**2019 Legislative Session Report Week 6**

**Summary**

This week the House passed a number of reforms impacting the health care sector.  These measures range from significant revisions to scope-of-practice to the establishment of a drug importation program.  The legislation is now in the hands of the Senate.  These issues may play a substantial role in the budget negotiation process.

**Insurance and Billing**

The Senate Health Policy Committee amended and passed SB 1180, relating to consumer protection from nonmedical changes to prescription drug formularies - 8 Yeas, 1 Nays.

The bill as amended requires a 60-day notice by the insurer of changes to its prescription drug formulary during a policy year. A general notice of the change must be posted on the insurer’s website in a readily accessible place and all insureds and their treating physicians affected by the change must be notified electronically or by first class mail. If the treating physician submits a request at least 30 days before the effective date of the change certifying the medical necessity of the drug, it will result in the continuation of the drug for the patient. The Financial Services Commission is responsible for the development of a standardized one-page form for use by the treating physicians seeking approval for drug continuation. The insurer must approve coverage for any prescribed drug based on the treating physician certifying that the coverage is medically necessary.

The House Government Operations & Technology Appropriations Subcommittee passed HB 1399, relating to workers compensation - 12 Yeas, 0 Nays.

The Legislature intends the workers’ compensation system to be a self-executing system and for the law to be interpreted to “assure the quick and efficient delivery of disability and medical benefits to an injured worker and to facilitate the worker’s return to gainful reemployment at a reasonable cost to the employer.” Workers’ compensation is the injured employee’s remedy for “compensable” workplace injuries. Employees generally cannot sue a covered employer in circuit court for workplace injuries. Benefit delivery and disputes are handled through an administrative process.

The bill makes changes to the workers’ compensation law to address the delivery of benefits and system cost drivers. The bill:

* Provides for Timely Treatment Authorizations
* Ability for Authorized Treating Physicians to use Ancillary Services (Imaging and DME) under $500 without authorization.

The House passed HB 1113, relating to health insurance savings programs - 114 Yeas, 0 Nays.  The bill now heads to the Senate for its consideration.

HB 1113 creates the Patient Savings Act, which allows health insurers to create a voluntary shared savings incentive program (Program) to encourage insured individuals to shop for high quality, lower cost health care services and share any savings realized as a result of the insured’s choice.

The bill directs health insurers who choose to offer a Program to develop a website outlining the range of shoppable health care services available to insureds. This website must provide insureds with an inventory of participating health care providers and an accounting of the shared savings incentives available for each shoppable service. When an insured obtains a shoppable health care service for less than the average price for the service, the bill requires the savings to be shared by the health insurer and the insured. An insured is entitled to a financial incentive that is no less than 25 percent of the savings that accrue to the insurer as a result of the insured’s participation.

The bill provides a range of methods by which a Program may financially reward insureds who use shoppable health care services. Insureds may receive financial incentives in the form of premium reductions, or deposits into a flexible spending account, health savings account, or health reimbursement account.

A Program must be a component part of the policy, contract, or certificate of insurance provided by each participating health insurer, and the insurer must notify its insureds of the Program annually and at the time of enrollment and renewal.

The House Health & Human Services Committee amended and passed HB 999, relating medical billing - 16 Yeas, 0 Nays.

The bill requires facilities licensed under chapter 395, F.S., to establish an internal grievance process for patients to dispute charges that appear on an itemized statement or bill. Additionally, the bill prohibits licensed facilities from taking extraordinary collection actions to collect medical debt before determining whether a patient is eligible for financial assistance, before providing an itemized bill, during an ongoing grievance process, prior to billing any applicable insurance coverage, and for 30 days after notifying a patient in writing that a collections action will commence.

Current law provides a court process for the collection of lawful debts and makes some limited exemptions for personal property. The bill creates s. 222.26, F.S., to add additional exemptions from attachment, garnishment, or other legal process to include a single motor vehicle and personal property of a debtor of a value up to $10,000 when debt is incurred as a result of medical services provided in a licensed hospital facility, provided that the debtor does not receive a homestead exemption.

