – to the primary care provider for defined primary care services, such as office visits, preventative care, annual physical examination, and routine laboratory tests. An estimated 1,000 DPC practices exist in 48 states and the District of Columbia, covering over 330,000 patients, including Florida.[107]

After paying the monthly fee, a patient can access all services under the agreement at no extra charge contingent upon the agreement's provisions. Typically, DPC practices provide routine preventative services, screenings, or testing services, such as lab tests, mammograms, Pap screenings, and vaccinations. A primary care provider DPC model can be designed to address most health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

DPC agreements in Florida are currently limited to primary care services offered by primary care providers licensed under chapters 458 (allopathic medicine), 459 (osteopathic medicine), 460 (chiropractic medicine), or 464 (nursing), or a primary care group practice.

Not all states call such arrangements DPC agreements or limit the agreements to primary care physicians. In Missouri, the agreement is a *medical retainer agreement* between a physician and an individual patient or a patient's representative. The Missouri statute requires that the fees for the agreement be paid from a health savings account in compliance with federal law.[108] In Alabama, the agreement is specific to both primary care physicians and dentists and is known as the *Alabama Physicians and Dentists Direct Pay Act.*[109]

Cost-Containment in Health Insurance

Step-Therapy Protocols

Insurers and health maintenance organizations (HMOs) use many cost containment and utilization review strategies to manage medical and drug spending and patient safety. For example, plans may impose clinical management or utilization management requirements on the use of certain medical treatments or drugs on their formulary. In some cases, insurers or HMOs require an insured to use a step-therapy protocol for drugs or a medical treatment, which requires

[105] *Id.*
[106] A study of 141 DPC practices found the average monthly retainer fee to be $77.38. Of the 141 practices identified, 116 (82 percent) have cost information available online. When these 116 practices were analyzed, the average monthly cost to the patient was $93.26 (median monthly cost, $75.00; range, $26.67 to $562.50 per month). Of the 116 DPCs noted, 36 charged a one-time enrollment fee and the average enrollment fee was $78. Twenty-eight of 116 DPCs charged a fee for office visits in addition to the retainer fee, and the average visit fee was $16. *See* Phillip M. Eskew and Kathleen Klink, *Direct Primary Care: Practice Distribution and Cost Across the Nation*, Journal of the Amer. Bd. of Family Med. (Nov.-Dec. 2015) Vol. 28, No. 6, p. 797, *available at:* http://www.jabfm.org/content/28/6/793.full.pdf (last viewed Mar. 12, 2019).
[107] Direct Primary Care Coalition, *About the Direct Primary Care Coalition* *https://www.dpcare.org/about* (last viewed Mar. 12, 2019).
[108] Mo. Rev. Stat. §376.1800 (2015).
[109] 2017 Ala. Laws 460.

the insured to try one drug or medical procedure first to treat the medical condition before the insurer or HMO will authorize coverage for another drug or procedure for that condition.

Regulation of Health Insurance

Federal Law

The federal Patient Protection and Affordable Care Act (PPACA)[110] requires health insurers to make coverage available to all individuals and employers without exclusions for preexisting conditions, and mandates specified essential health benefits, including prescription drugs.[111] Insurers are required to publish a current and complete list of all covered drugs on its formulary drug list, including any tiered structure and any restrictions on the way a drug can be obtained, in a manner that is easily accessible to insureds, prospective insureds, and the public.[112]

Florida Regulatory Entities

The Office of Insurance Regulation (OIR) regulates the activities of insurers, HMOs, and other risk-bearing entities.[113] The AHCA regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[114]

Florida State Employee Group Insurance Program

The Department of Management Services, through the Division of State Group Insurance, administers the state group insurance program by providing employee benefits such as health, life, dental, and vision insurance products under a cafeteria plan consistent with s. 125, Internal Revenue Code.[115] To administer the state group health insurance program, DMS contracts with third part administrators, HMOs, and a Pharmacy Benefits Manager for the state employees' prescription drug program.[116]

The Florida Medicaid Program

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, the AHCA oversees the Medicaid program.[117] The Statewide Medicaid Managed Care (SMMC) program comprises a Managed Medical Assistance (MMA) component and a Long-term Care (LTC) managed care component. The AHCA contracts with managed care plans to provide services to eligible enrollees.[118]

---

[110] The Patient Protection and Affordable Care Act (Pub. L. No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010.
[111] 42 U.S.C. s.18022.
[112] 45 C.F.R. s. 156.122(d).
[113] Section 20.121(3)(a), F.S.
[114] Section 641.21(1), F.S.
[115] Section 110.123, F.S.
[116] Section 110,12315, F.S.
[117] Parts II and III of ch. 409, F.S., govern the Medicaid managed care program.
[118] A managed care plan that is eligible to provide services under the SMMC program must have a contract with the agency to provide services under the Medicaid program and must also be a health insurer; an exclusive provider organization or a HMO authorized under ch. 624, 627, or 641, F.S., respectively; a provider service network authorized under s. 409.912(2), F.S., or an accountable care organization authorized under federal law. Section 409.962, F.S.

The benefit package offered by the MMA plans is comprehensive and covers all Medicaid state plan benefits (with very limited exceptions). This includes all medically necessary services for children. Most Florida Medicaid enrollees who are eligible for the full array of Florida Medicaid benefits are enrolled in an MMA plan. Florida Medicaid managed care plans cannot be more restrictive than these policies or the Florida Medicaid state plan (which is approved by the federal CMS) in providing services to their enrollees.

Health Care Price Transparency in Florida

Florida Patient's Bill of Rights and Responsibilities

Health care providers and health care facilities are required to make available to patients a summary of their rights under Florida law. Medical providers are expected to observe standards of care when providing medical treatment and communicating with their patients.[119] A patient has the right to request certain financial information from health care providers and facilities, such as a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[120]

Price Transparency Required of Urgent Care Centers

Urgent care centers[121] are required to publish a schedule of charges for the medical services offered to patients.[122] The schedule requirements for urgent care centers are the same as those established for primary care providers, including the requirement the schedule include the prices charged to an uninsured person paying for such services by cash, check, or credit or debit card.[123] The schedule must describe each medical service in language comprehensible to a layperson. An urgent care center that fails to publish and post the schedule of charges is subject to a fine of not more than $1,000 per day.[124]

Price Transparency Required of Hospitals and Ambulatory Surgical Centers (ASCs)

Hospitals and ASCs are required, within 7 days of a written request, to provide a good faith estimate of reasonably anticipated charges for the facility to treat a patient's condition.[125] The estimate may represent the average charges for that diagnosis related group or the average charges for that procedure.[126] When providing the estimate, the facility is required to inform the

[119] Section 381.026(4), F.S. The standards of care are defined in terms of individual dignity; provision of information; financial information and the disclosure of financial information; access to health care; experimental research; and the patient's knowledge of rights and responsibilities.
[120] Section 381.026(4)(c), F.S.
[121] Section 395.002(29), F.S. An "urgent care center" means a facility or clinic that provides immediate but not emergent ambulatory medical care to patients. The term includes an offsite emergency department of a hospital that is presented to the general public in any manner as a department where immediate and not only emergent medical care is provided. The term also includes hospital-physician joint ventures (licensed under chapters 395 and 458, or 459, F.S., respectively); and health care clinics licensed under part X of ch. 400, F.S., that operate in three or more locations.
[122] Section 395.107(2), F.S. *See also:* s. 381.026(4)(c)3., F.S.
[123] Section 395.107(2), F.S.
[124] Section 395.107(6), F.S.
[125] Section 395.301, F.S.
[126] *Id.*

patient to contact their health insurer or health maintenance organization for additional information concerning cost-sharing responsibilities.[127]

Hospitals and ASCs must notify a patient during admission and at discharge of his or her right to receive an itemized statement or bill. If requested, within 7 days of discharge or release, the licensed facility must provide an itemized statement or bill detailing the specific nature of charges or expenses incurred by the patient. The initial statement or bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility.[128]

Each Hospital and ASC is required to provide on its website information on payments made to that facility for defined bundles of services and procedures. The same information for each licensed facility is required to be made publicly available on pricing.floridahealthfinder.gov,[129] Florida Health Price Finder,[130] and provides consumers with the ability to research and compare health care costs in Florida at the national, state, and local levels. Supported by a database of more than 15 million lines of insurance claim data sourced directly from Florida insurers, the website displays costs as Care Bundles representing the typical set of services a patient receives as part of treatment for a specific medical conditions. Care Bundles are broken down into logical steps, which may include one or more procedures and tests and the 295 care bundles currently available on Florida Health Price Finder account for 90 percent of consumer searches on national pricing websites.

