HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7011 PCB HQS 17-01 Health Care Access
SPONSOR(S): Health Quality Subcommittee, Pigman
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Quality Subcommittee	10 Y, 3 N	Siples	McElroy
1) Ways & Means Committee	11 Y, 4 N	Aldridge	Langston
2) Health & Human Services Committee		Siples	Calamas

SUMMARY ANALYSIS

Florida, as well as the nation, is facing a shortage of health care practitioners. In order to broaden access to health care services, the bill seeks to eliminate unnecessary regulation and authorize and incentivize efficient methods of providing care.

The bill allows APRNs who meet certain criteria to practice advanced or specialized nursing without physician supervision or a protocol by registering with the Board of Nursing. In addition, the bill authorizes these "independent advanced practice registered nurses" to:

- Act as a patient's primary care provider;
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement currently required to be provided by a physician;
- Certify a cause of death and sign, correct, and file death certificates;
- Perform certain physical examinations currently reserved to physicians by Florida law, such as examinations of pilots, law enforcement officers, and suspected child abuse victims; and
- Be reimbursed under personal injury protection insurance for initial and follow-up medical services, consistent with current law applicable to physicians.

IAPRNs may be administratively disciplined if they commit specified prohibited acts related to unethical and substandard business practices. The bill also imposes additional requirements on IAPRNs for controlled substance prescribing. IAPRNs must complete 10 hours of continuing education related to pharmacology prior to biennial registration renewal and report controlled substance-related adverse incidents to the Board.

The bill changes the term "advanced registered nurse practitioner" to "advanced practice registered nurse" (APRN) throughout Florida Statutes. The bill authorizes an APRN or a physician assistant (PA) to certify a person for involuntary examination under the Baker Act.

The bill authorizes PAs to perform certain examinations that APRNs are authorized to perform under current law, such as those to detect child abuse and for the purpose of pilot certification. The bill authorizes PAs to file death registrations and certify a cause of death. The bill also authorizes PAs to participate in the Public School Volunteer Health Care Practitioner Program.

The bill creates s. 456.47, F.S., relating to the use of telehealth to provide health care services. Specifically, the bill:

- Authorizes Florida-licensed health care professionals to use telehealth and articulates a standard of care.
- Authorizes out-of-state health care professionals to use telehealth for Florida patients if they register with the Department of Health (DOH) or the applicable board, meet certain requirements, and pay a fee.
- Authorizes certain health care professionals to prescribe controlled substances using telehealth, with certain limitations.
- Requires registered telehealth pharmacists to use only Florida-registered pharmacies for Florida patients.
- Provides standards for record-keeping for those patients who are rendered health care services using telehealth.

For tax years beginning on or after January 1, 2018, the bill creates a tax credit for health insurers and health maintenance organizations (HMOs) that cover services provided by telehealth. A tax credit, in the amount of one tenth of one percent of total insurance premiums received on certain accident or health insurance policies issued or delivered in Florida in the previous calendar year, may be applied against the incurred corporate income tax or insurance premium tax. Any unused tax credit may be carried forward for up to 5 years. The bill authorizes the Department of Revenue to recoup any tax credit amounts for which it finds the health insurer or HMO was ineligible to receive.

The bill provides an appropriation of $261,389 recurring and $15,528 nonrecurring funds from the Medical Quality Assurance Trust Fund and four full time equivalent positions and $145,870 in salary rate to utilize the funds generated from the registration fee to offset the workload increase anticipated from additional licenses. The Revenue Estimating Conference estimated that the tax provisions in the bill will have a recurring negative fiscal impact on General Revenue, though the first cash impacts of -$30.8 million are delayed until FY 2019-20. The bill does not have a fiscal impact on local government.

