The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SPB 7078
INTRODUCER:	For consideration by the Health Policy Committee
SUBJECT:	Health Care
DATE:	March 15, 2019
REVISED:	

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Williams, et al	Brown		**Pre-meeting**

I. Summary:

SPB 7078 addresses a variety of health care and health insurance issues, including:

- Access to medical records
- Hospital quality information
- Access to primary and specialist care in a hospital setting
- Notification of hospital observation status
- Direct health care agreements
- Step-therapy protocols
- Price transparency for services covered by health insurance
- The Interstate Medical License Compact

The bill also makes necessary technical and conforming cross-reference revisions.

The bill has an indeterminate fiscal impact on the state.

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

II. Present Situation:

Access to Medical Records

The Baker Act and Mental Health Clinical Records and Confidentiality

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[1] The Baker Act authorized treatment programs for mental, emotional, and behavioral disorders. The Baker Act required programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery. Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health

[1] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.

examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Section 394.4615, F.S., of The Baker Act, was created in 1996 and modified provisions relating to the confidentiality of a patient's mental health records. Under this statute, patients were provided access to those records.[2] Section 394.4615, F.S., has been substantively amended only twice since being enacted in 1996, as follows:

- In 2000, clinical records relating to a Medicaid recipient were required to be furnished to the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request;[3,4] and information from clinical records could be used by the Florida advocacy councils, instead of human rights advocacy committees, for the purpose of monitoring facility activity and complaints concerning facilities;[5] and
- In 2004, clinical records could be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to appropriate mental health professionals, including the service provider identified in s. 394.4655(6)(b)2., in accordance with state and federal law for the purpose of determining whether a person meets the criteria for involuntary outpatient placement or for preparing the proposed treatment plan pursuant to s. 394.4655, F.S.[6]

Section 394.4615, F.S., provides the following to maintain the confidentiality of mental health clinical records:

- Mental health clinical records must be maintained for each patient and must include specific data;
- Mental health clinical records are confidential and exempt from the provisions of s. 119.07(1), F.S., 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.
- The confidential status of a patient's clinical record is not lost by either authorized or unauthorized disclosure to any person, organization, or agency.

Section 394.4615, F.S., provides the following circumstances when confidential mental health clinical records must be released:

- When the patient or the patient's guardian authorizes the release of information and clinical records to appropriate persons to ensure the continuity of the patient's health care or mental health care;
- When the patient is represented by counsel and the records are needed by counsel for adequate representation;

[2] Chapter 96-196, s. 14, Laws of Fla.
[3] Chapter 2000-163, s. 1, Laws of Fla.
[4] Section 394.4615 (5), F.S.
[5] Chapter 2000-263, s. 4, laws of Fla.
[6] Chapter 2004-385, s.14, Laws of Fla.

- When the court orders such release after determining that there is good cause for disclosure after weighing the need for the information to be disclosed against the possible harm of disclosure to the person to whom the information pertains; and
- When the patient is committed to, or is to be returned to, the Department of Corrections from the DCF, and the Department of Corrections requests such records.

Section 394.4615, F.S., provides the following circumstances when confidential mental health clinical records may be released:

- When a patient has declared an intention to harm other persons, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient;
- When the administrator of the facility, or Secretary of the Department of Children and Families (DCF) deems that release to a qualified researcher, an aftercare treatment provider, or an employee or agent of the DCF is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs;
- When the state attorney, the public defender, patient's private legal counsel, the court, or an appropriate mental health professional, including the service provider identified in s. 394.4655(7)(b)2., F.S., deem it necessary in determining whether a person meets the criteria for involuntary outpatient placement, or for preparing the proposed treatment plan pursuant to s. 394.4655, F.S.;
- For statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals;
- To the Agency for Health Care Administration (AHCA), the DCF, and the Florida advocacy councils for the purpose of monitoring facility activity and complaints concerning facilities;
- To the Medicaid Fraud Control Unit in the Department of Legal Affairs, upon request, if the patient is a Medicaid recipient.

Section 394.4615 also directs that any person, agency, or entity who receives mental health clinical records must maintain the information as confidential and exempt from the provisions of s. 119.07(1), F.S.; and any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this section is not subject to civil or criminal liability for such release.

The Legislature stated its intent in s. 394.4615, F.S., not to prohibit the parent or next of kin of a person who is held in, or treated under a mental health facility or program, from requesting and receiving information limited to a summary of that person's treatment plan and current physical and mental condition. 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. If a patient's right to inspect his or her mental health clinical record is restricted by a facility, it expires after seven days, but may be renewed, for a subsequent seven days. Written notice of the restriction of a patient's right to inspect his or her mental health clinical records must be given to the patient, the patient's guardian, guardian advocate, attorney, and representative, and the restriction must be recorded in the clinical record, together with the reasons for it.

Any person who fraudulently alters, defaces, or falsifies the mental health clinical records of any person receiving mental health services in a facility, or causes or procures any of these offenses to be committed, commits a misdemeanor of the second degree, punishable as provided in ss. 775.082 or 775.083, F.S.

Hospitals

Hospitals are regulated by the AHCA under ch. 395, F.S., and the general licensure provisions of part II, of ch. 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[7] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.[8]

The AHCA must maintain an inventory of hospitals with an emergency department.[9] The inventory must list all services within the capability of each hospital, and such services must appear on the face of the hospital's license. As of March 12, 2019, 217 of the 308 licensed hospitals in the state have an emergency department.[10]

Hospitals must meet initial licensing requirements by submitting a completed application and required documentation, and the satisfactory completion of a facility survey. The license fee is $1,565.13 or $31.46 per bed, whichever is greater.[11] The survey fee is $400 or $12 per bed, whichever is greater.[12]

Section 395.1055, F.S., authorizes the AHCA to adopt rules for hospitals. Separate standards may be provided for general and specialty hospitals.[13] The rules for general and specialty hospitals must include minimum standards to ensure:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards.[14]

The minimum standards for hospital licensure are contained in Chapter 59A-3, F.A.C.