Portability of Health Care Occupational Licensure in America

Occupational Licensure Compacts

Interstate compacts are authorized under the U.S. Constitution, art. I, section 10, cl. 3.[131] Compacts that affect a power delegated to the federal government or that affect or alter the political balance within the federal system require the consent of Congress.[132] There are currently more than 200 compacts between the states, including 50 national compacts of which six are for health professions.[133,134]

---

[127] *Id.*
[128] *Id.*
[129] Section 408.05, F.S.
[130] see https://pricing.floridahealthfinder.gov/#! (last visited Mar. 12, 2019).
[131] "No state shall, without the Consent of Congress…enter into any Agreement or Compact with another State, or with a foreign Power[.]" *see* U.S. Constitution, art. I, sect. 10, cl. 3. While the language of the provision says congressional approval is required, not all compacts require congressional approval.
[132] This issue was settled in *Virginia v. Tennessee*, 148 U.S. 503 (1893). *See also Interstate Compacts & Agencies (1998)*, William Kevin Voit, Sr. Editor and Gary Nitting, Council of State Governments, pg. 7, http://www.csg.org/knowledgecenter/docs/ncic/CompactsAgencies98.pdf (last visited Mar. 8, 2019)
[133] Ann O'M. Bowman and Neal D. Woods, *Why States Join Interstate Compacts,* The Council of State Governments (March 2017) p. 19 and 20, http://knowledgecenter.csg.org/kc/system/files/Bowman%202017.pdf, (last visited Mar. 8, 2019).
[134] Federal Trade Commission, *Policy Perspectives: Options to Enhance Occupational License Portability* (September 2018), p. 9, https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Mar. 8, 2019). The six health professions are nurses, medical, emergency medical services, physical therapy, psychology, and advanced registered nurse practitioners. The only two compacts currently operational are the Enhanced Nurse Compact and the physicians compacts as the others are awaiting the completion of an administrative structure.

The licensing of professions is predominantly a state responsibility as each state has developed its own regulations, oversight boards, and requirements for dozens of professions and occupations. More than 25 percent of the American workforce are currently in a profession that requires a professional license.[135]

In September 2018, the Federal Trade Commission (FTC) looked at the issue of state-by-state occupational licensure and its unintended consequences. In particular, the FTC noted that state-by-state licensing can have a particularly hard effect on those in the military and their spouses who are required to move frequently, those who provide services across state lines, or deliver services through telehealth.[136] The FTC also suggested that improved licensed portability would enhance competition, choice, and access for consumers, especially where services may be in short supply.[137]

Interstate Medical Licensure Compact

The Interstate Medical Licensure Compact (IMLC) provides an expedited pathway for medical and osteopathic physicians to qualify to practice medicine across state lines within a Licensure Compact. Currently, 24 states and one territory, which cover 31 medical and osteopathic boards participate in the IMLC, and, as of February 2019, six other states have active legislation to join the IMLC.[138, 139]

The Interstate Commission is created in Section 11 of the Compact and serves as the administrative arm of the Compact and member states. Each member state of the Compact has two voting representatives on the Commission. If a state has separate regulatory boards for allopathic and osteopathic, then the representation is split between the two boards.[140]

Approximately 80 percent of physicians meet the eligibility guidelines for licensure through the Compact.[141] The providers' applications are expedited by using the information previously submitted in their State of Principal Licensure (SPL), then the physician can select which states to practice in after a fresh background check is completed.

---

[135] Albert Downs and Iris Hentze, *License Overload? Lawmakers are questioning whether we've gone too far with occupational and professional licensing (April 1, 2018),* STATE LEGISLATURES MAGAZINE, *ncsl.org*, http://www.ncsl.org/bookstore/state-legislatures-magazine/occupational-licensing-can-balance-safety-and-employment-opportunities.aspx (last visited Mar. 8, 2019).

[136] Federal Trade Commission, *Policy Perspectives: Options to Enhance Occupational License Portability (September 2018), Executive Summary,* https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Mar. 8, 2019).

[137] *Id*.

[138] Interstate Medical Licensure Compact, *The IMLC,* https://imlcc.org/ (last visited Mar. 8, 2019).

[139] Interstate Medical Licensure Compact, Draft Executive Committee Meeting Minutes (February 5, 2019), https://imlcc.org/wp-content/uploads/2019/02/2019-IMLC-Executive-Committee-Minutes-February-5-2019-DRAFT.pdf (last visited Mar. 8, 2019).

[140] Interstate Medical Licensure Compact, Section 11, (d), pg. 11, https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf (last visited Mar. 8, 2019).

[141] Interstate Medical Licensure Compact, *The IMLC, https://imlcc.org/* (last visited Mar. 7, 2019).

To qualify for consideration, the physician must:

- Hold a full, unrestricted medical license from a Compact member state and meet one of the following additional qualifications:
  - The physician's primary resident is the State of Principal licensure (SPL).
  - The physician's practice of medicine occurs in the SPL for at least 25 percent of the time.
  - The physician's employer is located in the SPL.
  - The physician uses the SPL as his or her state of residence for U.S. federal income tax purposes.

Additionally, the physician must maintain his or her licensure from the SPL at all times. The SPL may be changed after the original qualification. Other requirements for eligibility for an IMLC Compact license include:

- Graduation from an accredited medical school, or a school listed in the International Medical Education Directory.
- Successful completion of graduate medical education from a school which has received accreditation from Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA).
- Passage – in no more than three attempts – of each component of the United States Medical Licensing Exam (USMLE) or the Comprehensive Osteopathic Medical Licensing Exam (COMLEX-USA) or equivalent.
- Holding a current specialty certification or time-unlimited certification by an American Board of Medical Specialties (ABMS) or American Osteopathic Association/Bureau of Osteopathic Specialists (AOABOS) board.
- Not having any history of disciplinary actions as to their medical license.
- Not having a criminal history.
- Not having any history of controlled substance actions as to their medical license.
- Not currently under investigation.[142]

The application cost is $700 plus the cost of the license for the state in which the applicant wishes to practice. The individual state fees currently vary from a low of $75.00 in Alabama to a high of $700 in Maine.[143]

Regulation of Physicians in Florida

Licensing of Florida Physicians

The regulation of the practices of medicine and osteopathic medicine fall under chapters 458 and 459, F.S., respectively. The practice acts for both professions establish the regulatory boards, a variety of licenses, the application process with eligibility requirements, and financial responsibilities for the practicing physicians. The boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[144] Such standards may include education and training, medication including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed

[142] Interstate Medical Licensure Compact, *Do I Qualify*, *https://imlcc.org/do-i-qualify/* (last visited Mar. 7, 2019).
[143] Interstate Medical Licensure Compact, *What Does It Cost?* https://imlcc.org/what-does-it-cost/ (last visited Mar. 8, 2019).
[144] Sections 458.331(1)(v) and 459.015(1)(z), F.S.

consent, and policy and procedures manuals.[145] The current licensure application fee for a medical doctor is $350 and is non-refundable.[146] Applications must be completed within one year. If a license is approved, the initial license fee is $355.[147] The entire process may take from t to 6 months from the time the application is received.[148]

For osteopathic physicians, the current application fee is non-refundable $200, and if approved, the initial licensure fee is $305.[149] The same application validity provision of one year applies and the processing time of two to six months is the range of time that applicants should anticipate for a decision.[150] If an applicant is licensed in another state, the applicant may request that Florida "endorse" those exam scores and demonstrate that the license was issued based on those exam scores. The applicant must also show that the exam was substantially similar to any exam that Florida allows for licensure.[151]

The general requirements for licensure under both practice acts are very similar with the obvious differences found in the educational backgrounds of the applicants. However, the practice acts are not identical in their licensure offerings as shown in the table below which compares some of the contents of the two practice acts. Where the practice acts share the most similarities are the qualifications for licensure. Both the Board of Medicine and the Board of Osteopathic Medicine require their respective applicants to meet these minimum qualifications:

- Complete an application form as designated by the appropriate regulatory board.
- Be at least 21 years of age.
- Be of good moral character.
- Have completed at least two years (medical) or three years (osteopathic) of pre-professional post-secondary education.
- Have not previously committed any act that would constitute a violation of this chapter or lead to regulatory discipline.
- Have not had an application for a license to practice medicine or osteopathic medicine denied or a license revoked, suspended or otherwise acted upon in another jurisdiction by another licensing authority.
- Must submit a set of fingerprints to the DOH for a criminal background check.
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the applicant's respective professional association.