The bill provides an effective date of July 1, 2017, except as otherwise expressly provided in the bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Health Care Professional Shortage

There is currently a health care provider shortage in the U.S.[1] For example, as of January 1, 2017, the U.S. Department of Health and Human Services has designated 6,626 Primary Care Health Professional Shortage Area (HPSA) (requiring 9,376 additional primary care physicians to eliminate the shortage), 5,493 Dental HPSAs (requiring 8,118 additional dentists to eliminate the shortage), and 4,627 Mental Health HPSAs (requiring 3,397 additional psychiatrists to eliminate the shortage). Similarly, according to a 2010 report prepared by the Florida Center for Nursing, Florida is projected to experience a shortage of more than 62,800 nurses by 2025.[2]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[3] and the passage of the Patient Protection and Affordable Care Act.[4] Aging populations create a disproportionately higher health care demand.[5] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services. There are several other factors which will likely increase the demand for a larger health care workforce. These include: [6]

- Shortage of health care professionals being educated, trained and licensed;
- Lack of specialists and health facilities in rural areas;
- Adverse events, injuries and illness at hospitals and physician's offices; and
- Need to improve community and population health.

Florida is not immune to the national problem and is experiencing a health care provider shortage itself. This is evidenced by the fact that for just primary care, dental care and mental health there are 655

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Shortage Areas*, available at https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx (last visited on April 12, 2017).
[2] Florida Center for Nursing, *RN and LPN Supply and Demand Forecasts, 2010-2025: Florida's Projected Nursing Shortage in View of the Recession and Healthcare Reform* (Oct. 2010), available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=17&PortalId=0&TabId=151 (last visited on April 12 2017).
[3] There will be an increase in the U.S. population, estimated to grow from just under 319 million in 2014 to approximately 359.4 million in 2030, eventually reaching 417 million in 2060. *See* U.S. Census Bureau, *Projections of the Size and Composition of the U.S. Population: 2014 to 2060* (March 2015), available at https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf (last visited on April 12, 2017).
[4] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Projecting the Supply and Demand for Primary Care Practitioners Through 2020* (November 2013), available at https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projectingprimarycare.pdf (last visited on April 12, 2017). Changes to or repeal of the Affordable Care Act is likely.
[5] One analysis measured current primary care utilization (office visits) and projected the impact of population increases, aging, and insured status changes. The study found that the total number of office visits to primary care physicians will increase from 462 million in 2008 to 565 million in 2025, and (because of aging) the average number of visits will increase from 1.60 to 1.66. The study concluded that the U.S. will require 51,880 additional primary care physicians by 2025. See Petterson, Stephen M., et al., "Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025", Annals of Family Medicine, vol. 10, No. 6, Nov./Dec. 2012, available at http://www.annfammed.org/content/10/6/503.full.pdf+html (last visited on April 12, 2017).
[6] Matthew A. Hein, *Telemedicine: An Important Force in the Transformation of Healthcare*, (June 25, 2009), available at http://trade.gov/td/health/telemedicine_2009.pdf (last visited on April 12, 2017).

federally designated Health Professional Shortage Areas (HPSA) within the state.[7] It would take 1,010 primary care, 1,203 dental care, and 254 mental health practitioners to eliminate these shortage areas.[8]

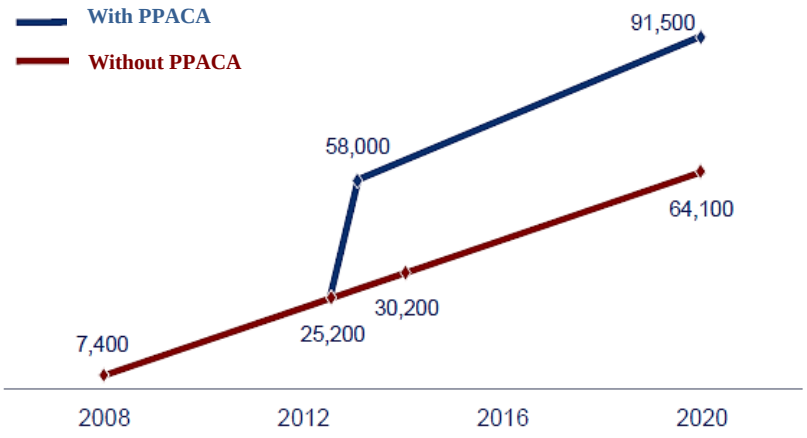
Physician Workforce Data

The Association of American Medical Colleges Center for Workforce Studies estimates that the U.S. will face a physician shortage of between 61,700 and 94,700 across all specialties by 2025.[9] The projected shortfall for primary care physicians ranges from 14,900 to 35,600 physicians by 2025.[10]

In 2014, there were 265.5 physicians[11] actively practicing per 100,000 population in the U.S., ranging from a high of 432.4 in Massachusetts to a low of 184.7 in Mississippi. The states with the highest number of physicians per 100,000 population are concentrated in the northeastern states.[12] Regarding primary care physicians, there were 91.1 per 100,000 population.[13]

The following chart illustrates the projected physician shortage, nationally, with and without full implementation of the PPACA.

