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 Appropriations Subcommittee on Health and Human Services

BILL:	SB 1526
INTRODUCER:	Senator Harrell
SUBJECT:	Telehealth
DATE:	April 15, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Brown	HP	**Favorable**
2.	McKnight	Kidd	AHS	**Pre-meeting**
3.			AP	

I. Summary:

SB 1526 establishes a statutory basis and definition for telehealth. Specifically, the bill:

- Creates s. 456.4501, F.S., as Florida's telehealth statute.
- Provides definitions for telehealth and telehealth provider.
- Establishes the standard of practice for telehealth providers as the same standard applied to in-person care under current law.
- Prohibits a telehealth provider, with limited exceptions, from using telehealth to prescribe a controlled substance.
- Requires a telehealth provider to document a telehealth encounter in the patient's medical records according to the same standards used for in-person services, and such information must be kept confidential.
- Provides an exemption for emergency medical services provided by emergency physicians, emergency medical technicians, paramedics, or emergency dispatchers. The exemption also applies to a health care provider caring for a patient in consultation with another provider or in an on-call or cross coverage situation where the provider has access to the patient's medical records.
- Authorizes the applicable board, or the Department of Health if there is no board, to adopt rules.
- Creates ss. 627.42393 and 641.31093, F.S., prohibiting individual, group, blanket, franchise health insurance and health maintenance organization (HMO) policies from denying coverage for telehealth services on any insurance policy delivered, renewed, or issued, to any insured person in this state on or after January 1, 2020, on the basis of the service being provided through telehealth if the same service would be covered if provided through an in-person encounter.
- Adds a provision prohibiting the HMO from requiring the subscriber to seek any type of referral or prior approval from a telehealth provider for HMO contracts under s. 641.31, F.S.

- Prohibits Medicaid Managed Medical Assistance (MMA) health plans from using providers who exclusively provide services through telehealth to meet Medicaid provider network adequacy requirements under the Medicaid managed care plan accountability standards.

The fiscal impact of the bill is indeterminate. See Section V.

The bill has an effective date of July 1, 2019.

II. Present Situation:

Telehealth and Telemedicine

The term, "telehealth," is sometimes used interchangeably with "telemedicine." Telehealth, however, generally refers to a wider range of health care services that may or may not include clinical services. The American Telemedicine Association refers to telemedicine as the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.[1]

Telehealth often collectively defines the telecommunications equipment and technology that are used to collect and transmit the data for a telemedicine consultation or evaluation. Telemedicine is not a separate medical specialty and does not change what constitutes proper medical treatment and services.

The federal Health Resource Services Administration (HRSA) defines telehealth as the use of electronic information and telecommunications technologies to support and promote long-distance clinical-health care, patient, and professional health-related education, public health and health administration. Technologies include videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.[2]

For another definition, the federal Centers for Medicare and Medicaid Services (CMS) defines telehealth as:

> The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes technologies such as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devises, which are used to collect and transmit data for monitoring and interpretation.[3]

Federal Medicaid law does not recognize telemedicine as a distinct service but as an alternative method for the delivery of services. Medicaid defines telemedicine and telehealth separately,

[1] Ron Hedges, *Telemedicine, Information Governance and Litigation: The Chicken and the Egg, IGIQ: A Journal of AHMIA Blog,* (Feb. 15, 2018) https://journal.ahima.org/2018/02/15/telemedicine-information-governance-and-litigation-the-chicken-and-the-egg/ (last visited Mar. 11, 2019).
[2] *Id.*
[3] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services *Telemedicine*, available at https://www.medicaid.gov/medicaid/benefits/telemed/index.html (last viewed March 14, 2019).

using telemedicine to define the interactive communication between the provider and patient and telehealth to describe the technologies, such as telephones and information systems.[4]

The Florida Medicaid Managed Medical Assistance (MMA) contract defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, or recommendation of treatment.[5]

Payment Parity Laws

Parity in telehealth can mean two things: service levels or payment amount. At the service level, if a service is available in-person, then an attempt is made to match that same service or benefit coverage through telehealth. In this way, for individuals who are unable to travel or leave their homes, or live in areas where there may be a lack of providers or lack of a certain type of providers, telehealth becomes a viable option for those patients.

Under payment parity, if a provider is paid for a service that is provided in-person and that service is also available via telehealth, then the payment level for the actual services should not be impacted by the mode of the delivery of the actual service if it is the exact same service as an in-person encounter.

Telehealth coverage laws also often include language to prohibit different co-payments, deductibles, or benefit caps for services that are provided via telehealth to avoid cost shifting by insurers.[6]

However, a study by the Millbank Memorial Fund in 2016, found that while at least 31 states passed laws that broadly require coverage or payment for telehealth services, most of these laws had additional provisions limiting the application of that mandate to different terms and conditions of a policyholder's or payer's policy or contract, the modality of the delivery of the service, the types of providers that may deliver the services, or the location the service can be delivered.[7] The study identifies only three states with an explicit mandate for unconditional payment parity: Delaware, Hawaii, and Michigan.[8,9]

Electronic Consultations

Most states with statutes or regulations dealing with telehealth or telemedicine specifically exclude consultations or communications via email or similar communication from the definitions of telehealth and telemedicine.