[7] Section 395.002(12), F.S.
[8] Id.
[9] Section 395.1041(2), F.S.
[10] Agency for Health Care Administration, Facility/Provider Search Results, Hospitals, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (reports generated on Mar. 12, 2019).
[11] Rule 59A-3.066(3), F.A.C.
[12] Section 395.0161(3)(a), F.S.
[13] Section 395.1055(2), F.S.
[14] Section 395.1055(1), F.S.

Ambulatory Surgical Centers (ASCs)

An ASC is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.[15] ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.[16] Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including:

- An affidavit of compliance with fictitious name;
- Proof of registration of articles of incorporation; and
- A zoning certificate or proof of compliance with zoning requirements.[17]

Upon receipt of an initial application, AHCA is required to conduct a survey to determine compliance with all laws and rules. ASCs are required to provide certain information during the initial inspection, including:

- Governing body bylaws, rules and regulations;
- A roster of registered nurses and licensed practical nurses with current license numbers;
- A fire plan; and
- The comprehensive Emergency Management Plan.[18]

The AHCA is authorized to adopt rules for ASCs.[19] Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals,[20] but the rules for all ASCs must include the minimum standards listed above for hospitals.

The minimum standards for ASCs are contained in Chapter 59A-5, F.A.C.

Hospital Compare

The federal Centers for Medicare & Medicaid Services (CMS) maintains the Hospital Compare website,[21] which provides consumers with data about the quality of care at over 4,000 Medicare-certified hospitals.[22] 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.[23] Performance measures include patient satisfaction survey

[15] Section 395.002(3), F.S.
[16] Sections 395.001-1065, F.S., and Part II, Chapter 408, F.S.
[17] Rule 59A-5.003(4), F.A.C.
[18] Rule 59A-5.003(5), F.A.C.
[19] Section 395.1055, F.S.
[20] Section 395.1055(2), F.S.
[21] 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)
[22] Medicare.gov, What is Hospital Compare? available at https://www.medicare.gov/hospitalcompare/About/What-Is-HOS.html (last visited March 12, 2018).
[23] Supra note 16

results[24] and readmission, hospital acquired infection and mortality rates.[25] Overall hospital performance is presented to consumers through a star rating of one to five stars.[26]

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center) provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data. The Florida Center is housed within the AHCA.[27]

Offices within the Florida Center, which serve different functions, are:

- Data Collection and Quality Assurance, which collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments.
- Risk Management and Patient Safety, which conducts in-depth analyses of reported incidents to determine what happened and how the facility responded to the incident.
- Data Dissemination and Communication, which maintains AHCA's health information website, provides technical assistance to data users, and creates consumer brochures and other publications.
- Health Information Exchange and Policy Analysis, which monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.[28]

The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ASC, emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The data is validated for accuracy and maintained in three major databases: the hospital inpatient database, the ambulatory surgery database, and the emergency department database.

- The hospital inpatient database contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data. This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.[29]

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[24] Data is from responses to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. HCAHPS is a national survey that asks patients about their experiences during a recent hospital stay. http://www.hcahpsonline.org/(last visited March 12, 2019)

[25] Medicare.gov, Measures and current data collection periods, available at https://www.medicare.gov/hospitalcompare/Data/Data-Updated.html # (last visited March 12, 2019).

[26] Medicare.gov, Hospital Compare overall hospital rating, available at https://www.medicare.gov/hospitalcompare/About/Hospital-overall-ratings.html (last viewed March 12, 2019).

[27] Section 408.05, F.S.

[28] See *Florida Center for Health Information and Transparency*, available at http://ahca.myflorida.com/SCHS/ (last visited on March 12, 2019).

[29] See s. 408.061, F.S., and ch. 59E-7, F.A.C.

- The ambulatory surgery database contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories. Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.[30]
- The emergency department database collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.[31]

The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead 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, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida.

The website also provides tools to researchers and professionals to allow specialized data queries, but requires users to have some knowledge of medical coding and terminology. Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.

The Florida Center also runs Florida Health Price Finder[32] which 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.

The Health Insurance Portability and Accountability Act (HIPAA)

The federal HIPAA provides that, except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information [33] in a covered entity's designated record set. 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. 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

[30] See s. 408.061, F.S., and ch. 59B-9, F.A.C.
[31] Id.
[32] see https://pricing.floridahealthfinder.gov/# (last visited March 12, 2019).
[33] 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.

Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, covered entities 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. Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.[34]

Florida Law

In addition to federal requirements, Florida law establishes medical record requirements for various facilities.

Hospital and Ambulatory Surgical Center (ASC) records are governed by s. 395.3025, F.S. Hospitals and ASCs are required to furnish records in a timely manner, without delays for legal review, to a patient or the patient's representative[35] but only after the patient has been discharged from the hospital or ASC. A hospital or ASC may charge up to $1 per page of paper records or up to $2 in total for non-paper records whether 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.

The provisions of s. 395.3025, F.S., do not apply to:
- Records maintained at a psychiatric hospital;
- Records or mental or emotional treatment at a facility where the records are governed by the Florida Mental Health Act under s. 394.4165, F.S.; or
- Records of a substance abuse impaired person.

Section 395.3025(4), F.S., specifies that patient records 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. The section allows access to a patient's records without the consent of the patient to specific entities for purposes related to the treatment of the patient, licensure actions, investigations, audits, and quality assurance.