---

[145] *Id.*
[146] Florida Board of Medicine, *Medical Doctor - Fees, https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted /*(Last visited Mar. 8, 2019).
[147] A change to Rule 64B-3.002, F.A.C., is effective March 11, 2019 which modifies the fee schedule for licensure applications. The fee for licensure by examination will increase to $500 and the fee for licensure by endorsement will increase also to $500. The time to complete an initial applications is also reduced from one year to six months.
[148] Florida Board of Medicine, *Medical Doctor Unrestricted – Process, https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/* (last visited Mar. 8, 2019).
[149] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees, https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/* (last visited: Mar. 8, 2019).
[150] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process, https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/* (last visited Mar. 8, 2019).
[151] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure – Requirements, https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/* (last visited Mar. 8, 2019).

- Demonstrate that she or he has successfully completed a resident internship (osteopathic medicine) or supervised clinical training (medical) of not less than 12 months in a hospital approved for this purpose by the applicant's respective professional association.
- Demonstrate that he or she has obtained a passing score, as established by the applicant's appropriate regulatory board, on all parts of the designated professional examination conducted by the regulatory board's approved medical examiners no more than five years before making application to this state; or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than five years after the applicant obtained a passing score on the required examination.[152]

Statutory References for Practice Acts - Licensure Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.		
Issue	**Medical Physicians**	**Osteopathic Physicians**
Regulatory Board	Board of Medicine s. 458.307, F.S.	Board of Osteopathic Medicine s. 459.004, F.S.
Rulemaking Authority	s. 458.309., F.S.	s. 459.005, F.S.
General Requirements for Licensure	s. 458.311, F.S.	s. 459.0055, F.S.
Licensure Types		
Restricted License	s. 458.310, F.S.	No provision
Restricted License Certain foreign physicians	s. 458.3115, F.S.	No provision
Licensure by Endorsement	s. 458.313, F.S.	No provision
Temporary Certificate (Approved Cancer Centers)	s. 458.3135, F.S.	No provision
Temporary Certificate (Training Programs)	s. 458.3137, F.S.	No provision
Medical Faculty Certificate	s. 458.3145, F.S.	s. 459.0077, F.S.
Temporary Certificate Areas of Critical Need	s. 458.315, F.S.	s. 459.0076, F.S.
Temporary Certificate Areas of Critical Need – Active Duty Military & Veterans	s. 458.3151, F.S.	s. 459.00761, F.S.
Public Health Certificate	s. 458.316, F.S.	No provision
Public Psychiatry Certificate	s. 458.3165, F.S.	No provision
Limited Licenses	s. 458.317, F.S.	s. 459.0075, F.S.
Expert Witness	s. 458.3175, F.S.	s. 459.0066, F.S.
License Renewal	s. 458.319, F.S. $500/max/biennal renewal	s. 459.008, F.S.
Financial Responsibility *Condition of Licensure*	s. 458.320, F.S.	s. 459.0085, F.S.

[152] *See* ss. 458.311, F.S. and 459.0055, F.S.

Statutory References for Practice Acts - Licensure Medical and Osteopathic Physicians: Ch. 458 and 459, F.S.		
Issue	**Medical Physicians**	**Osteopathic Physicians**
Penalty for Violations	s. 458.327, F.S.	s. 459.013, F.S.

In Florida, to practice medicine an individual must become a licensed medical doctor through licensure by examination[153] or licensure by endorsement.[154] Florida does not recognize automatically another state's medical license or provide licensure reciprocity. Licensure by endorsement requires the medical physician to meet the following requirements:

- Be a graduate of an allopathic United States Medical School recognized and approved by the United States Office of Education (AMG) and completed at least one year of residency training;
- Be a graduate of an allopathic international medical school (IMG) and have a valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate and completed an approved residency of at least two years in one specialty area; or
- Be a graduate who has completed the formal requirements of an international medical school except the internship or social service requirements, passed parts I and II of the National Board of Medical Examiners (NBME) or ECFMG equivalent examination, and completed an academic year of supervised clinical training (5th pathway) and completed an approved residency of at least two years in one specialty area.
- And both of the following:
  - Passed all parts of a national examination (the NBME; the Federation Licensing Examination offered by the Federation of State Medical Boards of the United States, Inc.; or the United States Medical Licensing Exam); and
  - Be licensed in another jurisdiction and actively practiced medicine in another jurisdiction for at least two of the immediately preceding four years; or passed a board-approved clinical competency examination within the year preceding filing of the application or; successfully completed a board approved postgraduate training program within 2 years preceding filing of the application.[155]

Financial Responsibility

Florida-licensed allopathic physicians are required to maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions.[156] Physicians who perform surgeries in a certain setting or have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim.[157] Physicians without hospital privileges must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim.[158] Certain physicians who are exempted from the

[153] Section 458.311, F.S.
[154] Section 458.313, F.S.
[155] Florida Board of Medicine, *Medical Doctor-Unrestricted; Licensure by Endorsement,* https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Apr. 1, 2019).
[156] Section 458.320, F.S.
[157] Section 458.320(2), F.S.
[158] Section 458.320(1), F.S.

requirement to carry professional liability insurance or other financial responsibility must provide notice to their patients.[159]

Florida-licensed osteopathic physicians have similar financial responsibility requirements as allopathic physicians[160]. With specified exceptions, the DOH must suspend, on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.[161]

Disciplinary Process: Fines and Sanctions

Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations under the Division of Medical Quality Assurance (MQA) in the DOH. Section 456.072, F.S., specifies 40 acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Section 458.331, F.S., identifies 43 acts that constitute grounds for which disciplinary actions may be taken against a medical physician and s. 459.015, F.S., identifies those acts which are specific to an osteopathic physician. Some parts of the review process are public and some are confidential.[162]

Complaints and allegations are received by the MQA unit for determination of legal sufficiency and investigation. A determination of legal sufficiency is made if the ultimate facts show that a violation has occurred.[163] The complainant is notified by letter as to the whether the complaint will be investigated and if any additional information is needed. Complaints which involve an immediate threat to public safety are given the highest priority.

The DOH is responsible for reviewing each report to determine if discipline against the provider is warranted.[164] Authorization for the discipline of allopathic and osteopathic physicians can be found in state law and administrative rule.[165] If held liable for one of the offenses, the fines and sanctions by category and by offense are based on whether it is the physician's first, second, or third offense.[166] The boards may issue a written notice of noncompliance for the first occurrence of a single minor violation.[167] The amount of fines assessed can vary depending on the severity of the situation, such as improper use of a substance to concealment of a material fact. A penalty may come in the form of a reprimand, a licensure suspension, or revocation followed by some designated period of probation if there is an opportunity for licensure reinstatement. Other

[159] Section 458.320(5)(f) and (g), F.S.
[160] Section 459.0085, F.S
[161] Sections 458.320(8) and 459.0085(9), F.S.
[162] Fla. Department of Health, Division of Medical Quality Assurance, *Enforcement Process,* http://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/enforcement-process-chart.pdf (last updated Mar. 11, 2019).
[163] Fla. Department of Health, *Consumer Services – Administrative Complaint Process,* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html (last visited Mar. 11, 2019).
[164] *See* ss. 458.351(5) and 459.026(5), F.S.
[165] *See* ss. 458.307 and 459.004, F.S., for the regulatory boards, and ss. 64B8-8 and 64B15-19, F.A.C., for administrative rules relating to disciplinary procedures.
[166] *Id.*
[167] Sections 64B8-8.011 and 64B15-19.0065, F.A.C. A minor violation is deemed to not endanger the public health, safety, and welfare and does not demonstrate a serious inability to practice.

sanctions may include supplemental continuing education requirements which require proof of completion before the license can be reinstated.

III. Effect of Proposed Changes:

Patient Records

Sections 1 through 5 direct that specified service providers required to release clinical or medical records must furnish applicable records in their possession within certain timeframes after receiving a request. These provider types and applicable authority are as follows:

- s. 394.4615, F.S., relating to mental health providers (Section 1),
- s. 395.3025, F.S., relating to hospitals and ambulatory surgical centers (Section 2),
- s. 397.501, F.S., relating to substance abuse treatment providers (Section 3),
- s. 400.145, F.S., relating to nursing facility providers (Section 4), and
- s. 456.057, F.S., relating to health care practitioners (Section 5).

Mental health and substance abuse treatment providers, hospitals, ambulatory surgical centers, and health care practitioners are required to furnish such records within 14 working days. Nursing facility providers are required to follow federal regulations which stipulate a resident must be provided such records upon request and with two working days advance notice to the facility.[168]

If a service provider or facility maintains a system of electronic health records,[169] the bill requires the service provider or facility to provide the records in the manner chosen by the requester, which may include:

- Paper document;
- Electronic format;
- Access through a web-based patient portal; or
- Submission through a patient's electronic personal health record.