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[4] *Id.*
[5] Agency for Health Care Administration, Core Contract Provisions (Effective 02/01/2018), Attachment II, p. 30, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2018-02-01/Attachment_II_Core_Contract_Provisions_Feb_1_2018.pdf (last visited March 18, 2019).
[6] Northeast Telehealth Resource Center, *Examining parity in telehealth laws, mHealth News* (August 10, 2015), http://netrc.org/news/examining-payment-parity-in-telehealth-laws/ (last viewed March 14, 2019).
[7] The Center for Connected Health Policy, *Telehealth Private Payer Laws: Impact and Issues* (August 2017), p. 6, The Millbank Memorial Fund, https://www.milbank.org/wp-content/uploads/2017/08/MMF-Telehealth-Report-FINAL.pdf (last viewed March 14, 2019).
[8] *Supra* note *6.*
[9] *Id* at *28; Appendix B, Table 1.*

In the United States, more than one-third of patients are referred to a specialist each year, and specialist visits account for more than half of outpatient visits.[10] For a referral to be successful, however, there must be a provider available for the patient. Access to specialists may be inadequate due to lack of specialists in the community or lack of specialists who take a particular patient's insurance, which can also be true for primary care services.[11]

A suggested strategy to improve the integration of primary care referrals to specialists is the utilization of virtual consultations through video conferencing.[12] Primary care physician (PCP) satisfaction with electronic consults (e-consults)[13] is generally good across systems with 70-95 percent of providers reporting high satisfaction.[14] However, in a U.S. Department of Veterans Affairs (VA) study in which 93 percent of PCPs were satisfied, only 53 percent of specialists were satisfied, while 26 percent remained dissatisfied.[15] Overall, patients reported very high levels of satisfaction.[16]

Other positive impacts felt by systems that have implemented e-consults have been decreases in wait times for specialty appointments.[17] At one large facility, a clinician reviewer screened each specialty referral request. If the request was unclear, the request was redirected. All other requests were sorted into four categories: those that could be managed by the referring clinical with specialist guidance without being seen; those needing additional diagnostic work before an appointment could be made; routine appointments that could wait for the next available appointment; and urgent cases that required an expedited appointment.[18] For some specialties, like rheumatology, the wait times decreased from 126 days to 29 days.[19] Among participating providers, 72 percent said e-Referrals improved care and 89 percent said it made tracking referrals easier; however, 42 percent said it was a more burdensome system administratively.[20]

Florida Physician Shortages

Health Professional Shortage Areas (HPSAs) are designated by the HRSA according to criteria developed in accordance with Section 332 of the Public Health Services Act (PHSA). HPSA designations are used to identify areas and groups within the United States that are experiencing a shortage of health professionals. A HPSA can be a geographic area, a population group, or a health care facility. These areas have a shortage of health care professionals or have population groups who face specific barriers to health care. There are three categories for a HPSA designation: primary medical care; dental care; and mental health.

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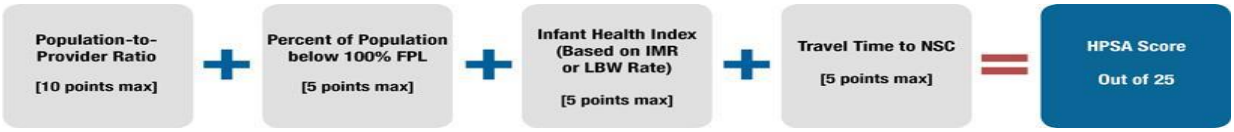
[10] Ateev Mehrotra, Christopher B. Forest, et al, *Dropping the Baton: Specialty Referrals in the United States,* MILBANK QUARTERLY, 2011 March, v. 89(1), p. 39, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160594/pdf/milq0089-0039.pdf (last visited March 18, 2019).
[11] *Id* at *52.*
[12] *Id* at *56.*
[13] An asynchronous consultative communication between providers occurring within a shared electronic health record or secure web-based platform. E-consults are interactions that occur between providers and is most frequently used between primary care providers and specialty care providers to receive feedback that can be achieved through chart reviews and diagnostic tests. *See:* Varsha G. Vimalananda, Gouri Gupte, *Electronic consultations (e-consults) to improve access to specialty care: A systematic review and narrative synthesis, J Telemed Telecare,* 2015 Sept 21(6) 323-33, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4561452/ (last visited March 18, 2019).
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] Alice Hm Chen, et al, *A Safety-Net System Gains Efficiencies Through 'e-Referrals to Specialists,* HEALTH AFFAIRS, (May 2010) https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0027 (last visited March 18, 2019).
[18] *Id.*
[19] *Id.*
[20] *Id.*

The primary factor used to determine a HPSA designation is the number of health care professionals relative to the population with consideration of areas with high need. State Primary Care Offices, usually located within a state's main health agency, apply to HRSA for most designation of HPSAs. HRSA will review provider level data, whether providers are actively engaged in clinical practice, if a provider has any additional practice locations, the number of hours served at each location, the populations served, and the amount of time that a provider spends with specific populations.[21] Primary care and mental health HPSAs can receive a score between 0-25. The figure below provides a broad overview of the four components used in Primary Care HPSA scoring:[22]



As of December 31, 2018, Florida had 275 primary care HPSA designations which met 22.09 percent of the need. It was estimated that 1,658 practitioners were needed to remove the HPSA designation for primary care.[23] For mental health, Florida had 183 HPSA designations which met 16.13 percent of the need. To remove the HPSA designation for mental health, Florida would need 409 additional mental health practitioners.[24]

Florida Telehealth and Telemedicine Issues

Florida Board of Medicine

The Florida Board of Medicine (board) regulates the practice of physicians licensed under ch. 458, F.S. In 2013, the board convened a Telemedicine Workgroup to review its rules on telemedicine, which had not been amended since 2003. The 2003 rules focused on standards for the prescribing of medicine via the Internet.