The Health and Human Services Committee adopted a strike-all amendment to the bill. The amendment:

* Clarifies that a cost estimate must be provided to a patient either upon scheduling a non- emergency, inpatient service or upon admission. For outpatient services, a cost estimate must be provided before a service is delivered.
* Requires facilities to establish internal grievance processes for responding to patients wishing to dispute facility charges.
* Prevents a facility from initiating a collection action against a patient until all applicable insurance coverage is exhausted.

**Scope of Practice**

The House Health & Human Services Committee passed CS/HB 821, relating to the health care practitioners - 15 Yeas, 3 Nays.

CS/HB 821 authorizes APRNs who meet certain criteria to practice advanced or specialized nursing without physician supervision or a protocol and authorizes PAs to practice primary care without physician supervision.

The bill also authorizes an advisory committee comprised of physicians and APRNs to develop a list of medical acts that an APRN that engaging in autonomous practice may perform.

The bill subjects APRNs engaging in autonomous practice to disciplinary action if they commit specified prohibited acts related to unethical and substandard business practices. Such APRNs must complete 10 hours of continuing education related to pharmacology prior to biennial registration renewal. An APRN or a PA who practices autonomously must report adverse incidents that result in the death of a patient, permanent physical injury to the patient, or a need to transfer a patient to hospital to the Department of Health (DOH). DOH must review each report to determine whether the APRN or PA is subject to disciplinary action.

The bill requires APRNs to apply to the Board for licensure, rather than DOH, to reflect current practice.

The bill also requires the Board of Medicine or the Board of Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council.

The bill expands the scope of practice for PAs to authorize them to certify a person for involuntary examination under the Baker Act and file death certificates and certify a cause of death. The bill removes a requirement that a PA must notify a patient that he or she has the right to see a physician prior to prescribing or dispensing a prescription.

The bill also revises the composition of the Council on Physician Assistants so that it has a PA majority.

The House passed CS/HB 833, relating to pharmacy - 112 Yeas, 4 Nays.  The bill now heads to the Senate for its consideration.

CS/HB 833 authorizes a consultant pharmacist to enter into a collaborative practice agreement with a health care facility33 medical director or a Florida-licensed allopathic physician, osteopathic physician, podiatric physician, or dentist, who is authorized to prescribe medication, to provide medication management services, which may include:

* Ordering and evaluating laboratory and clinical tests34 to monitor medication therapy and treatment outcomes, as well as promote and evaluate patient health and wellness;
* Conducting patient assessments to evaluate and monitor drug therapy;
* Initiating, modifying, or discontinuing medications as outlined in a patient-specific order or pre-approved treatment protocol; and
* Administering medication.

The bill prohibits a consultant pharmacist from modifying or discontinuing a medication if the consultant pharmacist does not have a collaborative practice agreement with the prescribing practitioner. The bill also clarifies that a consultant pharmacist is not authorized to diagnose any disease or condition.

The bill eliminates the restriction on the setting in which a consultant pharmacist’s services may be offered that is in current law, and allows such services to be provided in any setting. The consultant pharmacist and the collaborating health care practitioner must maintain the collaborative practice agreement, which must be available upon request or during an inspection. The consultant pharmacist must maintain all drug, patient care, and quality assurance records as required by law.

The Board previously established, by rule, the additional training required for licensure as a consultant pharmacist under its general rulemaking authority. The bill gives the Board express authority to establish additional education requirements for licensure as a consultant pharmacist.

The bill revises the definition of “practice of pharmacy” to authorize a pharmacist consult with a prescribing health care practitioner or others specifically authorized by the patient on a patient’s health care status; and to authorize consultant pharmacists to:

* Order and evaluate any laboratory or clinical testing;
* Conduct patient assessments; and
* Initiate, modify, discontinue, or administer medication.