Substance Abuse Treatment

Substance Abuse Services are governed by ch. 397, F.S, and the DCF is responsible for the oversight of a statewide system of care for the prevention, treatment, and recovery of children and adults with serious substance abuse issues. The state substance abuse program is designed to support the prevention and remediation of substance abuse through the provision of a

[34] See Summary of the HIPAA Privacy Rule, available at https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (last visited on March 11, 2019).
[35] 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.

comprehensive system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.[36]

The Right to Confidentiality of Individual Substance Abuse Records

A person's right to the confidentiality of their individual substance abuse records demands a service provider 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 state public records laws. Substance abuse records may not be disclosed without the written consent of the individual to whom they pertain, except under the following circumstances:

- To medical personnel in a medical emergency;
- To service provider personnel if such personnel need to know the information in order to carry out duties relating to the provision of services to an individual;
- To the secretary of the DCF or his or her designee, for the purposes of scientific research, in accordance with federal confidentiality regulations, but only upon agreement in writing that the individual's name and other identifying information will not be disclosed;
- In the course of review of service provider records by persons who are performing an audit or evaluation on behalf of any federal, state, or local government agency, or third-party payer providing financial assistance or reimbursement to the service provider; or
- Upon court order based on an application showing good cause for disclosure.[37]

The restrictions on the disclosure and use of confidential records held by substance abuse program service providers do not apply to:

- Communications from provider personnel to law enforcement officers which:
  - Are directly related to an individual's commission of a crime on the premises of the provider or against provider personnel or to a threat to commit such a crime; and
  - Are limited to the circumstances of the incident, including the status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts.
- The reporting of incidents of suspected child abuse and neglect to the appropriate state or local authorities as required by law.[38]

Any response to a request for disclosure of an individual's records under ch. 397, F.S., which is not permissible, must be done in such a manner that it will not affirmatively reveal the identity of the individual, or his or her diagnosis, or treatment for substance abuse. However, if the individual is not receiving, or has never received, substance abuse services, that fact may be disclosed.[39]

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[36] OPPAGA, *Department of Children and Families Substance Abuse and Mental Health Community Services*,(Jan. 15, 2019) *available at* http://www.oppaga.state.fl.us/profiles/5057/ (last visited Mar. 11, 2019).

[37] Section 397.501(7)(a), F.S. In determining whether there is good cause for disclosure, the court shall examine whether the public interest and the need for disclosure outweigh the potential injury to the individual, to the service provider and the individual, and to the service provider itself.

[38] Section 497.501(7)(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.

[39] Section 497.501(7)(d), F.S.

If a minor has the legal capacity to voluntarily apply for, and obtain, substance abuse treatment only the minor may consent to the disclosure of that minor's substance abuse records. However, when the consent of a parent, legal guardian, or custodian is required in order for a minor to obtain substance abuse treatment, any consent for the disclosure of substance abuse records must be given by both the minor and the parent, legal guardian, or custodian.[40]

A court order authorizing the disclosure and use of a person's confidential substance abuse records only authorizes the disclosure or use of identifying information. It does not compel disclosure. A subpoena or a similar legal mandate is required in order to compel disclosure. Both the order and subpoena may be requested and entered by the court at the same time.

Any person having a legally recognized interest in the disclosure of an individual's substance abuse records my seek an order and/or subpoena for disclosure. The application may be filed alone, or as part of a pending civil action, active criminal investigation, or criminal action in which it appears that the individual's records are needed to provide evidence. The application must use a fictitious name, such as John Doe or Jane Doe, to refer to the individual and may not contain any other identifying information unless:

- The individual is the applicant;
- The applicant has been given written consent for disclosure from the person or his or her legal representative; or
- The court has ordered the record of the proceeding sealed from public scrutiny.

In a civil action, the individual seeking confidential substance abuse records, and the person holding the records from whom disclosure is sought, must be given adequate notice of the application in a manner which will not disclose the individual's identity. All parties must be given an opportunity to respond to the application, or to appear in person, for the limited purpose of providing evidence on the legality of the request for the issuance of the court order.

Applications for confidential substance abuse records related to an active criminal investigation may be granted disclosure without notice to anyone upon a finding of probable cause by the judge. But, once an order has been issued for confidential substance abuse records, then the agents, owners, and employees of the treatment provider, or to any individual whose records are to be disclosed, must be afforded an opportunity to seek revocation, or limitation, of the order by presenting evidence for the purpose of challenging the legal basis for the issuance of the order. Any oral argument, review of evidence, or hearing on the application must be held in private so as not to disclose to anyone other than a parties to the proceeding, the individual, or the person holding the record, unless the person requests an open hearing. The proceeding may include an *in camera*[41] examination by the judge of the records referred to in the application.

A court may authorize the disclosure and use of confidential substance abuse records for the purpose of conducting a criminal investigation, or prosecution, of an individual only if the court finds that all of the following criteria have been met:

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[40] Section 497.501(7)(e), F.S.

[41] *In Camera* is Latin for, "in chambers." The Law Dictionary, *In Camera* available at https://thelawdictionary.org/search2/?cx=partner-pub-2225482417208543%3A5634069718&cof=FORID%3A11&ie=UTF-8&q=in+camera&x=3&y=6 (last visited Mar. 11, 2019)

- The crime involved is extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury, including but not limited to homicide, sexual assault, sexual battery, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect;
- There is reasonable likelihood that the records will disclose information of substantial value in the investigation or prosecution;
- Other ways of obtaining the information are not available or would not be effective; and
- The potential injury to the individual, to the physician-individual relationship, and to the ability of the program to provide services to other individuals is outweighed by the public interest and the need for the disclosure.[42]

Nursing Home Records

Nursing home records are governed by s. 400.145, F.S., which requires a nursing home to provide two copies of patient records to a patient, or their authorized representative, within 14 days for a current resident and 30 days for a former resident when it receives a written request that is compliant with the requirements of HIPAA. A nursing home is required to provide medical records and records concerning the care and treatment of a patient, but is not required to provide progress notes and consultation reports of a psychiatric nature.