On March 12, 2014, the board's new Telemedicine Rule, 64B8-9.0141 of the Florida Administrative Code (F.A.C.), became effective. The rule defined telemedicine,[25] established standards of care, prohibited the prescription of controlled substances, permitted the establishment of a doctor-patient relationship via telemedicine, and exempted emergency medical services.[26]

Two months after the initial rule's implementation, the board proposed an amendment to address concerns that the rule prohibited a physician from ordering controlled substances via

[21] U.S. Department of Health and Human Services, HRSA Health Workforce, *Health Professional Shortage Area (HPSA), Shortage Application and Scoring Process*, Shortage Designation Management System, https://bhw.hrsa.gov/shortage-designation/application-scoring-process (last visited March 18, 2019).
[22] U.S. Department of Health and Human Services, HRSA Health Workforce, *HPSA Application and Scoring Process*, https://bhw.hrsa.gov/shortage-designation/hpsa-process (last visited March 18, 2019).
[23] HRSA Data Warehouse, *Designated Health Professional Shortage Area Statistics – Tab 3: Primary Care* (as of December 31, 2018), https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false (last visited March 18, 2019).
[24] HRSA Data Warehouse, *Designated Health Professional Shortage Area Statistics – Tab 5: Mental Health Care Health Professional Shortage Areas, by States*, (as of December 31, 2018) https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false (last visited March 18, 2019).
[25] The term, "telemedicine," is defined to mean the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.
[26] Telemedicine, Rule 64B15-14.0081, F.A.C., also went into effect March 12, 2014, for osteopathic physicians.

telemedicine for hospitalized patients. The board indicated such a prohibition was not intended.[27] Additional changes followed to clarify medical record requirements and the relationship between consulting or cross-coverage physicians.

On December 18, 2015, the board published another proposed rule to allow controlled substances to be prescribed through telemedicine for the limited treatment of psychiatric disorders.[28] The change relating to psychiatric disorders under Rule 64B8-9.0141-Standards for Telemedicine Practice, F.A.C., became effective March 7, 2016.[29]

On February 3, 2017, the board held a public hearing on a proposed amendment to Rule 64B8-9.0141, F.A.C., to prohibit the ordering of low-THC (Tetrahydrocannabinol) cannabis or medical cannabis through telemedicine. Additional public hearings were noticed for April and August of that year on the amended rule; however, the rule was eventually withdrawn in August 2017 without being amended.

On March 7, 2019, a variance request was filed with the board seeking a waiver to the provision which prohibits a physician or physician assistant from providing treatment or treatment recommendations and issuing a prescription based solely on responses to an electronic medical questionnaire. The petitioners argue that the medical questionnaire is used only for certain low acuity medical conditions and a physician reviews the patient's responses which includes the patient's demographics, current medication list and allergies, and when necessary the patient's medical record where the provider has access to it, and the patient is provided a response to his or her request within an hour if the request is made within the hours of 8 a.m. to 7 p.m. Central Time, seven days a week, 365 days a year.[30] The petition lists 14 medical conditions that would be included in the service for patients 18 months of age through 75 years of age.[31] The clinics are currently offered by the Mayo Clinic in Minnesota, Iowa, and Wisconsin. The conditions currently covered are:

- Allergies
- Cold (upper respiratory illness)
- Cold sores
- Conjunctivitis (pink eye)
- Influenza
- Lice
- Oral contraceptives (females ages 18-34)
- Sinusitis (sinus symptoms)
- Smoking cessation (age 18 plus)
- Sore throat
- Sunburn
- Tick exposure

[27] Florida Board of Medicine, *Latest News - Emergency Rule Related to Telemedicine,* http://flboardofmedicine.gov/latest-news/emergency-rule-related-to-telemedicine/ (last visited March 15, 2019).
[28] Vol. 41/244, Fla. Admin. Weekly, Dec. 18, 2015, available at https://www.flrules.org/BigDoc/View_Section.asp?Issue=2011&Section=1 (last visited March 15, 2019).
[29] Florida Board of Medicine, Latest News, Feb. 23, 2016, available at http://flboardofmedicine.gov/latest-news/board-revises-floridas-telemedicine-practice-rule/ (last visited March 15, 2019).
[30] State of Florida, Department of Health, Board of Medicine, Petition for Waiver or Variance, Floyd B. Willis, M.D., et al, Mayo Clinic; Rule No. 64B8-9.0141, F.A.C. (March 8, 2019, Florida Admin. Register, Vol. 45, No. 47 p. 954) (on file with the Senate Committee on Health Policy).
[31] State of Florida, Department of Health, Board of Medicine, Petition for Waiver or Variance, *Id* at 10.

- Urinary tract infections (females ages 12-75)
- Vaginal yeast infections (females ages 18-65).[32]

In June 2019, the program, will add six new conditions:

- Acne
- Athlete's foot
- Impetigo
- Poison ivy
- Shingles
- Pertussis exposure without cough.

After a health care professional, a physician assistant, or nurse practitioner has reviewed the responses, the patient may be contacted if there are discrepancies between the form and an existing medical record with Mayo Health, discrepancies between the responses, or to clarify any information that was submitted electronically. Some patients may be prescribed a legend drug, other patients whose responses suggest a more serious illness or the provider would like to see the patient in person in order to meet the standard of care, may be advised that an in-person visit is necessary.[33] The patient receives an email message letting them know that a clinical note is in his or her patient portal, and if a drug has been prescribed, prescriptions are transmitted electronically to the patient's designated pharmacy via SureScripts service. No controlled substances are prescribed.[34]

Florida Medicaid Program's Use of Telehealth[35]

Medicaid managed care plans may elect to use telemedicine for any service as long as the managed care plan includes a fraud and abuse procedure to detect potential or suspected fraud or abuse in the use of telemedicine services.[36] The Agency for Health Care Administration's (AHCA) Medicaid managed care contracts for the MMA component of Statewide Medicaid Managed Care include specific contractual provisions for managed care plans that elect to use telehealth to deliver services, including, but not limited to:

- Must be licensed practitioners acting within the scope of their licensure.
- Telephone conversations, chart review, electronic mail message, or facsimile transmission are not considered telemedicine.
- Equipment and operations must meet technical safeguards required by 45 CFR 164.312.
- Providers must meet federal and state laws pertaining to patient privacy.
- Patient's record must be documented when telemedicine services are used.
- No reimbursement for equipment costs to provide telemedicine services.
- Must ensure the patient has a choice whether to access services through telemedicine or a face to face encounter.[37]

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[32] *Id.*
[33] *Id* at *12.*
[34] *Id.*
[35] *See* Agency for Health Care Administration, *Analysis of SB 280* (Oct. 9, 2017) (on file with the Senate Banking and Insurance Committee).
[36] *Id.*
[37] Agency for Health Care Administration, MMA Contract, Attachment II, Exhibit II-A (Effective 02/01/2018), p. 37, *available at* http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2018-02-01/EXHIBIT_II-A_MMA_Managed_Medical_Assistance_(MMA)_Program_Feb_1_2018.pdf (last visited March 18, 2019).