The bill authorizes a service provider or facility to charge a requester no more than the reasonable costs of reproducing the clinical records, including reasonable staff time, and defines the reasonable costs of reproducing various forms of clinical records as follows:

- Written or typed documents or reports, in any format or medium, may not exceed $1 per page for the first 25 pages and 25 cents per page for all pages thereafter; and
- X-rays and other forms of images must be the actual costs; and actual costs includes the cost of the material, supplies used to duplicate the record, and the labor and overhead costs associated with the duplication.

In addition to the charges above, a special service charge is authorized if the nature and volume of records requested requires extensive use of technology resources or extensive clerical or supervisory assistance by personnel of the service provider or facility. That special service charge must be reasonable and must be based on costs incurred.

[168] *See* 42 C.F.R. s. 483.10(g)(2)(ii).

[169] Section 408.051(2)(a), F.S., defines "Electronic health record" as a record of a person's medical treatment which is created by a licensed health care provider and stored in an interoperable and accessible digital format.

The bill directs that the reproduction charges apply to all records furnished, whether directly from a service provider or facility or from a copy service acting on behalf of a service provider or facility.

The bill directs that a patient whose records are being copied or searched for the purpose of continuing to receive care, may not be required to pay a charge for the copying or searching of their records.

In addition to the above provisions, the bill contains additional provisions applicable to specific provider types and facilities, including:

- Hospitals, ambulatory surgical centers, substance abuse treatment providers, nursing facility providers, and health care practitioners must provide that, within 10 working days of a request to view the provider's or facility's original records pertaining to a particular patient, from a requester who is authorized to have access, such requester must be provided access to examine such original records or other suitable reproductions. Service providers and facilities may impose reasonable terms to ensure that records are not damaged, destroyed, or altered in this process.
- The DOH, rather than the AHCA, is authorized to access records pursuant to a subpoena issued under s. 456.071, F.S.
- For purposes of access to substance abuse treatment records and health care practitioner records, the term "legal representative" is defined to mean an individual's guardian or, if the individual is younger than 18 years of age, his or her parent or legal guardian.

Hospital Quality Information

Section 6 amends s. 395.1012, F.S., to require each hospital to provide to any patient upon admission, upon scheduling of non-emergency care, or prior to treatment, written information on a form created by the AHCA that contains data reported for the most recent year available for the hospital and the statewide average for:

- The rate of hospital-acquired infections;
- The overall rating of the Hospital Consumer Assessment of Healthcare Providers Systems Survey; and
- The 15-day readmission rate.

The hospital must also provide the required data to any party upon request. The hospital must present the data in a manner that is easily understandable and accessible to the patient and include an explanation of the relationship between the data and patient safety.

Patient Access to Primary Care and Specialty Providers

Section 7 creates s. 395.1052, F.S., to require that a hospital notify a patient's primary care provider (PCP) within 24 hours of the patient's admission and discharge from the hospital. A hospital must also notify a patient of his or her right to request that the hospital's treating physician consult with the patient's PCP or specialist, and, if the patient so requests, the treating physician must make reasonable efforts to consult with the PCP or specialist when developing

the patient's plan of care. Additionally, a hospital is required to provide the discharge summary and any related information and records to the PCP within 14 days of the patient's discharge.

Notification of Hospital Observation Status

Section 8 amends s. 395.301, F.S., to require a hospital to provide a patient written notice of their observation status immediately when he or she is placed upon observation status. The bill requires Medicare patients receive the notice through the Medicare Outpatient Observation Notice form adopted under 42 C.F.R. s. 489.20, and non-Medicare patients through a form adopted by rule of the AHCA. The bill also makes conforming changes.

Pediatric Cardiac Technical Advisory Panel

Section 9 amends s. 395.1055, F.S., to modify the composition and duties of the Pediatric Cardiac Technical Advisory Panel (panel) as established in the AHCA by:

- Authorizing the AHCA to reimburse members of the panel for travel and per diem expenses.
- Authorizing the appointment of three alternate, at-large members from affiliations different than those of the voting at-large members.
- Adding a two-year term limit to voting panel members; however, members may be re-appointed to the panel after a two-year retirement period.
- Providing panel members immunity from criminal and civil liability for the good faith performance of duties assigned to them by the Secretary of the AHCA.
- Requiring the Secretary of the AHCA to consult with the panel for an advisory recommendation on all Certificate of Need (CON) applications to establish pediatric cardiac surgical centers.
- Authorizing the Secretary of the AHCA to request announced or unannounced site visits to any existing pediatric cardiac surgical center or a facility seeking licensure as a pediatric cardiac surgical center through the CON process to ensure compliance with the process.
- Authorizing the Secretary of the AHCA to request recommendations from the panel for in-state physician experts to conduct on-site visits and permitting the Secretary to appoint up to two out-of-state physician experts for such visits.
- Establishing procedures for site visit team on-site inspections of a hospital's pediatric medical and surgical programs and requiring each team member to submit a written report of their findings to the panel.
- Authorizing the panel to discuss the written reports from review team members and present an advisory opinion and suggested actions for correction to the Secretary of the AHCA.
- Requiring each on-site inspection to include:
  - An inspection of the program's physical facilities, clinics, and laboratories.
  - Interviews with support staff and hospital administration.
  - A review of randomly selected medical records and reports, clinical outcome data from the Society of Thoracic Surgeons (STS) and the American College of Cardiology (ACC), mortality reports, and program volume data from the preceding year.
- Requiring the Surgeon General of the Department of Health to provide quarterly reports to the Secretary of the AHCA consisting of data from the Children's Medical Services' (CMS) critical congenital heart disease screening program for review by the panel.

Direct Health Care Agreements

Section 10 amends s. 624.27, F.S., to authorize direct care agreements with health care providers licensed under chapters 458 (medicine), 459 (osteopathic medicine), 460 (chiropractic medicine), or 464 (nursing), F.S., or a primary care group practice, for any health care service within their competency and training and adds health care providers licensed under ch. 466, F.S., (dentistry) to the list of providers who can provide direct health care services. Additionally, all references to "primary care" are replaced with "health care" throughout the section.

Step-Therapy Protocols

Sections 11 through 13 create s. 627.42393 and amend s. 641.31(45), and s. 409.973(6), F.S., respectively, relating to step-therapy protocols of health insurers and HMOs issuing major medical coverage, both individual and group, and Medicaid managed care plans. **Sections 11** and **12** are effective January 1, 2020, and will therefore apply to all such health insurance policies and HMO contracts issued or renewed on or after that date.

The sections prohibit an insurer, HMO, or Medicaid managed care plan from requiring a covered individual to undergo a step-therapy protocol under the policy, contract, or plan, respectively, for a covered prescription drug if the insured, subscriber, or recipient has been approved previously to receive the drug through the completion of a step-therapy protocol required by a separate health coverage plan[170] or Medicaid managed care plan, respectively; however, an insurer or HMO is not required to add a drug to its prescription drug formulary or to cover a prescription drug that the insurer or HMO does not otherwise cover. To trigger this provision, a covered individual must provide documentation originating from the prior health coverage plan that the prescription drug was paid by the health coverage plan on behalf of the covered individual during the 180 days immediately prior to the request. The documentation requirement does not apply to a recipient enrolled in a Medicaid managed care plan. For Medicaid managed care, the AHCA must implement this requirement by amending the managed care plan contracts concurrent with the start of a new capitation cycle.

The term, "health coverage plan" means any of the following plans which previously provided coverage or is currently providing major medical or similar comprehensive coverage or benefits to the insured or subscriber: a health insurer or health maintenance organization, a plan established or maintained by an individual employer as provided by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, a multiple-employer welfare arrangement as defined in s. 624.437, F.S., or a governmental entity providing a plan of self-insurance.

[170] The bill defines the term "health coverage plan" to mean any of the following plans which previously provided coverage or is currently providing major medical or similar comprehensive coverage or benefits to the insured or subscriber: a health insurer or health maintenance organization, a plan established or maintained by an individual employer as provided by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, a multiple-employer welfare arrangement as defined in s. 624.437, F.S., or a governmental entity providing a plan of self-insurance.

Price Transparency for Services Covered by Health Insurance

Section 14 creates s. 627.4303, F.S., to prohibit a health insurer[171] from limiting a health care provider's ability to disclose whether a patient's cost-sharing obligation under his or her health coverage exceeds the cash price for a covered service in the absence of health insurance coverage or the availability of a more affordable service. The bill specifies that a health insurer may not require a covered individual to make payment for a covered service in an amount that exceeds the cash price of that service in the absence of health insurance coverage.