The House passed CS/HB 885, relating to health care licensing requirements - 116 Yeas, 0 Nays.  The bill now heads to the Senate for its consideration.

CS/HB 885 requires the Department of Health (DOH) to exempt certain VA physicians from licensure requirements. To qualify for the exemption, a VA physician must submit to DOH:

* Proof that he or she holds an active, unencumbered license to practice medicine from another state or territory of the United States;
* Proof of current employment with the VA; and
* An attestation that he or she will only provide medical services to veterans in Florida-licensed hospitals that are pursuant to his or her employment with the VA.

DOH must notify the physician within 15 business of receipt of the documentation that the physician is exempt from Florida licensure requirements.

The Senate Health Policy Committee passed SB 1620, relating health care licensing requirements - 9 Yeas, 0 Nays.

CS/SB 1620 creates s. 456.0231, F.S., to grant physicians who are employees of the U.S. Department of Veterans Affairs (VA) an exemption from Florida’s physician licensure statutes when providing medical treatment to veterans in a Florida-licensed hospital, if such physicians meet certain criteria and furnish specified documentation to the state Department of Health (DOH).

The House passed HB 111, relating to the practice of pharmacy - 99 Yeas, 16 Nays.  The bill now heads to the Senate for its consideration.

The bill authorizes a pharmacist to enter into a collaborative pharmacy practice agreement (CPPA) with a physician to manage chronic health conditions if the pharmacist meets certain qualifications. A CPPA must meet certain terms and specify the health conditions, treatments, and tests governed by the CPPA.

The bill prohibits a collaborating pharmacist from initiating or prescribing a controlled substance or modifying or discontinuing any medication that is prescribed by a health care practitioner who does not have a CPPA with the pharmacist.

The bill also authorizes a pharmacist to perform testing or screening for and testing of minor, non-chronic health conditions if the pharmacist meets and maintains certain qualifications.

The bill requires the board to adopt, by rule, a formulary of medicinal drugs that an authorized pharmacist may prescribe to treat minor, non-chronic health conditions. A pharmacist may not prescribe any controlled substance; however, the board-developed formulary may include any non-controlled substance, including those that typically need a prescription to dispense, such as antibiotics, and over-the-counter medications. The bill authorizes a pharmacist to use any CLIA-waived test that guides diagnosis or clinical decision-making, as well as any established screening procedures for which no test is available.

Although typically considered non-chronic conditions, the bill explicitly requires pharmacists who test for influenza and streptococcus to do so within the framework of a written protocol with a supervising physician, which must be submitted to the board. The bill establishes minimum criteria for the content of such protocols.

**Telehealth**

The House passed HB 23, relating to Telehealth - 102 Yeas, 14 Nays.  The bill now heads to the Senate for its consideration.

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

The bill also establishes standards of practice for services provided using telehealth, including patient examination, record-keeping, and prohibition on prescribing controlled substances for chronic malignant pain.

**Drug Importation**

The House passed CS/HB 19, relating to Prescription Drug Importation Programs - 93 Yeas, 22 Nays.  The bill now heads to the Senate for its consideration.

HB 19 establishes two programs to safely import FDA-approved prescription drugs into the state: the Canadian Drug Importation Program and the International Drug Importation Program. For both programs, the bill establishes eligibility criteria for the types of prescriptions drugs which may be imported and the entities that may export or import prescription drugs. The bill also outlines the importation process, safety standards, drug distribution requirements, and penalties for violations of program requirements. Both programs require federal approval or cooperation before prescription drug importation under the programs can begin.

**Facility**

The House passed HB 843, relating to patient access to primary care providers - 114 Yeas, 0 Nays.  The bill now heads to the Senate for its consideration.