National projected physician shortages



Source: Kirch DG, Henderson MK, Dill MJ (2011). "Physician Workforce Projections in an Era of Health Care Reform." *Annual Review of Medicine.*

Florida had 257.2 actively practicing physicians per 100,000 population in 2014. Although Florida is the third most populous state in the nation,[14] it ranks as having the 22nd highest physician to population

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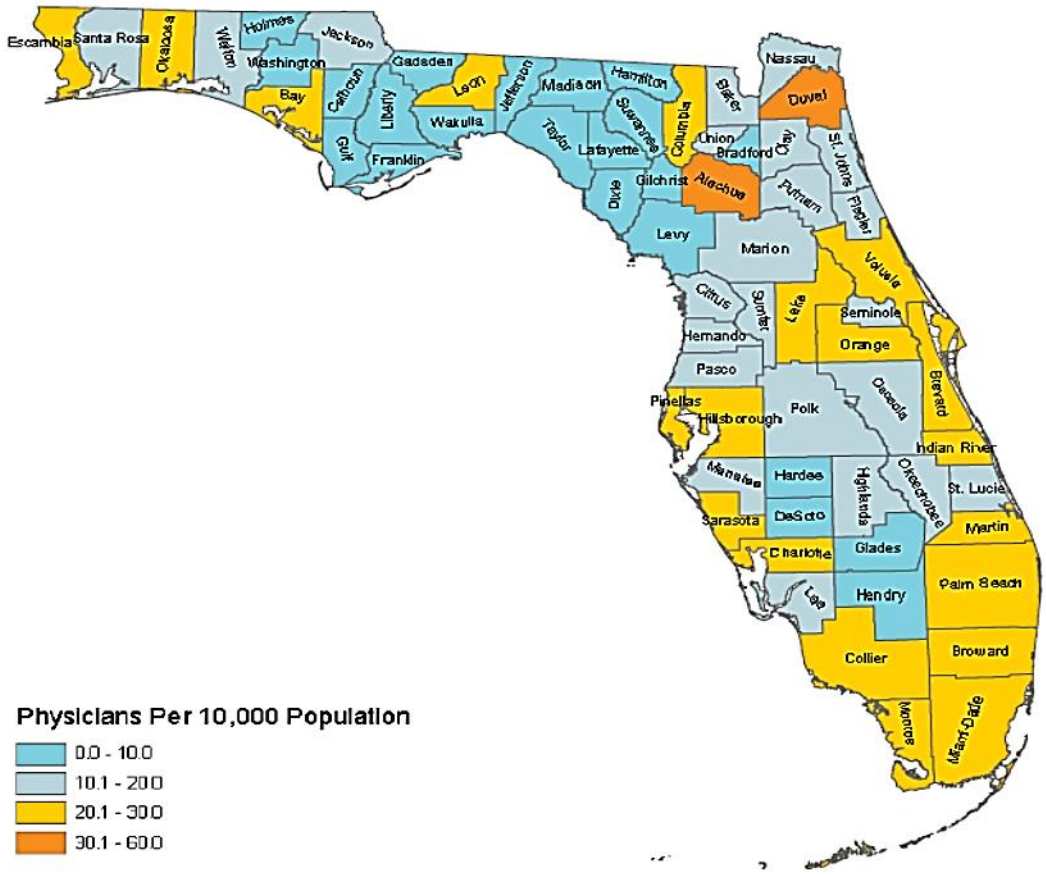
[7] *Supra* note 1.
[8] *Id.*
[9] The Association of American Medical Colleges (AAMC), *2016 Update: The Complexities of Physician Supply and Demand: Projections from 2014 to 2025*, (April 5, 2016), available at: https://www.aamc.org/download/458082/data/2016_complexities_of_supply_and_demand_projections.pdf (last visited on April 12, 2017).
[10] *Id.*
[11] These totals include allopathic and osteopathic doctors.
[12] AAMC, "2015 State Physician Workforce Data Book," November 2015, pg. 4, available at: http://members.aamc.org/eweb/upload/2015StateDataBook%20(revised).pdf (last visited on April 12, 2017).
[13] *Id.* at pg. 5.
[14] As of July 1, 2015, the U.S. Census Bureau estimated Florida to have 20,271,272 residents, behind California (39,144,818) and Texas (27,469,114). U.S. Census Bureau, "Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015: 2015 Population Estimates," available at: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on April 12, 2017).