A nursing home may refuse to furnish the records directly to the resident if the nursing home determines that disclosure of the records would be detrimental to the resident's physical or mental health, however, a nursing home must still disclose the records to any other medical provider designated by the resident.[43] Additionally, a nursing home is not required to provide a resident's records more than once per month except as necessary to allow effective monitoring of the resident's condition.

Section 400.145(2), F.S., specifies that requests for a deceased resident's records may be made by, in descending order of authority:
- A person appointed by a court to act as the personal representative, executor, administrator, curator, or temporary administrator of the deceased resident's estate;
- A person designated by the resident to act on his or her behalf in the resident's self-proved will;
- A surviving spouse;
- A surviving child; or
- A parent of the resident.

Section 400.145(3), F.S, specifies proof that must be submitted with each request to demonstrate that the person making the request is authorized to receive the records. A nursing home is indemnified from criminal and civil liability for releasing records in good faith to the representative of a deceased resident.[44]

[42] Section 497.501(7)(f) through (j), F.S.
[43] Section 400.145(5), F.S.
[44] Section 400.145(6), F.S.

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 also 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.[45]

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 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. The term also includes:

- Any health care practitioner to whom a patient's records are transferred to by a previous records owner; or
- Any health care practitioner's employer.[46]

The following persons and entities are not authorized to own medical records, but they are authorized to maintain documents required by ch. 456, F.S., and their respective practice acts:

- Certified nursing assistants;[47]
- Pharmacists and pharmacies;[48]
- Dental hygienists;[49]
- Nursing home administrators;[50]
- Respiratory therapists;[51]
- Athletic trainers;[52]
- Electrologists;[53]
- Clinical laboratory personnel;[54]
- Medical physicists;[55]
- Opticians and optical establishments;[56] and
- Persons or entities performing personal injury protection (PIP) examinations for insurance carriers.[57]

Any health care practitioner licensed by the Department of Health (DOH), or a board within the DOH ,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

[45] Section 400.145(4), F.S.
[46] Section 456.057(1), F.S.
[47] *See* part II, ch. 464, F.S.
[48] *See* ch. 465, F.S.
[49] *See* s. 466.023, F.S.
[50] *See* part II, ch. 468, F.S.
[51] See part V, ch. 468, F.S.
[52] *See* part XIII, ch. 468, F.S.
[53] *See* ch. 478, F.S.
[54] *See* part II, ch. 483, F.S.
[55] *See* part III, ch. 483. F.S.
[56] *See* part I, ch. 484, F.S.
[57] *See* s. 627.736(7), F.S.

for legal review, copies of all reports and records relating to the examination, treatment, X rays and insurance information.[58]

When a patient's psychiatric, psychological, or psychotherapeutic records are requested by the patient, or the patient's legal representative, the health care practitioner may provide a report of examination and treatment in lieu of copies of records. Upon a patient's written request, complete copies of the patient's psychiatric records must be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies cannot be conditioned upon payment of a fee for services rendered.[59]

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.[60]

Florida Board of Medicine Rule

The Board of Medicine encourages allopathic physicians to provide patients with a copy of their medical records free of charge, especially if the patient is disadvantaged.[61] However, an allopathic physician is authorized to charge a patient or governmental entity a $1 per page for the first 25 pages, and no more than 25 cents for each subsequent page.[62] 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.[63] Actual costs include the materials, supplies, labor, and overhead costs associated with such duplication.[64] No timeline is specified for the provision of these records.

Florida Board of Osteopathic Medicine Rule

An osteopathic physician may charge up to $1.00 per page for the first 25 pages, and no more than 25 cents for each subsequent page, regardless of the requestor.[65] 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.[66] An osteopathic physician may charge the actual cost for reproducing certain documents, such as X-rays and other special kinds of records.[67] Actual costs include the materials, supplies, labor, and overhead costs associated with such duplication.[68]

The provisions of the section do not apply to:

[58] Section 456.057(6), F.S.
[59] *Id*.
[60] Section 456.057(17), F.S.
[61] Fla. Admin Code R. 64B8-10.003 (2019).
[62] *Id*.
[63] *See* note 16.
[64] *Id*.
[65] Fla. Admin. Code R. 64B15-15.003, (2019).
[66] *Id*.
[67] *Supra* note 20.
[68] *Id*.

- Records maintained at any hospital or ambulatory surgical center if the primary function of the facility is to provide psychiatric care;
- Records of treatment for any mental or emotional condition if the release of the records is governed by the Florida Mental Health Act under s. 394.4615, F.S.;
- Records of substance abuse impaired persons governed under s. 397.501, F.S.; or
- Requests for records of a deceased resident of a nursing home facility.

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 the patient presents.[69]

Observation status is commonly ordered for a person who comes to the emergency department and requires treatment or monitoring to determine if he or she should be admitted or discharged.[70] 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.[71]

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.[72] 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 well as 20 percent of the Medicare-approved amount for doctor services.[73] 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.[74]

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[69] Medicare Benefit Policy Manual, ch. 1 sec. 10, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html (last visited Mar. 13, 2019).
[70] *Id* at ch. 6 at 20.6.
[71] 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).
[72] 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).
[73] 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.
[74] *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).