HB 843 requires hospitals to notify a patient’s primary care or specialist provider, if any, within 24 hours of the patient’s admission to the hospital. Additionally, the bill requires the hospital to inform patients immediately upon admission that they may request to have their primary care or specialist provider consulted during the development of their plan of care. If the patient makes this request, the treating physician at the hospital must make reasonable efforts to consult with the patient’s primary care or specialist provider during the patient’s admission.

Upon discharge, the bill requires the hospital to notify the patient’s primary care or specialist provider, if any, of the discharge within 24 hours and provide the discharge summary and any related information or records to the primary care or specialist provider within 7 days.

**Electronic Prescribing**

The Senate Health Policy Committee amended and passed SB 1192, relating to electronic prescribing - 9 Yeas, 0 Nays.

The bill Requires certain health care practitioners to begin issuing all prescriptions through e-prescribing no later than July 1, 2021, if such prescribers have access to an electronic health records (EHR) system.  It also:

* Provides an exception to mandatory e-prescribing for those prescribers who do not have access to an EHR system;
* Creates seven exceptions to the requirement that prescribers with access to an EHR system must issue all prescriptions through e-prescribing, which are all consistent with federal-law exceptions to the e-prescribing requirement for the Medicare program;
* Authorizes the DOH to adopt rules in consultation with the Board of Medicine and the Board of Osteopathic Medicine; and
* Makes numerous conforming changes throughout other areas of the Florida Statutes.

**Group Practice**

The House passed HB 1243 relating to hospital or group practice mergers, acquisitions and other transactions - 115 Yeas, 0 Nays.  The bill now heads to the Senate for its consideration.

CS/CS/HB 1243 amends the Florida Antitrust Act relating to the acquisition of hospitals or group practices in the health care market. The bill imposes certain reporting requirements when a transaction between two entities in the health care market results in an affiliation or a material change to the health care market which could create a monopoly. An entity that fails to comply with these reporting requirements is subject to a civil penalty up to $500,000.

These new notice requirements will provide a mechanism for the OAG to review transactions before they occur and will allow the OAG time to determine whether a proposed transaction has antitrust implications and if warranted, pursue action to prevent coercive monopolies from forming in the health care market.

The bill also addresses invalid restrictive covenants, or non-compete clauses, as they relate to monopolies on physician specialties in the health care market. Specifically, when one entity has a monopoly on all of the physicians who practice a certain medical specialty in one county, the bill makes non-compete clauses with physicians of that specialty void and unenforceable until 3 years after another entity enters the market and begins offering that medical specialty to the patients of that county.

**In the News:**

**Telehealth Tax Credits Draw Criticism**

**By CHRISTINE SEXTON – NEWS SERVICE OF FLORIDA**

Some Democratic lawmakers Wednesday assailed a proposal to boost the use of telehealth as a giveaway to insurance companies, suggesting that the legislation violates oft-repeated pledges of House Republicans that they don’t want to pick “winners and losers” in the economy.

The GOP-controlled House is primed Thursday to pass the bill (HB 23), which is part of House Speaker Jose Oliva’s ambitious plans to overhaul the health-care system.

During a floor discussion Wednesday, Democrats were skeptical of the measure because it includes tax credits for the insurance industry. House Democrats twice tried to alter the $30 million in tax breaks, which they unsuccessfully argued would interfere with the free market.

Rep. Anna Eskamani, an Orlando Democrat who sponsored amendments that sought to alter the tax breaks, said she wanted to improve the bill by removing what she described as “corporate welfare.”

One amendment would have required the Legislature to revisit the tax breaks after five years.

“We can have some fiscal responsibility here. The corporate welfare component will still exist, but at the very least there is a timeline to it being eliminated and perhaps an evaluation to reassess,” she said.

But bill sponsor Clay Yarborough, R-Jacksonville called the tax breaks an “investment” that the state should make in telehealth services.

That amendment failed on a 70-41 vote.

Eskamani’s second amendment would have deleted the tax breaks from the bill altogether. It also was shot down after Yarborough described it as unfriendly.