Interstate Medical Licensure Compact

Section 15 creates the Interstate Medical Licensure Compact (compact) as s. 456.4501, F.S., which enters Florida into the compact. The compact has 24 sections which establish the compact's administration and components and prescribe how the Interstate Medical Licensure Compact Commission will oversee the compact and conduct its business. The table below describes new statutory language, by compact section, which creates the components of the compact.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
1	Provides the purpose of the Compact Establishes prevailing standard of care	The purpose of the Interstate Medical Licensure Compact (compact) is to provide a streamlined, comprehensive process that allows physicians to become licensed in multiple states. It allows physicians to become licensed without changing a state's Medical Practice Act(s). The compact also adopts the prevailing standard of care based on where the patient is located at the time of the patient-provider encounter. Jurisdiction for disciplinary action or any other adverse actions against a physician's license is retained in the jurisdiction where the license is issued to the physician.
2	Definitions Establishes standard definitions for operation of the compact and the Commission.	Definitions are provided for: - Bylaws: means those Bylaws established by the Commission pursuant to Section 11 for governance, direction, and control of its action and conduct. - Commissioner: means the voting representative appointed by each member board pursuant to Section 11 whereby each member state appoints two members to the Commission. If the member state has two medical boards, the two representatives should be split between the two boards. - Conviction: means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. A conviction also means evidence of an entry of a conviction of a criminal offense by the court

[171] The bill defines the term "health insurer" to mean a health insurer issuing major medical coverage through an individual or group policy or an HMO issuing major medical coverage through an individual or group contract.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		shall be considered final for the purposes of disciplinary action by a member board. - Expedited license: means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the compact. - Interstate Commission: means the interstate commission created pursuant to Section 11. - License: means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization. - Medical Practice Act: means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state. (In Florida, the Medical Practice Act for allopathic medicine is under ch. 458, F.S., and for osteopathic medicine, under ch. 459, F.S.) - Member Board: means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government. (The Florida Board of Medicine and the Florida Board of Osteopathic Medicine are responsible for the licensure, regulation, and education of physicians in Florida.) - Member State: means a state that has enacted the compact. - Practice of medicine: means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical, or mental condition, by attendance, advise, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts. - Physician means: any persons who is a graduate of medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent; passed each component of the USMLE or the COMPLEX-USA within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes; successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; holds specialty certification or time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Board of Osteopathic Specialties; however, the times unlimited specialty certificate does not have to be maintained once the physician is initially determined through the expedited compact process; possess a full and unrestricted license to engage in the practice of medicine issued by a member board; has never been convicted received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction; has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license; has never had a controlled substance license or permit suspended or revoked by a

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		state or the United States Drug Enforcement Administration; and is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction. - Offense means: A felony, high court misdemeanor, or crime of moral turpitude. - Rule means: A written statement by the Commission promulgated pursuant to Section 12 of the compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the compact, or an organizational, procedural, or practice requirement of the Commission, and has the force and effect of statutory law in a member state, if the rule is not inconsistent with the laws of the member state. The term includes the amendment, repeal, or suspension of an existing rule. - State means: Any state, commonwealth, district, or territory of the United States. - State of Principal License means: A member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the compact.
3	Eligibility Provides minimum requirements to receive an expedited license	To be eligible to participate and receive an expedited license, a physician must meet the requirements of Section 2 (definition of physician). A physician who does not meet the requirements of Section 2 may obtain a license to practice medicine in a member state outside of the compact if the individual complies with all of the laws and requirements to practice medicine in that state.
4	State of Principal License (SPL) Defines a SPL	The compact requires participating physicians to designate a State of Principal License (SPL) for purposes of registration for expedited licensure if the physician possesses a full and unrestricted license to practice medicine in that state. The SPL must be a state where: - The physician has his/her primary residence, or - The physician has at least 25 percent of his/her practice, or - The state where the physician's employer is located. If no state qualifies for one of the above options, then the state of residence as designated on physician's federal income taxes. A SPL may be re-designated at any time as long as the physician possesses a full and unrestricted license to practice medicine in that state. The Commission is authorized to develop rules to facilitate the re-designation process.
5	Application and Issuance of Expedited Licensure	Section 5 of the compact establishes the process for the issuance of the expedited license. A physician must file an application with the member of the state selected as the SPL. The SPL will evaluate the application to determine whether the physician is eligible for the expedited

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
	Qualifications *Commission rulemaking provisions*	licensure process and issue a letter of qualification, either verifying or denying eligibility, to the Commission. - Static Qualifications: Include verification of medical education, graduate medical education, results of any medical or licensing examinations and any other qualifications set by the Commission through rule. - Performance of Criminal Background Checks by the member board through FBI, with the exception of federal employees who have suitability determined in accordance with U.S. 5 CFR section 731.202. - Appeals on eligibility determinations are handled through the member state. - Upon completion of eligibility verification process with member state, applicants suitable for an expedited license are directed to complete the registration process with the Commission, including the payment of any fees. - After receipt of registration and payment of fees, the physician receives his/her expedited license. The license authorizes the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state. - An expedited license shall be valid for a period consistent with the member state licensure period and in the same manner as required for other physicians holding a full and unrestricted license. - An expedited license obtained through the compact shall be terminated if a physician fails to monitor a license in the SPL for a non-disciplinary reason, without re-designation of a new SPL. - The Commission is authorized to develop rules relating to the application process, including fees and issuing the expedited license.
6	Fees for Expedited Licensure *Rulemaking authority*	A member state is authorized to charge a fee for an expedited license that is issued or renewed through the compact. The Commission is authorized is develop rules relating to fees for expedited licenses. The rules are not permitted to limit the authority of the member states, the regulating authority of the member states, or to impose and determine the amount of the fee charged by the member states.
7	Renewal and Continued Participation *Renewal license process created*	A physician with an expedited license in a member state must complete a renewal process with the Commission if the physician: - Maintains a full and unrestricted license in a SPL. - Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction. - Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action relating to non-payment of fees related to a license.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
	Continuing education required for renewal with member state *Fees collected, if any, by member state.* *Rulemaking authority.*	- Has not had a controlled substance license or permit suspended or revoked by a state or the United State Drug Enforcement Administration. Physicians are required to comply with all continuing education and professional development requirements for renewal of a license issued by a member state. The Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the appropriate member board. Upon payment of fees, a physician's license shall be renewed. Any information collected during the renewal process shall also be shared with all member boards. The Commission is authorized to develop rules to address the renewal of licenses.
8	Coordinated Information Systems *Authorized to create database of all applicants* *By request, may share data* *Rulemaking authority*	The Commission is required to establish a database of all licensed physicians who have applied for licensure. Member boards are required to report disciplinary or investigatory actions as required by Commission rule. Member boards may also report any non-public complaint, disciplinary, or investigatory information not required to be reported to the Commission. Upon request, member boards shall share complaint or disciplinary information about physicians to another member board. All information provided to the Commission or distributed by the member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters. The Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.
9	Joint Investigations *Permits joint investigations between the state and the member boards*	Licensure and disciplinary records of physicians are deemed investigative. A member board may participate with other member boards in joint investigations of physicians licensed by the member boards in addition to the authority granted by the member board and its respective Medical Practice Act or other respective state law. Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the compact. Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
10	Disciplinary Actions *Discipline by a member state has reciprocal actions* *Licensure actions specific actions to reinstate*	Any disciplinary action taken by any member board against a physician licensed through the compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that State. If the physician's license is revoked, surrendered, or relinquished in lieu of discipline in the SPL, or suspended, then all licenses issued to that physician by member boards shall be automatically placed, without any further action necessary by any member board, on the same status. If the SPL subsequently reinstates the physician's license, a license issued to the physician by any other member board shall remain encumbered until that respective board takes action to specifically reinstate the license in a manner consistent with the Medical Practice Act in that state. If a disciplinary action is taken against the physician in a member state that is the physician's SPL, any other member state may deem the action conclusive as to matter of law and fact decided, and: - Impose the same or lesser sanction or sanctions against the physician so long as such sanctions are consistent with the Medical Practice Act of that state; or - Pursue separate disciplinary action against the physician under the Medical Practice Act, regardless of the action taken in other member states. If a license granted to a physician by a member board is revoked, surrendered, or relinquished in lieu of discipline, or suspended, then any license issued to the physician by any other member board or boards shall be suspended, automatically, and without further action necessary by the other board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period in a manner consistent with the Medical Practice Act of that state.
11	Interstate Medical Licensure Compact Commission *Recognizes creation of Commission*	The member states create the Interstate Medical Licensure Compact Commission as a joint agency of the member states and administration of the compact. The Commission has all the duties, powers, and responsibilities set forth in the compact, plus any other powers conferred upon it by the member states through the compact. Each member state has two (2) two voting representatives appointed by each member state to serve as Commissioners. For states with separate regulatory boards for allopathic and osteopathic regulatory