The MMA contracts also allow an MMA plan to assure access to specialists by providing telemedicine consultations with specialists not listed in the MMA plan's network at a location or via the patient's PCP office within 60 minutes travel time or 45 miles from the patient's zip code.[38] MMA plans must also have policies and procedures specific to telemedicine, if they elect to provide services through this delivery system, relating to fraud and abuse, record-keeping, consent for services, and privacy.

Florida Medicaid statutes and the federal Medicaid laws and regulations consider telemedicine to be a delivery system rather than a distinct service; as such, Florida Medicaid does not have reimbursement rates specific to the telemedicine mode of service. In the fee-for-service system, Florida Medicaid reimburses services delivered via telemedicine at the same rate and in the same manner as if the service were delivered face-to-face.

Medicaid health plans can negotiate rates with providers, so they have the flexibility to pay different rates for services delivered via telemedicine. The managed care plans are required to submit their telemedicine policies and procedures to the AHCA for approval, but are not required to do so prior to use.[39]

Other Statutory References to Telehealth or Telemedicine

Sprinkled throughout the Florida Statutes are numerous other references to the use of telehealth, telemedicine, or teleconference services to deliver health care services, including the following references:

- The Department of Management Services, to facilitate the development of applications, programs, and services, including, but not limited to telework and telemedicine.[40]
- Legislative intent for the Department of Children and Families (DCF) to use telemedicine for the delivery of health care services to children and adults with mental health and substance abuse disorders diagnoses for patient evaluation, case management, and ongoing patient care.[41]
- Recommendations by the DCF for voluntary and involuntary outpatient and inpatient services under ch. 394, F.S., with authorizations or second opinions provided by a physician assistant, a psychiatrist, a clinical social worker, or a psychiatric nurse.[42]
- Opinions provided under s. 394.467, F.S., relating to admission to a treatment facility to be provided through face-to-face examination, in person, or by electronic means.[43]

[38] *Id* at *57*.
[39] Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) Policy Transmittal* (March 11, 2016), http://ahca.myflorida.com/medicaid/statewide_mc/pdf/plan_comm/PT_16-06_Telemedicine_03-11-2016.pdf (last visited March 18, 2019).
[40] Section 365.0135(2)(d)4, F.S.
[41] Section 394.453(3), F.S. The provision states, in part: The Legislature further finds the need for additional psychiatrists to be of critical state concern and recommends the establishment of an additional psychiatry program to be offered by one of Florida's schools of medicine currently not offering psychiatry. The program shall seek to integrate primary care and psychiatry and other evolving models of care for persons with mental health and substance use disorders. Additionally, the Legislature finds that the use of telemedicine for patient evaluation, case management, and ongoing care will improve management of patient care and reduce costs of transportation.
[42] Sections 394.4655(3)(a)1, and 349.4655(3)(b), F.S.
[43] Section 394.467(2), F.S. The examination under this section may be performed by a psychiatrist, a clinical psychologist, or if neither one of those is available, the second opinion may be provided by a physician who has the postgraduate training and experience in diagnosis and treatment of mental illness or by a psychiatric nurse.

Florida Telehealth Advisory Council

In 2016, legislation[44] was enacted that required the AHCA, with assistance from the DOH and the Office of Insurance Regulation (OIR), to survey health care practitioners, facilities, and insurers on telehealth utilization and coverage, and submit a report on the survey findings to the Governor, President of the Senate, and Speaker of the House of Representatives by December 31, 2016. The law also created a 15-member Telehealth Advisory Council and tasked the Council with developing recommendations and submitting a report on the survey findings to the Governor, President of the Senate, and Speaker of the House of Representatives by October 31, 2017.

Federal Telemedicine Provisions

Federal laws and regulations address telemedicine from several perspectives, including prescriptions for controlled substances, Medicare reimbursement requirements and privacy and security standards.

Special Registration Process – Drug Enforcement Agency

In Section 3232 of the federal Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act signed by President Trump on October 24, 2018,[45] Section 311(h)(2) requires the U.S. Attorney General (Attorney General), no later than one year after enactment, in consultation with the U.S. Department of Health and Human Services (HHS) Secretary, to promulgate regulations specifying the limited circumstances under which a special registration for telemedicine may be issued and the procedure for obtaining the registration. Previously, the federal Controlled Substances Act (CSA) contained language directing the Attorney General to promulgate rules for a special registration process for telemedicine; however, to date, no rule has been issued from the U.S. Department of Justice (DOJ) or the Drug Enforcement Agency (DEA). The Fall 2018 Unified Agenda of Office of Management and Budget had indicated that the DEA planned to publish a proposed rule in the *Federal Register*.[46] A registration process would allow a practitioner[47] to deliver, distribute, dispense, or prescribe via telemedicine a controlled substance to a patient that has not been medically examined in-person by a prescribing practitioner.[48]

Federal law further requires that practitioners meet three general requirements for the special registration:

- Must demonstrate a legitimate need for the special registration.
- Must be registered to deliver, distribute, dispense, or prescribe controlled substances in the state where the patient is located.

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[44] Chapter 2016-240, Laws of Fla. The law designated the Secretary of the Agency for Health Care Administration (AHCA) as the council Chair, and designated the State Surgeon General and Secretary of the Department of Health as a member. The AHCA's Secretary and the State Surgeon General appointed 13 council members representing specific stakeholder groups.

[45] Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, Pub. Law 115-271, 56-57 (2019).