ratio.[15] In 2014, Florida had a ratio of 86.4 primary care physicians per 100,000 population, ranking Florida 30th compared to other states.[16]

In its 2016 Physician Workforce Annual Report, the Department of Health (DOH) indicated that 13.7 percent of Florida's physicians reported that they were planning to retire within the next five years, which will exacerbate Florida's shortage of physicians.[17] The following map[18] illustrates that not only does Florida have a shortage of physicians, but also there is a maldistribution of physicians and they are generally concentrated in urban areas.

Figure 7: Florida's Physician Workforce by County
2015 - 2016



This map illustrates a per capita distribution of licensed, practicing physicians at the county level. There were 45,746 licensed, practicing physicians who participated in the 2015-2016 survey cycle.

[15] *Supra* note 12, at pg. 9.
[16] *Supra* note 12, at pg. 13.
[17] Florida Department of Health, "2016 Physician Workforce Annual Report," (November 2016), available at: http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/2016%20DOH%20Physician%20Workforce%20Report.pdf (last visited on April 11, 2017).
[18] *Id*. at pg. 11.

Nurse Workforce Data

In 2014, there were approximately 126,900 certified nurse practitioners (CNPs), 38,200 certified registered nurse anesthetists (CRNAs), 5,300 certified nurse midwives (CNMs), and 2,751,000 registered nurses (RNs) employed in the U.S.[19] There were approximately 40 CNPs, 12 CRNAs, 2 CNMs, and 863 RNs per 100,000 population in 2014.[20]

As of February 2017, there were 27,881 advanced registered nurse practitioners (ARNPs) holding a certificate to practice in Florida, including 21,586 CNPs, 5,471 CRNAs, and 824 CNMs.[21] There were also 278,284 actively licensed registered nurses. Based on those figures, Florida has approximately the following number of nurses per 100,000 population: 106.7 CNPs, 4.1 CNMs, 27.0 CRNAs, and 1,375.5 RNs.[22,23]

The Florida Center for Nursing (center) projects that there will be a shortage of approximately 20,600 RNs in 2025, and if PPACA were to be fully implemented Florida would have a shortage of approximately 50,300 RNs.[24]

The center has also reported that almost 44 percent of Florida's RNs[25] and 41.5 percent of the state's ARNPs[26] are 51 years old or older, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.[27]

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[19] U.S. Department of Labor, Bureau of Labor Statistics, "Employment Projections," *available at*: http://data.bls.gov/projections/occupationProj (last visited on April 11, 2017).

[20] These ratios were calculated using the U.S. Census Bureau's total population estimate for 2014, which was 318,857,056, which is available at: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on April 11, 2017) and the U.S. Bureau of Labor Statistics 2012 data on employment projections available at: http://data.bls.gov/projections/occupationProj (last visited on April 11, 2017).

[21] E-mail correspondence with the Department of Health dated February 2, 2017, on file with the staff of the Health Quality Subcommittee.

[22] These ratios were calculated using population estimates for FY 2015-2016 provided by the Florida Office of Economic & Demographic Research, which is 20,231,092, and available at: http://edr.state.fl.us/Content/conferences/population/ComponentsofChange.pdf (last visited April on 11, 2017).