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
	and state's representative with 2 Commissioners, one from each regulatory board *Availability of Commission meetings, except for certain topics* *Availability of public data from the Commission* *Public notice required* *Creates an executive committee to act on behalf of the Commission*	boards, the member state shall appoint one representative from each member board. A Commissioner shall be: - An allopathic or osteopathic physician appointed to a member board. - Executive director, executive secretary, or similar executive or a member board, or - Member of the public appointed to a member board. The Commission shall meet at least once per calendar year and at least a portion of the meeting shall be a business meeting which shall include the election of officers. The Chair may call additional meeting and shall call for all meeting upon the request of a majority of the member states. Meetings are permitted via telecommunication according to the Bylaws. Each Commissioner is entitled to one vote. A majority of Commissioners shall constitute a quorum, unless a larger quorum is required by the Bylaws of the Commission. A Commissioner shall not delegate a vote to another Commissioner. In the absence of its Commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who meets the requirements of being a Commissioner. The Commission shall provide public notice of all meetings and all meetings shall be open to the public. A meeting may be closed to the public, in full or in portion, when it determines by a 2/3 vote of the Commissioners present, that an issue or matter would likely to: - Relate solely to the internal personnel practices and procedures of the Interstate Commission. - Discuss matters specifically exempted from disclosure by federal statute; - Discuss trade secrets, commercial, or financial information that is privileged or confidential; - Involve accusing a person of a crime, or formally censuring a person; - Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy; - Discuss investigative records compiled for law enforcement purposes; or - Specifically relate to the participation in a civil action or other legal proceeding. The Commission shall make its information and official records, to the extent, not otherwise designated in the Compact or by its rules, available to the public for inspection.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		An executive committee is established which has the authority to act on behalf of the Commission, with the exception of rulemaking, when the Commission is not in session. The executive committee shall oversee the administration of the compact, including enforcement and compliance with the compact, its bylaws and rules, and other such duties as necessary. The Commission may establish other committees for governance and administration of the compact.
12	Powers and Duties of the Interstate Commission *Recognizes creation of the Commission*	The Commission shall have the duties and the powers to: - Oversee and administer the compact. - Promulgate rules which are binding. - Issue advisory opinions upon the request of member states concerning the meaning or interpretation of the compact or its bylaws, rules, and actions. - Enforce compliance with the compact, provisions, the rules, and the bylaws. - Establish and appoint committees, including the executive committee, which has the power to act on behalf of the Interstate Commission. - Pay, or provide for the payment of Commission expenses. - Establish and maintain one or more offices. - Borrow, accept, hire, or contract for services of personnel. - Purchase and maintain insurance and bonds. - Employ an executive director with power to employ, select, or appoint employees, agents, or consultants, determine their duties, and fix their compensation. - Establish personnel policies and programs. - Accept donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize and dispose of it consistent with conflict of interest policies as established by the Commission. - Lease, purchase, accept contributions, or donation of, or otherwise own, hold, improve or use, any property, real, personal, or mixed. - Establish a budget and make expenditures. - Adopt a seal and bylaws governing the management and operation of the Commission. - Report annually to the legislatures and governors of the members concerning the activities of the Commission during the preceding year, including reports of financial audits and any recommendations that may have been adopted by the Commission. - Coordinate education, training, and public awareness regarding the compact, its implementation and operation. - Maintain records in accordance with bylaws. - Seek and obtain trademarks, copyrights, and patents. - Perform such functions as may be necessary or appropriate to achieve the purpose of the compact.
13	Finance Powers	The compact authorizes an annual assessment levied on each member state to cover the costs of operations and activities of the

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
	Provides for annual assessment *Requires rule for any assessment* *No pledging credit without authorization* *Yearly audits*	Commission and its staff. The assessment must be sufficient to cover the amount not provided by other sources and needed to cover the annual budget approved each year by the Commission. The compact requires that the assessment be memorialized by rule binding all the member states. The Commission is not authorized to pledge the credit of any of the member states, except by, and with the authority of, the member states. The compact requires yearly financial audits conducted by a certified or licensed public accountant and the report is to be included in the Commission's annual report.
14	Organization and Operation of the Interstate Commission *Annual officer election* *No officer remuneration* *Liability protection for actions within scope of duties and responsibilities only for officers, employees, and agents*	The compact creates a requirement for the Commission to adopt bylaws by a two-thirds (2/3) vote within twelve months of the first meeting which has already occurred. The first Bylaws were adopted in October 2015.[172] A Chair, Vice Chair, and Treasurer shall be elected or appointed each year by the Commission. Officers serve without remuneration. Officers and employees are immune from suit and liability, either personally or in their professional capacity, for a claim for damage to or loss of property or personal injury or other civil liability cause or arising out of, or relating to, an actual or alleged act, error or omission that occurred with the scope of Commission employment, duties, or responsibilities, provided such person should not be protected from suit or liability for damage or loss, injury or liability caused by the intentional or willful and wanton conduct of such a person. The liability of the executive director and Commission employees or representatives of the Commission, acting within the scope of their employment, may not exceed the limits set forth under the state's Constitution and laws for state officials, employees, and agents. The compact provides that the Commission is considered an instrumentality of the state for this purpose. The compact provides that the Commission shall defend the executive director, its employees, and subject to the approval of the state's attorney general or other appropriate legal counsel, shall

[172] Interstate Medical Licensure Compact, *Annual Report 2017*, https://imlcc.org/wp-content/uploads/2018/03/IMLCC-Annual-Report-2017-1.pdf (last visited Mar. 11, 2019).

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		defend in any civil action seeking to impose liability within scope of duties. The compact provides that employees and representatives of the Commission shall be held harmless in the amount of any settlement or fees, including attorney fees and costs that occurred within the scope of employment or responsibilities and not a result of willful or wanton misconduct.
15	Rulemaking Functions of the Interstate Commission *Promulgate reasonable rules* *Judicial review at U.S. Federal District Court*	The Commission is required to promulgate reasonable rules in order to implement and operate the compact and the commission. The compact adds that any attempt to exercise rulemaking beyond the scope of the compact renders the action invalid. The rules should substantially conform to the "Model State Administrative Procedures Act" of 2010 and subsequent amendments thereto. The compact allows for judicial review of any promulgated rule. A petition may be filed thirty (30) days after a rule has been promulgated in the U.S. District Court in Washington, D.C., or the federal court where the Commission is located.[173] The compact requests deference to the Commission's action consistent with state law.
16	Oversight of Interstate Contract *Enforcement* *Service of process*	The compact is the responsibility of each state's own executive, legislative, and judicial branch to oversee and enforce. All courts are to take judicial notice of the compact and any adopted administrative rules in a proceeding involving compact subject matter. The compact provides that the Commission is entitled to receive service of process in any proceeding and shall have standing in any proceeding. Failure to serve the Commission shall render a judgment null and void as to the Commission, the compact, or promulgated rule.
17	Enforcement of Interstate Contract	The compact provides the Commission reasonable discretion to enforce the provisions and rules of the compact, including when and where to initiate legal action. The Commission is permitted to seek a range of remedies.
18	Default Procedures	The compact provides a number of reasons a member state may default on the compact, including failure to perform required duties and responsibilities and the options available to the Commission. The compact requires the Commission to promulgate rules to address how physician licenses are affected by the termination of a

[173] The Interstate Medical Licensure Compact Commission is currently headquartered in Littleton, Colorado. *See* Interstate Medical License Commission, Frequently Asked Questions (FAQS), https://imlcc.org/faqs/

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		member state from the compact. The rules must also ensure that a member state does not bear any costs when a state has been found to be in default. The compact provides an appeal process for the terminating state and procedures for attorney's fees and costs.
19	Dispute Resolution	The compact authorizes the Commission to use dispute resolution tools to resolve disputes between states, such as mediation and binding dispute resolution. The Commission shall promulgate rules for the dispute resolution process.
20	Member States, Effective Date and Amendment	The compact allows any state to become a member state and that the compact is binding upon the legislative enactment of the compact by no less than seven (7) states.[174]
21	Withdrawal	A member state may withdraw from the compact through repeal of this section of law which inserted the compact into state statute. Any repeal of the compact through repeal of the state law cannot take effect until one (1) year after the effective date of such an action and written notice has been given by the withdrawing state to the governor of each other member state. The compact provision also requires that upon introduction of any repeal legislation, that the withdrawing state immediately notify the Chairperson of the Commission of the legislation. The compact provides that it is the Commission's responsibility to notify the other member states within 60 (sixty) days of its receipt of information about legislation that would repeal that state's participation in the compact. The withdrawing state would be responsible for any dues, obligations, or liabilities incurred through the date of withdrawal. Reinstatement is an option under the compact. The compact authorizes the Commission to develop rules to address the impact of the withdrawal of a member state on licenses.
22	Dissolution	When the membership of the compact is reduced to one, the compact shall be dissolved. Once dissolved, the compact shall be null and void. Once concluded, any surplus funds of the Commission shall be distributed in accordance with the bylaws.