[46] Victoria Elliot, Congressional Research Service, *The Special Registration for Telemedicine: In Brief* (December 7, 2018), p. 1, *available at* https://fas.org/sgp/crs/misc/R45240.pdf (last visited March 18, 2019).

[47] A practitioner is defined under Section 802(21) of Title 21, U.S.C., as a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

[48] *Supra* note 46 at 2.

- Must maintain compliance with federal and state laws when delivering, distributing, dispensing, and prescribing a controlled substance, unless the prescriber is:
  - Exempt from such registration in all states,[49] or
  - Is an employee or a contractor of the VA who is acting within the scope of his or her contract or is utilizing the registration of a hospital or clinic operated by the VA as permitted under these regulations.[50]

Protection of Personal Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information (PHI). Initial privacy rules were issued in 2000 by the HHS and later modified in 2002. These rules address the use and disclosure of an individual's health information and create standards for privacy rights. Additional privacy and security measures were adopted in 2009, with the Health Information Technology for Economic Clinical Health (HITECH) Act as part of the American Recovery and Reinvestment Act (ARRA).[51] The Office of the National Coordinator (ONC) under the HITECH Act was given the responsibility of implementing provisions relating to interoperability, accessibility, privacy, and security of health information technology.[52]

Only certain entities are subject to HIPAA's provisions. These "covered entities" include:
- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of the entities listed above.

While not a covered entity as an individual, the patient still maintains his or her privacy and confidentiality rights regardless of the method in which a medical service is delivered. The HITECH Act specifically identified telemedicine as an area for review and consideration, and funding was provided to, in part, strengthen infrastructure and tools to promote telemedicine.[53]

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in telemedicine is required to meet the same technical and physical HIPAA and HITECH requirements as would be required for a physical office visit. These requirements include ensuring that the equipment and technology are HIPAA compliant, reduce travel requirements for patients in remote areas, and facilitate home health care and remote patient monitoring.[54]

The HITECH and ARRA legislation also expanded who was considered a "business associate" under the updated security and privacy rules. The final rule in January 2013 modified the definition to include patient safety organizations, health information organization, e-prescribing gateways, and other persons that facilitate data transmissions and vendors of personal health

[49] The Act exempts certain manufacturers, distributers, and dispensers of controlled substances.
[50] *Supra* note 46 at 5 and 21 U.S.C. ss. 823 and 831(h)(1) (January 2019).
[51] American Recovery and Reinvestment Act (ARRA); Public Law 111-5 (2009).
[52] Office of the National Coordinator for Health Information Technology, HealthIT.gov, *Health IT Legislation* (February 10, 2019), *available at* https://www.healthit.gov/topic/laws-regulation-and-policy/health-it-legislation (last visited March 18, 2019).
[53] ARRA; Public Law 111-5 (2009), s. 3002(b)(2)(C) and s. 3011.
[54] *Supra* note 51.

records to one or more persons. These organizations and businesses would be required to enter into business associate agreements under the revised definition.[55]

The final rule also includes two new e-prescribing measures relating to opioids (Schedule II controlled substances) in the performance based scoring methodology for the Medicare's Electronic Health Records Incentive Program. Beginning in Calendar Year (CY) 2019, a query of a state's prescription drug monitoring program (PDMP) is optional; however, this query becomes required in CY 2020.[56] The second measure added is verification of an Opioid Treatment Agreement.[57] As with the PDMP query, the verification of the agreement is also optional for CY 2019 and mandatory in CY 2020.

Prescribing Via the Internet

Federal law has specifically prohibited the prescribing of controlled substances via the Internet without an in-person evaluation. A valid prescription is one that is issued for a legitimate medical purpose in the usual course of professional practice by a practitioner who has conducted at least one in-person medical evaluation of the patient or a covering practitioner.[58] The in-person evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.[59]

Federal law at 21 U.S.C. s. 829 provides:

> No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed or dispensed by means of the Internet without a valid prescription.

Telemedicine Exception

The DEA and the DOJ issued their own definition of telemedicine in April 2009, as required under the Ryan Haight Online Pharmacy Consumer Protection Act (Haight Act).[60] The federal regulatory definition of telemedicine under the DEA includes, but is not limited to, the following elements:

- The patient and practitioner are located in separate locations;
- The Patient and practitioner communicate via a telecommunications system;
- The practitioner must meet other registration requirements for the dispensing of controlled substances via the Internet; and
- Certain practitioners (VA employees, for example) or practitioners in certain situations (public health emergencies) may be exempted from registration requirements.[61]

However, the Haight Act[62] created an exception for the delivery, distribution, or dispensing of a controlled substance by a practitioner engaged in the practice of telemedicine or for a covering

[55] 78 Fed. Reg. 5687, (Jan. 25, 2013) (to be codified at 45 CFR 160.103, Definition of Business associate).
[56] Centers for Medicare and Medicaid Services, *Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospect Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Final Rule Fact Sheet)* (August 2, 2018), *available at* https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2019-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute-0 (last visited Mar. 19, 2019).
[57] *Id.*
[58] Ryan Haight Online Pharmacy Consumer Protection Act of 2008; Public Law 110-425 (H.R. 6353); 21 U.S.C. sec. 829(e)(2)(A)(2006 Ed., Supplement 4).
[59] *Id.*
[60] *Id.*
[61] Drug Abuse and Prevention, Definitions, 21 U.S.C. s. 802 (54).
[62] *Supra* note 58.

practitioner where the practitioner has conducted the required one, in-person medical evaluation through the practice of telemedicine within the previous 24 months.[63] The practitioner is still subject to the requirement that all controlled substances be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice. The definition of the "practice of telemedicine" includes seven distinct categories or exceptions. Those seven distinct categories require the practice of telemedicine be delivered or conducted:

- To a patient that is located in a hospital or a clinic.
- During an in-person examination with another practitioner.
- Through the Indian Health Service.
- During a public health emergency.
- By a practitioner that has obtained a special registration for telemedicine.
- During a medical emergency situation.
- At the discretion of the DEA.[64]

The DEA regulations require practitioners to meet certain requirements before issuing prescriptions for controlled substances electronically. All controlled substance prescriptions must be issued through an application that can meet standards which include, but is not limited to, user controls and locks, prescriber signature verification, final prescription review and approval by the prescriber, two factor authentication, and record archival and audit functionality.[65]

Medicare Provisions

In a proposed rule issued on November 30, 2018, prescription drug plan sponsors and Medicare Advantage organizations will be required to establish electronic prescription drug programs that comply with e-prescribing standards under the Medicare Prescription Drug, Improvement, and Modernization Act.[66] The law and regulation does not require that prescribers or dispensers comply with the requirement; however, any prescribers and dispensers who electronically transmit and receive prescriptions and certain other pieces of information for covered drugs on behalf of Medicare Part D eligible beneficiaries, directly or through an intermediary, are required to comply with any standards.[67]

U.S. Department of Veterans Affairs Telehealth

The VA has been using telehealth to increase access to health care for veterans through a variety of programs including real-time telehealth, the Polytrauma Rehabilitation Network, TeleMental Health, TeleRehabilitation, and Telesurgery. The VA's telehealth services use real-time technologies to provide health care access through Clinical Video Telehealth (CVT). Examples of services that might be provided include access to a specialty care physician with the patient located at a local clinic closest to the veteran's home and a specialty physician who may not be available at the clinic closest to the veteran's home. Not all of the clinics have the specialty care available and it may be difficult for some of the veterans to travel distances to receive care, so

[63] *Id*.
[64] Information from the Congressional Research Service, *The Special Registration for Telemedicine: In Brief* (December 7, 2018), *available at* https://www.everycrsreport.com/files/20181207_R45240_d2f8e1a6693c4181f2c46db32a29f0595dfb5d03.pdf. (last visited March 19, 2019). Based on 21 U.S.C. s. 802(54) and s. 831(h).
[65] Requirements for Electronic Orders and Prescriptions, 21 C.F.R., pt. 1311, sub. C.
[66] Fed. Reg. Vol. 83, No. 231 (Nov. 30, 2018), p. 62164, 423.160.
[67] *Id.*

CVT is used to make diagnoses, manage care, perform check-ups, and actually provide care for these veterans.[68]

A VA telehealth report in 2013, on home health services showed that home telehealth services had reduced bed days care 59 percent and hospital admissions by 35 percent, while clinical video telehealth services reduced bed days of care for mental health patients by 38 percent.[69] Clinical video telehealth saved approximately $34.45 per consult and store-and-forward telehealth saved approximately $38.81 per consult in travel costs for the patient.[70]

For the VA, a health care provider who is licensed to practice a health care specialty listed and qualified under 38 U.S.C. 7402(b),[71] is appointed to an occupation within the Veterans Health Administration that is listed as authorized, maintains his or her health credentials as required, and is not a contractor for the VA. The health care provider is authorized to provide telehealth services within the scope of their practice and in accordance with the privileges granted by the VA, irrespective of the state or location within the state where the health care provider or the beneficiary is located.[72] The health care provider must practice within the limitations imposed by the Controlled Substances Act, 21 U.S.C. 801, et seq, as well as any other provisions set forth by the VA. This federal regulation preempts state law to achieve an important federal interest to care for veterans.[73]

Federal Trade Commission

In recent years the Federal Trade Commission (FTC) has sent comments or intervened in state and federal actions relating to telehealth and telemedicine rulemaking and litigation and how it relates to competition. In one of its more recent letters on the topic, to the VA, the FTC commented on a proposed telemedicine rule allowing VA telehealth providers to provide services to or from non-federal sites, regardless of whether the provider was licensed in the state where the provider was located.[74] The FTC writes in support of the proposed rules with the following:

> Our findings reinforce the view that the Proposed Rule would enable the use of telehealth to reach underserved areas and VA beneficiaries who are unable to travel, improving the ability of the VA to utilize its health care resources. Accordingly, we believe that the Proposed Rule would likely increase access to telehealth services, increase the supply of telehealth providers, increase the range of choices available to patients, improve health care outcomes, and reduce the VA's health care costs, thereby benefitting veterans.

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[68] U.S. Department of Veterans Affairs, *VA Telehealth Services: Real-Time Clinic Based Video Telehealth, https://www.telehealth.va.gov/real-time/index.asp* (last visited March 11, 2019).
[69] Center for Connected Health Policy, *Telehealth Private Payer Laws: Impact and Issues*, Millbank Memorial Fund (August 2017), p. 4, https://www.milbank.org/wp-content/uploads/2017/08/MMF-Telehealth-Report-FINAL.pdf (last viewed March 14, 2019).
[70] *Id.*
[71] To be eligible for appointment in the Administration, a health care provider must meet the federal qualifications as listed in this statute for a physician, dentist, nurse, director of hospital, domiciliary, center, or outpatient clinic, podiatrist, optometrist, pharmacist, psychologist, social worker, marriage and family therapist, licensed professional mental health counselor, chiropractor, peer specialist, or other health care position as designated by the Secretary.
[72] 38 CFR section 17.417, Health care providers practicing via telehealth.
[73] 38 CFR section 17.417(c), Health care providers practicing via telehealth.
[74] U.S. Federal Trade Commission, Letter to Director of Regulation Policy and Management (November 1, 2017), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-department-veterans-affairs-regarding-its-proposed-telehealth-rule/v180001vatelehealth.pdf (last visited March 18, 2019).