Telehealth, a term insurance companies have coined, involves using the internet and other technology to provide services to patients remotely. Telehealth is not a type of health-care service but rather is a mode to deliver services.

In December 2016, the Agency for Health Care Administration issued the findings of a survey it helped conduct. The results showed that 45 percent of hospitals said they provided telehealth, while only 6 percent of practitioners, such as physicians, did.

A state-created task force submitted a report in October 2017 recommending ways to jump-start telehealth. Chief among those recommendations was a requirement that insurance companies reimburse physicians for telehealth services.

A key issue is whether physicians will get reimbursed the same amounts for telehealth services as they get for providing in-person services --- a concept known as “parity.”

The House doesn’t contain a parity requirement. But physician groups argue such a requirement is needed.

“We absolutely need to make sure that the providers of the service get paid for it so we can continue to expand it,” Florida Medical Association President Corey Howard, a Naples physician, said earlier in the legislative session.

A Senate version of the telehealth bill includes a parity requirement but doesn’t contain the tax breaks.

**Canadian Drug Importation Continues Advancing**

By CHRISTINE SEXTON – NEWS SERVICE OF FLORIDA *•* APR 10, 2019

Gov. Ron DeSantis’ push to allow the state to import drugs from Canada is moving ahead in the Legislature, though some lawmakers say there has been a sustained effort to try to stop the plan.

The Senate Health and Human Services Appropriations Subcommittee on Tuesday became the latest panel to approve a proposal (SB 1528) that would authorize the state to ask the federal government to approve the importation program.

DeSantis has championed the legislation as a way to curb prescription drug costs. But his effort continues to draw opposition from representatives of the pharmaceutical industry who say importing drugs could increase the amount of unsafe and counterfeit drugs.

Mark Delegal, a lobbyist for the Pharmaceutical Research and Manufacturers of America, told senators Tuesday that they can lower prescription drug costs in other ways, including cracking down on pharmacy benefit managers that, he said, don’t pass along savings and rebates to consumers.

“People are watching you,” he said. “Counterfeiters are watching you. The public is watching you. And when you give a green light to this Canadian system, it’s going to change public conduct. They are going to go out and start saying, “Hey, this has been green-lighted.’ And all the counterfeiters will pop up and begin to make their products available.”

The Senate Health and Human Services Appropriations Subcommittee added two amendments to the bill, one of which deleted a proposed requirement that Canadian suppliers export drugs “at prices that will provide cost savings to the state.”

Chairman Aaron Bean, a Fernandina Beach Republican and sponsor of the bill, said the federal government wouldn’t approve the program if there weren’t cost savings and that the language was redundant and unnecessary.

But Sen. Kathleen Passidomo, R-Naples, pressed Bean about eliminating the requirement, noting that savings are her top priority. Passidomo said she wants to make sure that the program ‘bears fruit” and that it doesn’t just create an opportunity for the “middleman.”

DeSantis has made the creation of a drug-importation program a top health care priority since taking office in January. DeSantis on Monday made a trip to Sun City Center, a well- known retirement community outside Tampa to rally support for the proposal.

DeSantis was joined by Bean, House sponsor Tom Leek, R-Ormond Beach, and Agency for Health Care Administration Secretary Mary Mayhew, who would be charged with carrying out the program.

The House is poised Wednesday to debate its version of the bill (HB 19) on the House floor. The House version would establish two drug-importation programs. One would apply to state government programs and would be run by the Agency for Health Care Administration. The other program would be known as the International Drug Importation Program and would be run by the Department of Business and Professional Regulation and more geared to consumers.

The Senate version of the bill differs in that it would establish one program to allow drug importation from Canada. If the federal government signed off, the Senate bill also would require the program to come back to the Legislature for final approval before it could be implemented. The House bill would not require final legislative approval before implementation.