[174] The Compact is in force now. The Commission was seated for the first time in October 2015 and issued its first letters of qualification to physicians in April 2017. *See* Interstate Medical Licensure Compact, *https://imlcc.org/faqs/* (last Mar. 11, 2019).

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
23	Severability and Construction	If any part of this compact is not enforceable, the remaining provisions are still enforceable. The provisions of the compact are to be liberally construed. and nothing is to be construed so as to prohibit the applicability of other interstate compacts to which states might be members.
24	Binding Effect of Compact and Other Laws	This compact does not prohibit the enforcement of other laws which are not in conflict with this compact. All laws which are in a member state which are inconsistent with this compact are superseded to the point of the contact. The actions of the Commission are binding on the member states, including all promulgated rules and the adopted bylaws of the Commission. All agreements between the Commission and the member state are binding in accordance with their terms. In the event that any provision of this Compact exceeds Florida's constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent that the conflict of the constitutional provision in question in that member state.

Section 16 provides an effective date of July 1, 2019, except as otherwise provided in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Section 15. The Interstate Commission requires most of its meetings to be open to the public. The notice requirements vary depending on the purpose of the meeting, however. Rulemaking hearings, where rules are proposed in a manner substantially similar to the model state administrative procedure act of 2010, are submitted to the Bylaws and Rules Committee for review and action. Prior to final consideration by the Commission, the final proposed rule must be publicly noticed on the Commission's website or other agreed upon distribution site at least 30 days prior to the meeting at which the vote is scheduled.[175] A reason for the proposed rule action will also be posted.[176] The public must also be provided a reasonable opportunity to provide public comment, orally or in

[175] Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(c),* https://imlcc.org/wp-content/uploads/2018/02/IMLCC-Rule-Chapter-1-Rule-on-Rulemaking-Adopted-June-24-2016.pdf (last visited Mar. 11, 2019).
[176] *Supra,* Note 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(b).*

writing, for proposed rules. A committee of the Commission may propose a rule at any time by a majority vote of that committee.

The written procedure states for every proposed rule action that there will also be instruction on how interested parties may attend the scheduled public hearing, may submit their intent to attend the public hearing and submit any written comments.[177] A transcript of these meetings are not made unless one is specifically requested and then the requestor is responsible for the cost the transcription.[178]

Not later than 30 (thirty) days after its adoption, any interested party may petition for judicial review of the rule in the United States District Court for the District of Columbia or in the federal court where the Commission's headquarters are currently located. The Commission's mailing address currently is in Littleton, Colorado.[179]

The compact also permits the commission, with a two-thirds vote of the Commissioners present, to meet in closed, nonpublic meetings if the commission must address any matters that:

- Relate solely to the internal personnel practices and procedures of the Interstate Commission.
- Specifically exempted from disclosure by federal statute;
- Discuss trade secrets, commercial, or financial information that is privileged or confidential;
- Involve accusing a person of a crime, or formally censuring a person;
- Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Discuss investigative records compiled for law enforcement purposes; or
- Specifically relate to the participation in a civil action or other legal proceeding.[180]

The rulemaking process, its timelines and public involvement process, plus the closure of public meetings for some of these detailed reasons, may be inconsistent with Florida law on public meetings.

While the provisions of the compact and its administrative rules and corporate bylaws require minutes to be kept of some of these closed sessions, it is not clear that it is applicable to all closed sessions and it does require an interested party to request a transcriber in some cases to be present and to expend personal funds to ensure the availability of minutes. A third party may or may not be as likely either to fully describe all matters discussed and provide an accurate summary of actions taken, including a record of any roll call votes.[181]

---

[177] *Supra,* Note, 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(d).*
[178] *Supra* Note 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(e).*
[179] Interstate Medical Licensure Compact, FAQs, *https://imlcc.org/faqs/* (last visited Mar. 10, 2019).
[180] Interstate Medical License Compact Bylaws, *Section 11 – Interstate Medical License Compact Commission, Section (h)-(l), https://imlcc.org/wp-content/uploads/2018/04/IMLC-Compact-Law.pdf (last visited Mar. 11, 2019).*
[181] *Id.*

According to the Commission's Bylaws, the public notice for a regular meeting of the Commission is at least ten (10) days prior to the meeting according to the compact and the notice will be posted on the Commission's website or distributed through another website designated by the Commission for interested parties to receive notice who have requested to receive such notices.[182]

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

Article VII, section 19 of the State Constitution requires that a new state tax or fee, as well as an increased state tax or fee, must be approved by two-thirds of the membership of each house of the Legislature and must be contained in a separate bill that contains no other subject. Article VII, section 19(d)(1) of the State Constitution defines "fee" to mean "any charge or payment required by law, including any fee for service, fee or cost for licenses, and charge for service."

Section 15 of the bill authorizes the Interstate Medical Licensure Compact to assess and collect fees from allopathic and osteopathic physicians who elect to participate in the expedited licensure process.

For physicians who elect this license, a non-refundable service fee of $700 for the letter of qualification is charged to the applicant when the initial application is submitted to the Interstate Commission on Medical Licensure (ICML). Of that $700, $300 is remitted to the applicant's home state or state of principal licensure and the remaining $400 is sent to the Interstate Commission's general fund.

Every time the applicant requests that a letter of qualification be disseminated to one or more of the member states that participate in the ICML after the initial dissemination of the letter for the expedited license, the cost to the registrant is $100. Of this amount, one hundred percent is sent to the ICML General Fund.

For each expedited licensed that is renewed through the compact, a non-refundable fee of $25 shall be assessed to the physician and paid to the ICML General Fund. The ICML receives 100 percent of these funds.

E. Other Constitutional Issues:

The Interstate Compact authorizes compact administrators to develop rules that member states must adopt, which is potentially an unlawful delegation of legislative authority. If enacted into law, the state will bind itself to rules not yet promulgated and adopted by the commission. The 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

[182] *Id.*

unconstitutional delegation of legislative authority to prospectively adopt federal statutes not yet enacted by Congress and rules not yet promulgated by federal administrative bodies.[183,184] Under this holding, the constitutionality of the bill's adoption of prospective rules might be questioned, and there does not appear to be Florida case law that squarely addresses this issue in the context of interstate compacts.

The most recent case Florida courts have had to address this issue was in *Department of Children and Family Services v. L.G.*, involving the Interstate Compact for the Placement of Children (ICPC).[185] The First District Court of Appeal considered an argument that the regulations adopted by the Association of Administrators of the Interstate Compact were binding and that the lower court's order permitting a mother and child to relocate to another state was in violation of the ICPC. The court denied the appeal and held that the Association's regulations did not apply as they conflicted with the ICPC and the regulations did not apply to the facts of the case.

The court also references language in the ICPC that confers to its compact administrators the "power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact."[186] The court states that "the precise legal effect of the ICPC compact administrators' regulations in Florida is unclear," but noted that it did not need to address the question to decide the case.[187] However, in a footnote, the court said:

> 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.,*

[183] *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).
[184] 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).
[185] 801 So.2d 1047 (Fla. 1st DCA 2001).
[186] Id at 1052.
[187] Id.

398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.[188]

In accordance with that footnote, 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. The referenced case, however, does not appear to be binding as precedent as the court's footnote discussion is dicta.[189]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Sections 1 through 5, in **s**pecifying a specific cost for various forms of copies of clinical and medical records, could reduce the costs of a patient obtaining copies of his or her records.

Section 10, by modifying the availability of direct patient contracting for health care services, access to expanded health care services may be extended to patients who may not otherwise have access to certain types of health care services or in underserved or rural areas of the state. Statistics also show that more than one third of current direct primary care patients nationally are Medicare patients.

Current Florida law allows physicians to contract only for primary care agreements. This bill removes that restriction and expands the scope of those agreements so patients may have additional options. This model is seen as a mechanism for providers to reduce their administrative burdens with payers. By adding reimbursement options for more provider types and health care services, provider access may be improved for Floridians.