…

> The VA's Proposed Rule involves the intersection of two important and current FTC advocacy areas that directly affect many consumers: occupational licensing and telehealth. Since the late 1970s, the Commission and its staff have conducted economic and policy studies relating to licensing requirements for various occupations and professions[75], and submitted numerous advocacy comments to state and self-regulatory entities on competition policy and anti-trust law issues relating to occupational regulation, including the regulation of health professions.[76]

The FTC also commented on telemedicine legislation in Alaska, occupational board rules in Delaware, investigated the Texas Board of Medicine, and filed a joint brief with the DOJ over restrictions relating to dentistry in Texas.[77, 78, 79]

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.[80, 81]

Approximately 80 percent of physicians meet the eligibility guidelines for licensure through the IMLC.[82] The providers' applications are expedited by using the information previously submitted in their State of Principal Licensure (SPL). Once the SPL has been established and a Letter of Qualification has been awarded, the physician can select which states to practice in under his or her compact license. However, to qualify for consideration for that compact license, 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 residency is the SPL.
- The physician's practice of medicine occurs in the SPL for at least 25 percent of the time.

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[75] *See* Carolyn Cox & Susan Foster, BUREAU OF ECON., FED. TRADE COMM'N, The Costs and Benefits of Occupational Regulation (1990), http://www.ramblemuse.com/articles/cox_foster.pdf (last visited March 18, 2019).
[76] *Supra* note 74.
[77] The Alaskan legislation would allow licensed Alaskan physicians located out of state to provide telehealth services in the same manner as in-state providers. *See* https://www.ftc.gov/news-events/press-releases/2016/03/ftc-staff-comment-alaska-legislature-should-consider-potential (last visited March 18, 2019).
[78] In Delaware, there were three situations, one involving whether telepractice was appropriate for Speech/Language Pathologists, another for the occupational board which regulates occupational therapists, and a third for the board which regulates the dietitians and nutritionists. https://www.ftc.gov/policy/advocacy/advocacy-filings/2016/08/ftc-staff-comment-delaware-board-occupational-therapy, https://www.ftc.gov/policy/advocacy/advocacy-filings/2016/11/ftc-staff-comment-delaware-board-speechlanguage , and https://www.ftc.gov/news-events/press-releases/2016/08/ftc-staff-comment-delaware-dieteticsnutrition-board-proposal (last visited March 18, 2019).
[79] In Texas, the FTC began an investigation of whether the Texas Medical Board violated federal antitrust law by adopting rules restricting the practice of telemedicine. *See* https://www.ftc.gov/news-events/press-releases/2017/06/federal-trade-commission-closes-investigation-texas-medical-board (last visited March 18, 2019).
[80] Interstate Medical Licensure Compact, *The IMLC*, https://imlcc.org/ (last visited Mar. 8, 2019).
[81] 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).
[82] *Supra* note 80.

- 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. 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 vary from a low of $75 in Alabama to a high of $700 in Maine.[83]

A current Senate bill (SB 7078) would enter Florida into the IMLC on July 1, 2019, if enacted into Florida law.

III. Effect of Proposed Changes:

Section 1 amends s. 409.967, F.S., to prohibit Medicaid managed care plans from using providers who exclusively provide services through telehealth, as defined in the bill, to meet the current-law network adequacy standards for Medicaid managed care.

The bill also deletes obsolete language from s. 409.967, F.S.

Section 2 creates s. 456.4501, F.S., and establishes statutory provisions for telehealth. The bill:

- Provides definitions for:
  - Telehealth: the practice of a Florida-licensed telehealth provider's profession in which patient care, treatment, or services are provided through the use of medical information exchanged between one physical location and another through electronic communications. The term excludes audio-only telephone calls, email messages, text messages, U.S. mail or other parcel services, facsimile transmissions, or any combination thereof.
  - Telehealth provider: an individual who provides health care and related services using telehealth and who holds a Florida license under chs. 458 (medical) or 459 (osteopathic), including providers who become Florida-licensed by way of the Interstate Medical Licensure Compact.[84]
- Establishes the practice standard for telehealth as the same standard for providers who provide in-person health care services.
- Provides that no controlled substances may be prescribed by a telehealth provider, except:
  - For the treatment of a psychiatric disorder;
  - For inpatient treatment at a hospital licensed under ch. 395, F.S.;
  - For the treatment of a patient receiving hospice services as defined in s. 400.601, F.S.;[85] and,
  - The treatment of a patient in a nursing home facility as defined in s. 400.021, F.S.
- Prohibits the use of an electronic medical questionnaire solely to prescribe medications.
- Places responsibility for quality and safety of equipment on telehealth providers.

[83] Interstate Medical Licensure Compact, *What Does It Cost?* https://imlcc.org/what-does-it-cost/ (last visited Mar. 8, 2019).
[84] The Interstate Medical Licensure compact is one component of SB 7078 (2019).
[85] Under s. 400.601(6), F.S., hospice services means "items and services furnished to a patient and family by a hospice or by others under arrangements with such a program, in a place of temporary or permanent residence used as the patient's home for the purpose of maintaining the patient at home; or, if the patient needs short-term institutionalization, the services shall be furnished in cooperation with those contracted institutions or in the hospice inpatient facility."

- Requires telehealth providers to document in the patient's medical record any health care services rendered using telehealth to the same standards used for in-person services.
- Provides that any medical records generated as a result of a telehealth visit are confidential.[86]
- Clarifies that providers may continue to consult to the extent that such practitioners are acting within the scope of their practice.
- Provides that emergency medical services provided by emergency physicians, emergency medical technicians, paramedics, or emergency dispatchers are excluded from the bill's provisions for telehealth and provides a definition of emergency medical services.
- Provides that health care providers who are providing immediate medical care to a patient with an emergency medical condition are excluded from the bill's provisions for telehealth.
- Provides that, to the extent that a health care provider is acting within his or her scope of practice, the bill does not prohibit:
  - A practitioner caring for a patient in consultation with another practitioner where the practitioner has an ongoing relationship and has agreed to supervise treatment, including prescribed medications; or
  - The health care provider from caring for a patient in on-call or cross-call situations in which another practitioner has access to patient records.
- Provides the applicable board, or the DOH if there is no board, with rulemaking authority.