Once a person is discharged, additional rehabilitation in a nursing home is often necessary. Hospital admission can also affect a person's eligibility for other services.[75] When a person is admitted and has a three-night stay in a hospital and needs rehabilitative care, Medicare will pay for up to 60 days in a skilled nursing home. However, if a person is not admitted to the hospital and subsequently goes into a nursing home, Medicare will not pay for the nursing home stay.[76]

Direct Primary Care

Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the provider-patient relationship. Section 624.27, F.S., provides that a direct primary care contractual agreement is not insurance and is not subject to regulation under the Florida Insurance Code (Code). 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. The section also exempts a primary care provider, which includes a primary care group practice, or his or her agent, from any certification or licensure requirements in the Code for marketing, selling, or offering to sell an agreement, and establishes criteria for direct primary care agreements.

A patient generally pays a monthly retainer fee, on average $77 per individual,[77] 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 direct primary care practices exist in 48 states and the District of Columbia, covering over 330,000 patients, including Florida.[78]

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 tests, like 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.

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

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[75] *Id.*

[76] Medicare.gov., *Skilled nursing facility (SNF) care*, available at http://www.medicare.gov/coverage/skilled-nursing-facility-care.html (last visited Mar. 12, 2019).

[77] 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).

[78] Direct Primary Care Coalition, *About the Direct Primary Care Coalition* https://www.dpcare.org/about (last viewed March 12, 2019).

Not all states call such arrangements direct primary 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.[79] 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.*[80]

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 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

The Office of Insurance Regulation (OIR) regulates the activities of insurers, HMOs, and other risk-bearing entities.[81] 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.[82]

The federal Patient Protection and Affordable Care Act (PPACA)[83] 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.[84] 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.[85]

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.[86] The Statewide Medicaid Managed Care (SMMC) program is composed of the Managed Medical Assistance (MMA) program and the

[79] Mo. Rev. Stat. §376.1800 (2015).
[80] 2017 Ala. Laws 460.
[81] Section 20.121(3)(a), F.S.
[82] Section 641.21(1), F.S.
[83] 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.
[84] 42 U.S.C. s.18022.
[85] 45 C.F.R. s. 156.122(d).
[86] Parts II and III of ch. 409, F.S., govern the Medicaid managed care program.

Long-term Care (LTC) managed care program. The AHCA contracts with managed care plans to provide services to eligible enrollees.[87]

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.

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.[88] 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 consent, and policy and procedures manuals.[89] The current licensure application fee for a medical doctor is $350 and is non-refundable.[90] Applications must be completed within one year. If a license is approved, the initial license fee is $355.[91] The entire process may take from 2 to 6 months from the time the application is received.[92]

For osteopathic physicians, the application fee is currently a non-refundable $200 and if approved, the initial licensure fee is $305.[93] The same application validity provision of one year applies and the processing time of 2 to 6 months is the range of time that applicants should anticipate for a decision.[94] 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.[95]

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[87] 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.

[88] Sections 458.331(1)(v) and 459.015(1)(z), F.S.

[89] *Id.*

[90] Florida Board of Medicine, *Medical Doctor - Fees*, https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted /(Last visited Mar. 8, 2019).

[91] 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.

[92] Florida Board of Medicine, *Medical Doctor Unrestricted – Process*, https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Mar. 8, 2019).

[93] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees*, https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited: Mar. 8, 2019).

[94] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process*, https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/ (last visited Mar. 8, 2019).

[95] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure – Requirements*, *https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/* (last visited Mar. 8, 2019).

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 2 years (medical) or three (osteopathic) years 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 licensed 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.
- 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.[96]

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	s. 458.3135, F.S.	No provision

[96] *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**
(Approved Cancer Centers)		
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.
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[97] or licensure by endorsement.[98] 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 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 (NBME, FLEX, or USMLE); 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;

[97] Section 458.311, F.S.
[98] Section 458.313, F.S.

successfully completed a board approved postgraduate training program within 2 years preceding filing of the application.[99]

Financial Responsibility

Section 458.320, F.S., requires Florida-licensed allopathic physicians to also maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions. Under s. 458.320(2), F.S., 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.

Physicians without hospital privileges, under s. 458.320(1), F.S., must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim. Physicians who do not carry professional liability insurance must provide notice to their patients. A physician is said to be "going bare" when that physician has elected not to carry professional liability insurance. Physicians who go bare must either provide notice by posting a sign which is prominently displayed in the reception area and clearly noticeable by all parties or provide a written statement to each patient. Under s. 458.320(5), F.S., such sign or statement must specifically state:

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law.

Florida-licensed osteopathic physicians have similar financial responsibility requirements under s. 459.0085, F.S. 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.[100]

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.[101]

[99] Florida Board of Medicine, *Medical Doctor-Unrestricted; Licensure by Endorsement,* https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited Mar. 8, 2019).
[100] Sections 458.320(8) and 459.0085(9), F.S.
[101] 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).

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.[102] 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 repsonsible for reviewing each report to determine if discipline against the provider is warranted.[103] Authorization for the discipline of allopathic and osteopathic physicians can be found in state law and administrative rule.[104] If held liable for one of the offenses, the fines and sanctions under Rule 648B-8.001, F.A.C., by category, by offense are based on whether it is the physician's first, second or third offense. Fines can vary in some instance from lows of $1,000 per instance in situations such as improper use of a substance to concealment of a material fact. A penalty may also come with a reprimand, a licensure suspension, or revocation followed by some designated period of probation if there is an opportunity for licensure reinstatement. Other sanctions may include supplemental continuing education requirements or require proof of completion before the license can be reinstated.

For minor violations, a written notice of noncompliance may be issued. The administrative rule defines a minor vioaltion as something which does not endanger the public health, safety, and welfare and which does not demonstrate a serious inability to practice. When a physician complaint is received, an investigation is undertaken and the physician is given an opportunity to provide additional information as part of the investigation.