Sen. Ed Hooper, R-Clearwater, noted that he had been heavily lobbied on the bill and called it controversial. But at the end of the day, Hooper said the costs of “prescription drugs are way too high in this country,” and not enough is being done to bring down the costs.

**AHCA Secretary Mary Mayhew Comes Another Step Closer To Senate Confirmation**

By [RYAN DAILEY](https://health.wusf.usf.edu/people/ryan-dailey) *•* APR 9, 2019

New Agency for Health Care Administration secretary Mary Mayhew got her second positive vote of confirmation from a Senate committee Monday. Mayhew faced more tough lines of questioning from Health Policy committee members, but won over one key Democratic vote.

At Mayhew’s first confirmation hearing last week, Democratic Senator Darryl Rouson inquired about reports that AHCA was pushing cuts to reimbursement rates for providers who treat children with autism. The former top Medicaid official for the Trump administration surprised the committee by announcing the agency was no longer going forward with the proposed cuts.

Rouson says he’s concerned that funding for the program is only protected “at this time”

“How do we know that you’re not going to turn around after this confirmation and do the rate cuts to those providing services to autistic children,” Rouson asked.

Mayhew acknowledged to the Senate Health Policy committee the timing may have seemed suspect to some.

“I realize the timing seemed remarkably close to my confirmation hearing, where I obviously came out with it during my confirmation hearing,” Mayhew said. “We had just had the first public information meeting about the rates, about other changes that we were proposing.”

Mayhew didn’t guarantee that cuts are completely off the table, saying meetings will be held through the rest of the year on the issue.

“We are not moving forward (with rate changes), and we are going to use the summer, the fall, to get comprehensive information from providers, to have meetings,” Mayhew said. “We’re going to continue with meetings around the state so we can hear from individuals to get good information about the costs.”

Rouson’s fellow Democratic senator Janet Cruz had questions about the former Maine head of healthcare’s record.

“According to the reports, you proposed to cut your department’s budget in Maine, which were freed up to pay for income tax cuts for the wealthiest two percent in your state,” Cruz said. “How does this maintain your claim that you protect Maine’s truly needy?”

Mayhew defended what she characterized as a necessary financial move that she insists ultimately benefitted programs.

“Our focus was to get the financial house in order,” Mayhew said. “And when we did that, we dramatically increased our funding for individuals with intellectual and developmental disabilities to reduce our waitlists. We eliminated the waitlist for homemaker services, which is the meal preparation support with housecleaning.”

Karen Woodall from the Florida Center for Fiscal and Economic Policy was one of those who urged Senators not to confirm Mayhew.

“Senators, I just want to remind you: Florida’s Medicaid population is three times larger than the entire population of Maine. (More) than the entire population – not Medicaid – the population,” Woodall said.

Ultimately, Senator Darryl Rouson, who was a ‘no’ vote at Mayhew’s first confirmation hearing last week, said he’s willing to take a chance on the new secretary. Rouson adds he met with Mayhew for an hour and a half after last week’s meeting.

“And in this instance I looked her in the eye and I said ‘The cost is human capital if you do not do right by the vulnerable,” Rouson said. “The cost is loss of life, loss of access to beneficial services, needy services by the neediest of our population. So, I’m willing to give a chance, based on sworn testimony by her – not a newspaper article, not a speech on Youtube – but twice now, sworn testimony.”

Cruz, meanwhile, says the AHCA secretary post isn’t something on which she’s willing to gamble.

“Many have said – I think I just heard it – they want to give you a chance and see how you handle this new role,” Cruz said, eluding to Rouson’s remarks. “Well AHCA’s budget is almost $29 billion dollars – Florida’s Medicaid program has four million enrollees, and this is not something that you take a chance on.”

Mayhew ultimately passed her second of three confirmation hearings with a 7-2 vote. The only two ‘no’ votes came from Democratic Senators, with Lauren Book and Darryl Rouson voting for Mayhew’s confirmation.