Sections 3, 4, and 5 creates ss. 627.42393 and 641.31093, F.S., and amends s. 641.31, F.S., to require insurers and HMOs, including the plans that participate in the Medicaid MMA program, to reimburse healthcare providers the same amount for a billed service regardless of the modality of its delivery. The change would affect all policies renewed or contracted for as new contracts as of January 1, 2020. Insurers and HMOs would also be prohibited from:

- Denying coverage for a covered service on the basis of the service being provided through telehealth if the same service would have been covered through an in-person encounter.
- Excluding an otherwise covered service solely because the service is being providing through telehealth rather than through an in-person encounter.
- Charging a greater deductible, copayment, coinsurance amount than would apply if the same service were provided through an in-person encounter.
- Imposing any deductible, copayment, coinsurance amount or other durational benefit limitation or maximum for benefits or services provided via telehealth that is not imposed equally upon all terms and services covered under the policy.

Insurers and HMOs may conduct utilization reviews for appropriateness of service delivery in comparison to in-person encounters and insurers may also elect to limit the covered services offered to enrollees.

Section 6 provides an effective date of July 1, 2019.

[86] Patient medical records are confidential under s. 395.3025, F.S., and any Florida licensed facility has a duty to maintain that confidentiality in accordance with the statute. Patient records held by health care providers are confidential under s. 456.056, F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Providing a statutory definition for telehealth will add clarity to an area that has lacked a standard in state law. According to many users within the state, including respondents to the Telehealth Survey and the findings within the Telehealth Advisory Council Report mentioned previously, health practitioners indicated a need for a definition of the term, "telehealth." A definition would clarify the use of technological modalities as an acceptable way to treat patients within their scope of practice. Further, health plans noted the need for clarity in the allowable modes for telehealth for coverage and reimbursement purposes.

These changes may encourage the use of telehealth options, which may result in reduced health care costs; increased patient access to providers, especially in medically underserved areas; improved quality and continuity of care; and faster and more convenient treatment resulting in reduction of lost work time and travel costs for patients. Preventing the unnecessary use of intensive services, such as emergency department visits, can reduce overall health care costs and improve health outcomes.

SB 1526 restricts the use of telehealth to only those persons licensed under ch. 458 (medical doctors) and ch. 459 (osteopathic physicians), F.S., with some limited exceptions for emergency medical care, hospice, and nursing homes. With committee

testimony from previous years of telehealth bills, provisions in other state statutes, and current practices ongoing in the community, other non-physician health care professionals are currently providing telehealth services. It is unclear what would happen to their ability to continue to practice under this modality should this bill pass in its current form.

C. Government Sector Impact:

Similar to the private sector impact, these changes may encourage the expanded use of telehealth options by government entities and employers, which may result in reduced health care costs; increased patient access to providers, especially in medically underserved areas; improved quality and continuity of care; and faster and more convenient treatment resulting in reduction of lost work time and travel costs for patients.

According to the AHCA, the bill would not limit a MMA plan's ability to pay for telehealth services beyond those specified in the bill.[87] The direct fiscal impact to the state and local entities should be minimal to address any rulemaking issues and potential changes in health care utilization.

The bill does not specifically make the provisions in newly created ss. 627.42393 or 641.31093, F.S., applicable to plans operating under the Statewide Medicaid Managed Care (SMMC) program as it does not explicitly state the provisions apply to health insurers regulated under ch. 641, F.S., or the SMMC program governed under ch. 409, F.S. However, if it is the intent of the legislation that these changes apply to Medicaid, there is an indeterminate fiscal impact on the Medicaid program. While the AHCA already requires coverage parity for services delivered via telemedicine to the extent that the same service is covered via an in-person encounter, the AHCA has not required payment parity, and the plans still have the flexibility to negotiate mutually agreed upon rates for telehealth services. This may mean that the rates paid by plans differ from the rates paid for an in-person encounter.

To the extent the plans are able to negotiate better rates for telehealth services, requiring the plan to pay the same amount as an in-person encounter could increase costs to the Medicaid managed care plans, which would have to be accounted for in the capitation rates. In addition, the plans are increasingly using value-based purchasing agreements with providers to incentivize higher quality and increasingly efficient delivery of care. Payment mandates such as this are difficult to reconcile under those types of arrangements, which can allow providers to share in savings and take on financial risk if quality or other performance goals are not met.

The fiscal impact is indeterminate at this time as the AHCA does not currently possess comprehensive data on whether plans are paying differently for telehealth.

[87] *See* Agency for Health Care Administration, Analysis of SB 1526 (April 14, 2019) (on file with the Senate Appropriations Subcommittee on Health and Human Services).

VI. Technical Deficiencies:

None.

VII. Related Issues:

As noted in Section V., the definition of telehealth as proposed in the bill limits the practice of telehealth to only those physicians licensed under chs. 458 and 459, F.S. It is unclear what adoption of telehealth definition may mean for non-physician health care professionals that are currently using telehealth, either in whole or in part, in their practices.

Additionally, in other states where restrictions on who or which type of professions can participate in telehealth were proposed by the state or its regulatory boards, the FTC submitted comments with concerns that such restrictions were a possible restraint on trade and raised antitrust issues in some cases. In its report, *Options to Enhance Occupational License Portability,* in September 2018, the FTC noted that 30 percent of Americans require an occupational license today up from less than five percent in the 1950s.[88] The report suggested mechanisms in which states could reduce those barriers such as interstate compacts, model laws, mutual recognition, and license portability for cross-state practice.[89]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967 and 641.31.

This bill creates the following sections of the Florida Statutes: 456.4501, 627.42393, and 641.31093.

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.

[88] Bilal Sayyed, et al, *Policy Perspectives: Options to Enhance Occupational License Portability* (September 2018), p. iv, https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited Mar. 19, 2019).
[89] *Id* at 26.