C. Government Sector Impact:

Section 6. The bill will create an insignificant negative fiscal impact to the Agency for Health Care Administration (AHCA) to create the form hospitals must provide to patients, and any other person upon request, pertaining to required hospital quality measures, and the additional workload for the AHCA to monitor compliance by hospitals of such requirements. The fiscal impact can be absorbed within existing resources of the AHCA.[190]

---

[188] *Id.*

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

[190] Email from James Kotas, Agency for Health Care Administration (April 2, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

Section 8. The bill requires the AHCA to create a form for hospitals and ambulatory surgical centers to immediately notify non-Medicare patients of their placement on observation status. Such form must be adopted by the AHCA through rule which will create an insignificant negative fiscal impact that can be absorbed within existing resources of the AHCA.[191]

Section 9. The bill authorizes, but does not require, the AHCA to reimburse members of the Pediatric Cardiac Technical Advisory Council Panel (panel) for per diem and travel expenses; therefore, there is no impact on state expenditures. The AHCA estimates an annual cost of approximately $21,000 if it were to reimburse panel members.[192]

The bill authorizes, but does not require, the Secretary of the AHCA to request announced or unannounced site visits of existing pediatric cardiac centers or facilities seeking licensure as a pediatric cardiac surgical center through the certificate of need process. At the Secretary's request, the panel must recommend in-state physician experts to conduct such on-site visit, and the Secretary may appoint up to two out-of-state physician experts. The bill does not establish a deadline nor a frequency for the site visits required of existing pediatric cardiac centers; however, the panel has recommended that experts conduct three annual site visits.[193] The increase in state expenditures as a result of the onsite visits for the existing pediatric cardiac centers is addressed through an appropriation of $150,000 in SB 2500, First Engrossed, the Senate's proposed General Appropriations Bill for the 2019-2020 fiscal year.[194] The number of facilities seeking licensure as a pediatric cardiac surgical center is unknown; therefore, the fiscal impact of conducting onsite visits prior to the completion of the certificate of need process is indeterminate.

The Surgeon General of the Department of Health (DOH) is required to provide a quarterly report to the Secretary of the AHCA that summarizes data from the Children's Medical Services critical congenital heart disease (CCHD) newborn screening program. This data will be reviewed by the panel. The bill does not specify the data to be included in such quarterly report. According to the DOH, the current aggregate data collected and provided to the Genetic and Newborn Screening Advisory Council (GNSAC) for CCHD is minimal. To the extent that the information required in the quarterly report is the same data that is provided to the GNSAC, there would be no increase in state expenditures; however, if the requested data exceeds that which is provided to the GNSAC, then there would be an indeterminate increase in state expenditures.[195]

---

[191] *Id.*
[192] *Id.*
[193] Pediatric Technical Advisory Panel, Agency for Health Care Administration, *Draft Meeting Minutes*, pg. 2 (Dec. 13, 2018), *available at:* http://ahca.myflorida.com/SCHS/PCTAP/docs/020719/PCTAPDraftMinutes121318.pdf (last visited Apr. 5, 2019).
[194] *See* SB 2500, First Engrossed, the Senate's proposed Fiscal Year 2019-2020 General Appropriations Bill, Section 3, Specific Appropriation 226, at page 61. An appropriation of $150,000 of nonrecurring funds from the Health Care Trust Fund is provided to the Agency for Health Care Administration for the Pediatric Cardiac Technical Advisory Panel.
[195] Email correspondence from Gary Landry, Department of Health (April 5, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

Section 13. The bill prohibits Medicaid managed care plans from requiring an enrolled Medicaid recipient to use a step-therapy protocol before the plan approves a requested covered prescription drug if the recipient has already been approved to receive the drug through the completion of a step-therapy protocol employed by another Medicaid managed care plan which paid for the drug on the recipient's behalf during the 180 days immediately prior to the request. This provision could have a negative fiscal impact on the Medicaid program to the extent that it causes Medicaid managed care plans to spend more on prescription drugs than they currently spend under current law. Whether such a result will materialize is indeterminate.[196]

Section 15. As a member state to the compact, the state will see an increased volume in the number of licensure applications at the Division of Medical Quality Assurance, Board of Medicine, and Board of Osteopathic Medicine. Applicants for the expedited licensure process must have a designated state of principal license (SPL) where the physician has acquired his full and unrestricted license to practice medicine, is in good standing, practices medicine at least 25 percent of the time, is the physician's primary state of residence, or is the location of the physician's employer. Applications for an expedited license with a member board through the Interstate Commission would first go through a Florida eligibility vetting process to issue a letter of qualification or to deny a letter of qualification.

The DOH could experience an indeterminate increase in administrative costs from:

- Processing applications from out-of-state physicians for expedited licensure under the compact;
- Conducting a fresh background screening for Florida physicians wishing to apply for licensure in other member compact states:
- Participation in joint investigations and disciplinary actions related to physicians located within member states of the Interstate Commission; and
- Information technology costs related to information sharing between the DOH and the Interstate Commission.

The Interstate Commission is authorized to levy an annual assessment on member states to offset the Commission's administrative and information technology costs. The cost of the annual assessment is indeterminate because the amount of the assessment is contingent on the formula developed by the Commission and is proportional to the number of participating member states.

The state could experience a need for additional resources at DOH to handle an increase in physician applications for expedited licensure under the compact, as well as additional revenue from application fees. The resulting overall impact of **Section 15** is indeterminate.

Overall, the bill has an indeterminate fiscal impact on state revenues and state expenditures.

[196] *Supra* note 208.

VI. Technical Deficiencies:

Line 553 of the bill authorizes panel members to be reimbursed for travel and per diem; however, the provision does not include the statutory cross reference to s. 112.061, F.S., which limits travel reimbursement for individuals who travel on public business. Without the cross reference to the state guidelines, a different travel reimbursement schedule could be implemented for the panel members.

Line 621 of the bill grants immunity to panel members from any civil or criminal liability for events resulting from their good faith performance of duties assigned to them by the Secretary of the AHCA; however, the use of the term "immunity" is likely broader than intended, and could have unintended consequences. An amendment should be considered to clarify that the panel members are instead granted sovereign immunity in the performance of their duties rather than civil liability.

Lines 671 through 697 of the bill authorizes the Pediatric Cardiac Technical Advisory Council Panel (panel) to review and discuss the results of the onsite visits and inspections for existing pediatric cardiac centers or facilities seeking licensure as a pediatric cardiac surgical center through the certificate of need process. The bill prescribes the activities of the onsite review team members during the inspection of existing pediatric cardiac centers or facilities seeking licensure as a pediatric cardiac surgical center through the certificate of need process.

SB 7080, the linked public records bill, may need to be amended to exempt from public meetings requirements the portions of meetings of the panel where results of the onsite visits and inspections are discussed for existing pediatric cardiac centers or facilities seeking licensure as a pediatric cardiac surgical center, and to exempt from public records disclosure requirements the activities of the onsite review team members during the inspection of existing pediatric cardiac centers or facilities seeking licensure as a pediatric cardiac surgical center through the certificate of need process.

VII. Related Issues:

Section 10. The Office of Insurance Regulation suggests that several additional terms or conditions be added to the Direct Access Agreements:

- Define the term "health care group practice." Under currently law, the term "primary care group practice" is used and is also not defined.
- Include guaranteed renewal terms or continuity of care provisions for patients who are undergoing treatment or receiving services for a condition to limit risk of a contract being canceled with 30 days' notice and no recourse.
- Add an enforcement mechanism for violations of the statute or failure to include the mandatory provisions in the agreement.[197]

Section 15. The Interstate Medical Licensure Compact is inserted into statute as written by the Interstate Medical Licensing Commission (IMLC). Unlike other compacts entered by the state,

[197] Office of Insurance Regulation, *2019 Agency Legislative Bill Analysis – HB 7* (February 20, 2019) (on file with the Senate Committee on Health Policy).

existing statutes relating to physician licensure have not been modified to recognize the existence of this new process.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.4615, 395.1012, 395.1055, 395.301, 395.3025, 397.501, 400.145, 409.973, 456.057, 624.27, and 641.31.

This bill creates the following sections of the Florida Statutes: 395.1052, 456.4501, 627.42393, and 627.4303.

IX. Additional Information:

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

Recommended CS by Appropriations Subcommittee on Health and Human Services on April 4, 2019:
The committee substitute:

- Requires that any medium or format of medical records requested is subject to the maximum amount permitted to be charged by health care facilities and health care practitioners rather than just those records in paper format;
- Reduces the timeframe that a nursing facility provider is required to respond to a request for a residents' records from 14 days to 2 days in compliance with federal regulations;
- Extends the timeframe that a hospital is required to provide the discharge summary and any related information and records to a patient's primary care provider from seven to 14 days of the patient's discharge;
- Modifies the composition and duties of the Pediatric Cardiac Technical Advisory Panel;
- Provides members of the Pediatric Cardiac Technical Advisory Panel immunity from civil or criminal liability for the good faith performance of duties assigned to them by the Secretary of the AHCA; and
- Clarifies step-therapy protocols such that an insurer or HMO is not required to add a drug to its prescription drug formulary or to cover a prescription drug that the insurer or HMO does not otherwise cover.

B. Amendments:

None.