Occupational Licensure Compacts

Interstate compacts are authorized under the U.S. Constitution, art. I, section 10, cl. 3.[105] While the language of the provision says Congressional approval is required, not all compacts require Congressional approval. Only those 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.[106] Today, there are more than 200 compacts between the states, including 50 national compacts of which six are for health professions.[107,108]

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. Today, more than 25 percent of the American workforce are in a profession that

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[102] 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).
[103] *See* ss. 458.351(5) and 459.026(5), F.S.
[104] *See* ss. 458.307 and 459.004, F.S., for the regulatory boards, and 64B8-8, F.A.C. and 64B15-19, F.A.C. for administrative rules relating to disciplinary procedures.
[105] "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.
[106] 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)
[107] 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).
[108] 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.

requires a professional license.[109] 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.[110]

The FTC also suggested that improved licensed portability would enhance competition, choice and access for consumers, especially where services may be in short supply.[111] In remarks about an Alaskan legislative proposal in March 2016, special standards for behavioral health care providers providing services remotely would have been established. Developing additional safeguards and "unnecessary restrictions that only serve to restrict competition" were identified as barriers to the goal of enhancing access to services.[112]

The FTC has also recently commented where professional licensing boards comprised of private professionals recommended restrictions for telehealth and raised concerns over whether the boards had adopted unnecessary restrictions that would serve only to restrict competition.[113]

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 legislative to join the IMLC.[114, 115]

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 and if the state has separate regulatory boards for allopathic and osteopathic, then the representation is split between the two boards.[116]

Approximately 80 percent of physicians meet the eligibility guidelines for licensure through the Compact.[117] 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.

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[109] 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).
[110] 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).
[111] *Id* at 2.
[112] Center for Connected Health Policy, *National Policy: The Federal Trade Commission and Professional Licensure Boards*, https://www.cchpca.org/telehealth-policy/federal-trade-commission-and-professional-licensure-boards (last visited Mar. 8, 2019).
[113] Center for Connected Health Policy, *National Policy: The Federal Trade Commission and Professional Licensure Boards*, https://www.cchpca.org/telehealth-policy/federal-trade-commission-and-professional-licensure-boards (last visited Mar. 8, 2019).
[114] Interstate Medical Licensure Compact, *The IMLC*, *https://imlcc.org/* (last visited Mar. 8, 2019).
[115] 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).
[116] 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).
[117] 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 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 a IMLC Compact license include:

- Have graduated from an accredited medical school, or a school listed in the International Medical Education Directory.
- Successfully completed graduate medical education from a school which has received accreditation from Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA).
- Passed each component of the United States Medical Licensing Exam or the Comprehensive Osteopathic Medical Licensing Exam (USMLE or COMLEX-USA) or equivalent in no more than three attempts.
- Hold 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.
- Must not have any history of disciplinary actions toward medical license.
- Must not have any criminal history.
- Must not have any history of controlled substance actions toward medical license.
- Must not currently be under investigation.[118]

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 in Alabama to a high of $700 in Maine.[119]

III. Effect of Proposed Changes:

Patient Records

Section 1 amends s. 394.4615, F.S., to direct that a service provider required to release mental health clinical records must furnish the clinical records in their possession within 14 working days after receiving a request. This does not apply to records that may be released under renumbered s. 394.4615(5), F.S.

If a service provider maintains a system of electronic health records,[120] the bill requires the service provider to provide the records in the manner chosen by the requester, which may include:

[118] Interstate Medical Licensure Compact, *Do I Qualify*, *https://imlcc.org/do-i-qualify/* (last visited Mar. 7, 2019).
[119] Interstate Medical Licensure Compact, *What Does It Cost?* https://imlcc.org/what-does-it-cost/ (last visited Mar. 8, 2019).
[120] 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.

- 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 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:

- Paper copies of written or typed documents or reports may not exceed $1 per page for the first 25 pages and 25 cents per page for all pages thereafter;
- 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; and
- Electronic records or electronic access to records may not exceed $2. A service provider may charge up to $1 for each year of records requested.

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

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

Section 2 amends s. 395.3025, F.S., is amended to conform the provisions of that section to provisions of s. 408.833, F.S., and to allow the DOH, rather than the AHCA, to access records of a hospital or ambulatory surgical center pursuant to a subpoena issued under s. 456.071, F.S. The DOH is the agency responsible for regulating physicians pursuant to ch. 456, F.S.

Section 3 amends s. 397.501(7), F.S., to require that within 14 working days of a substance abuse service provider receiving a written request for confidential substance abuse records for an individual, or from the individual's legal representative,[121] a service provider must furnish a true and correct copy of all records in its possession. If the service provider maintains a system of electronic health records,[122] the service provider must furnish the requested records in the manner chosen by the requester, which could include:

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

[121] The term "legal representative" has the same meaning as in s. 408.833, F.S., created in section 5 of the bill, at ll. 319 – 330, and is defined in that section as:
• A client's attorney who has been designated by a former or current client to receive copies of the client's medical records;
• A legally recognized guardian of the client;
• A court appointed representative of the client; or
• A person designated by the client or by a court to receive copies of the client's records.
[122] The bill refers to s. 408.051(a), F.S., to define an "electronic health record," which means 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.

A substance abuse service provider may charge the requester no more than the reasonable costs of reproducing the records, including reasonable staff time. The reasonable costs of reproduction for the various mediums is defined as:

- Paper copies of written or typed documents or reports may not exceed $1 per page for the first 25 pages, and 25 cents per page for all pages thereafter;
- X-rays and such other kinds of records shall be the actual costs. Actual costs includes the cost of the material and supplies used to duplicate the records and the labor and overhead costs associated with the duplication; and
- Electronic copies of records or electronic access to records may not exceed $2. A service provider may charge up to $1 for each year of records requested.

The bill further requires that within 10 working days after receiving a request for confidential substance abuse records from an individual, or the individual's legal representative, a service provider must provide access to examine the original records in its possession, or microforms or other suitable reproductions of the records. A service provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

The charges must apply to all records furnished, whether directly from a service provider or from a copy service providing such services on behalf of the service provider. However, an individual whose records are copied or searched for the purpose of continuing to receive care is not required to pay a charge for copying or for the search.

Section 4 amends s. 400.145, F.S., is amended to restrict current-law standards regulating the copies of records of care and treatment in a nursing home facility specifically to records of deceased residents. The bill specifies that such records must be furnished within 30 work days; restricts a facility from charging more than $1 per year and more than $2 in total for electronic records; and makes other conforming changes.

Section 5 creates s. 408.833, F.S., to regulate client access to medical records maintained by specified facilities. The provisions of the section apply to all providers regulated by the AHCA under part II of ch. 408, F.S., including, but not limited to, hospitals, ambulatory surgical centers, hospice facilities, nursing homes, and assisted living facilities.[123] The bill defines the term “legal representative” to mean:

- A client’s attorney who has been designated by a former or current client of the facility to receive copies of the client’s medical records;
- A legally recognized guardian of the client;
- A court appointed representative of the client; or
- A person designated by the client or by a court to receive copies of the client’s records.

The bill requires a provider to furnish a true and correct copy of all records in the provider’s possession of a former or current client to the client or the client’s legal representative within 14 days of receiving a written request. If the provider maintains a system of electronic health records, the provider must furnish the records in a manner chosen by the requester. The requester

[123] See s. 408.802, F.S.

may choose between paper documents, electronic documents, access through a web-based patient portal, or submission through a client's electronic personal health record.

The bill also requires a provider to grant access to a current or former client or his or her legal representative to examine the client's original records in the provider's possession, or microforms or other suitable reproductions of the records. The provider may impose reasonable terms to ensure that the records are not damaged, destroyed, or altered.

The bill specifies that a provider may not charge more than the reasonable costs of reproducing records, including staff time. Reasonable costs cannot exceed $1 per page for pages 1 through 25, and 25 cents per page for all additional pages for paper copies; the actual costs, specified as the cost of the material and overhead costs associated with duplication, of reproducing X-rays and other forms of images; and $1 per year of electronic copies with a maximum charge of $2. The bill also specifies that these charges apply whether the provider furnishes the copies directly or through a copy service, however clients whose records are copied or searched for the purpose of continuing to receive medical care are not required to pay such charges.

The bill allows a provider to refuse to furnish records to a client if the provider determines that disclosure of the records would be detrimental to the physical or mental health of the client, however the provider must furnish the records to any other medical provider designated by the client if the client requests such in writing. Additionally, a provider may refuse any request under the section if the requesting client is a client of a nursing home and is not competent and a provider is not required to provide copies of a nursing home's client's records more than once per month except copies of physician's reports as needed to allow effective monitoring of the client's condition.

The provisions of the section do not apply to:
- Records maintained at any hospital or ambulatory surgical center if the primary function of the facility is to provide psychiatric care;
- Records of treatment for any mental or emotional condition if the release of the records is governed by the Florida Mental Health Act under s. 394.4615, F.S.;
- Records of substance abuse impaired persons governed under s. 397.501, F.S.; or
- Requests for records of a deceased resident of a nursing home facility governed under s. 400.145, F.S.

Section 6 amends s. 456.057, F.S., to require that upon written request of a person, or that person's legal representative, a health care practitioner must furnish within 14 working days after such request copies of all reports and records relating to any examination or treatment, including X-rays and insurance information. If the health care practitioner maintains a system of electronic health records, the provider must furnish the records in a manner chosen by the requester. The requester may choose between paper documents, electronic documents, access through a web-based patient portal, or submission through a client's electronic personal health record.

Within 10 working days after receiving a written request by a patient, or a patient's legal representative, a health care practitioner must provide access to examine the original reports and records, or microforms or other suitable reproductions of the reports and records in the

healthcare practitioner's possession. The healthcare practitioner may impose any reasonable terms necessary to ensure that the reports and records will not be damaged, destroyed, or altered.

The bill amends s. 456.057(17), F.S., to permit a licensed healthcare practitioner to charge the requester no more than the reasonable costs of reproducing the reports and records, including reasonable staff time; and defines reasonable costs as follows:

- For paper copies of written or typed documents or reports, the cost may not exceed $1 per page for the first 25 pages and 25 cents per page for all pages thereafter;
- For X-rays and such other kinds of records, the cost must be the actual costs; and actual costs is defined as the cost of the material and supplies used to duplicate the record and the labor and overhead costs associated with the duplication; and
- For electronic copies of reports and records or electronic access to reports and records, the cost may not exceed $2. A licensed healthcare practitioner may charge up to $1 for each year of records requested.

The charges described above must apply to all reports and records furnished, whether directly from a healthcare practitioner or from a copy service providing such services on behalf of the healthcare practitioner. However, a patient whose reports and records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search.

Hospital Quality Information

Section 11 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 also present the data in a manner that is easily understandable and accessible to the patient and with an explanation of the relationship between the data and patient safety.

Patient Access to Primary Care and Specialty Providers

Section 12 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 should 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 seven days of the patient's discharge.

Notification of Hospital Observation Status

Section 13 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.

Direct Health Care Agreements

Section 14 amends s. 624.27, F.S., to authorize direct care agreements with health care providers licensed under ch. 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 "direct" throughout the section.

Step-Therapy Protocols

Sections 15 -17 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 15 and 16 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 or Medicaid managed care plan, respectively. 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 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.

Price Transparency for Services Covered by Health Insurance

Section 18 creates s. 627.4303, F.S., which prohibits a "health insurer," as defined in the bill, 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 also specifies that a health insurer may not require a covered individual to make payment for a covered services in an amount that exceeds the cash price of that service in the absence of health insurance coverage. The term "health insurer" is defined 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.

Interstate Medical Licensure Compact

Section 19 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

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. CFR section 731.202.[124] - Appeals on eligibility determinations are handled through the member state. - Upon completion of eligibility verification process with member state, applicant's 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.

[124] The assumption is that this citation is 5 CFR 713.202, Criteria for making suitability determinations. Under this standard, the federal Office of Personnel Management or an agency which has delegated authority must base its suitability determination on the presence or absence of one or more of the specific factors for employment which include: misconduct or negligence in employment; criminal or dishonest conduct; material, intentional false statement; deception or fraud in examination or appointment; refusal to furnish testimony; alcohol abuse without evidence of substantial rehabilitation; illegal use of narcotics and drugs, or other controlled substances without evidence of substantial rehabilitation; knowing and willful engagement in acts to overthrow the U.S. Government; and statutory or regulatory bar which prevents the lawful employment of the person.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
7	Renewal and Continued Participation *Renewal license process created* *Continuing education required for renewal with member state* *Fees collected, if any, by member state.* *Rulemaking authority.*	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. - 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*	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

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
	state and the member boards	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.
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.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
11	Interstate Medical Licensure Compact Commission *Recognizes creation of Commission and state's representative with two 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*	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 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;

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		- 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. 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,

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		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 *Provides for annual assessment* *Requires rule for any assessment* *No pledging credit without authorization* *Yearly audits*	The compact authorizes an annual assessment levied on each member state to cover the costs of operations and activities of the 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,*	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.[125] 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.

[125] 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).

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	employees, and agents	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 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 attorneys 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 of Appeal for the 9th District in Washington, D.C. or the federal court where the Commission is located.[126] 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.

[126] 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/*

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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 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.[127]
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

[127] 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).

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		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.
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 20 provides for an effective date of July 1, 2019, except as otherwise provided

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Section 19. 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.[128] A reason for the proposed rule action will also be posted.[129] The public must also be provided a reasonable opportunity to provide public comment, orally or in 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.[130] A transcript of these meetings are not made unless one is specifically requested and then the requestor is responsible for the cost the transcription.[131]

Not later than 30 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.[132]

The compact also permits the commission, with a 2/3 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.[133]

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

[128] 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).
[129] *Supra*, Note 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(b).*
[130] *Supra*, Note, 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(d).*
[131] *Supra* Note 42, Interstate Medical Licensure Commission, *Rule on Rulemaking (Adopted June 24, 2016), Rule 1.4(e).*
[132] Interstate Medical Licensure Compact, FAQs, *https://imlcc.org/faqs/* (last visited Mar. 10, 2019).
[133] 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.)*

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.[134]

According to the Commission's Bylaws, the public notice for a regular meeting of the Commission is at least 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.[135]

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 19 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 $700.00, $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 $100.00. Of this amount, one hundred percent is sent to the ICML General Fund.

[134] *Id.*
[135] *Id.*

For each expedited licensed that is renewed through the compact, a non-refunded 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 unconstitutional delegation of legislative authority to prospectively adopt federal statutes not yet enacted by Congress and rules not yet promulgated by federal administrative bodies.[136,137] Under this holding, the constitutionality of the bill's adoption of prospective rules might be questioned, and there does not appear to be binding Florida case law that squarely 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).[138] 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."[139] 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.[140] However, in a footnote, the court provided:

> Any regulations promulgated before Florida adopted the ICPC did not, of course, reflect the vote of a Florida compact administrator, and no such regulations were ever themselves enacted into law in Florida. When the Legislature did adopt the ICPC, it did not (and could not) enact as the law of Florida or adopt prospectively regulations then yet to be promulgated by an entity not even covered by the Florida Administrative Procedure Act. *See Freimuth v. State,* 272 So.2d 473, 476 (Fla.1972); *Fla. Indus.*

[136] *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).
[137] 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).
[138] 801 So.2d 1047 (Fla. 1st DCA 2001).
[139] Id at 1052.
[140] Id.

> *Comm'n v. State ex rel. Orange State Oil Co.,* 155 Fla. 772, 21 So.2d 599, 603 (1945) ("[I]t is within the province of the legislature to approve and adopt the provisions of federal statutes, and all of the administrative rules made by a federal administrative body, that are in existence and in effect at the time the legislature acts, but it would be an unconstitutional delegation of legislative power for the legislature to adopt in advance any federal act or the ruling of any federal administrative body that Congress or such administrative body might see fit to adopt in the future."); *Brazil v. Div. of Admin.,* 347 So.2d 755, 757–58 (Fla. 1st DCA 1977), *disapproved on other grounds by LaPointe Outdoor Adver. v. Fla. Dep't of Transp.,* 398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.[141]

In accordance with the discussion provided by the court in this above-cited footnote, it may be argued that the bill's delegation of rule-making authority to the commission is similar to the delegation to the ICPC compact administrators, and thus, could constitute an unlawful delegation of legislative authority. This case, however, does not appear to be binding as precedent as the court's footnote discussion is dicta.142

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Section 1 through 5, in specifying 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 3, in **s**pecifying a specific cost for various forms of copies of mental health records, could reduce the costs of a patient obtaining copies of his or her substance abuse treatment clinical records.

Section 14, 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

[141] *Id.*
[142] 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).

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 17. 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.

Section 19. 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 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 is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 14. 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.[143]

Section 19. 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, 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: 316.1932, 316.1933, 394.4615, 395.1012, 395.301, 395.3025, 395.4025, 397.501, 400.145, 409.973, 440.185, 456.057, 624.27, and 641.31.

This bill creates the following sections of the Florida Statutes: 395.1052, 408.833, 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.)

None.

B. Amendments:

None.

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