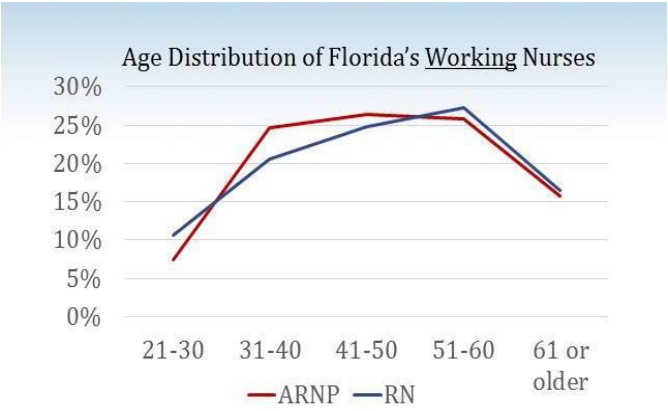
[23] Although it appears from this data that Florida has a higher ratio of nurses than the national ratio, the national data used to calculate the ratios only considers the number of nurses "employed" in the U.S. No similar employment data exists in Florida for 2014 to correlate with the national numbers. The numbers used to calculate Florida's ratios includes all active licensees, whom may not necessarily be employed, as well as out-of-state licensees that may or may not be actively practicing in this state, hence the larger ratios.

[24] The estimates are based on full-time equivalent (FTE) registered nurses. The Florida Center for Nursing, "RN and LPN Supply and Demand Forecasts, 2010-2025: Florida's Projected Nursing Shortage in View of the Recession and Healthcare Reform," pg. 7, (October 2010), available at: http://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=17&PortalId=0&TabId=151 (last visited on April 11, 2017).

[25] Florida Center for Nursing, "Florida's Registered Nurse Supply: 2014-2015 Workforce Characteristics and Trends," pg. 10, (May 2016), available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=1194&PortalId=0&TabId=151 (last visited on April 11, 2017) Of working RNs in this state, 27.3 percent are 51 to 60 years old and 16.5 percent are 61 or older.

[26] Florida Center for Nursing, "Florida's Advanced Registered Nurse Practitioner Supply: 2014-2015 Workforce Characteristics and Trends, pg. 10, (May 2016), available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=1196&PortalId=0&TabId=151 (last visited on April 11, 2017). Of working ARNPs in this state, 25.8 percent are 51 to 60 years old and 15.7 percent are 61 or older.

[27] Florida Center for Nursing, Presentation on Florida's Nurse Workforce, February 8, 2017, available at: http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2918&Session=2017&DocumentType=Meeting%20Packets&FileName=hqs%202-8-17.pdf (last visited on April 11, 2017).



Advanced Practice Nurses

The term advanced practice nurse (APN) refers to registered nurses who have completed rigorous training and advanced education, usually resulting in a master's degree or higher. The titles of APNs vary from state to state. The National Council of State Boards of Nursing encourages states to use the term "advanced practice registered nurse" (APRN) to promote uniformity and title recognition across the nation.[28]

Florida Advanced Practice Nurses

In Florida, an APN is titled as an "advanced registered nurse practitioner" (ARNP)[29] and is categorized as a certified nurse practitioner (CNP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA).[30] As of February 2017, Florida has 21,586 CNPs, 5,471 CRNAs, and 824 CNMs.[31]

ARNPs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The Board of Nursing (Board), established under s. 464.004, F.S., provides by rule the eligibility criteria for applicants to be certified as ARNPs and the applicable regulatory standards for ARNP nursing practices. Additionally, the Board is responsible for administratively disciplining an ARNP who commits an act prohibited under ss. 464.018 or 456.072, F.S.

Section 464.003(2), F.S., defines the term "advanced or specialized nursing practice" to include, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the Board as appropriate for ARNPs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[32] In addition to advanced or specialized nursing practices, ARNPs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[33]

To be eligible to be certified as an ARNP, the applicant must be licensed as a registered nurse, have a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.[34] A nursing specialty board must:

[28] National Council of State Boards of Nursing, "Model for Uniform National Advanced Practice Registered Nurse (APRN) Regulation: A Handbook for Legislators," *available at* https://www.ncsbn.org/2010_APRN_HandbookforLegislators_web.pdf (last visited on April 11, 2017).
[29] Section 464.003(3), F.S.
[30] Section 464.012(4), F.S.
[31] Email correspondence from DOH dated February 2, 2017, on file with committee staff.
[32] *Supra* note 30.
[33] *Supra* note 29.
[34] Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.

- Attest to the competency of nurses in a clinical specialty area;
- Require nurses to take a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.[35]

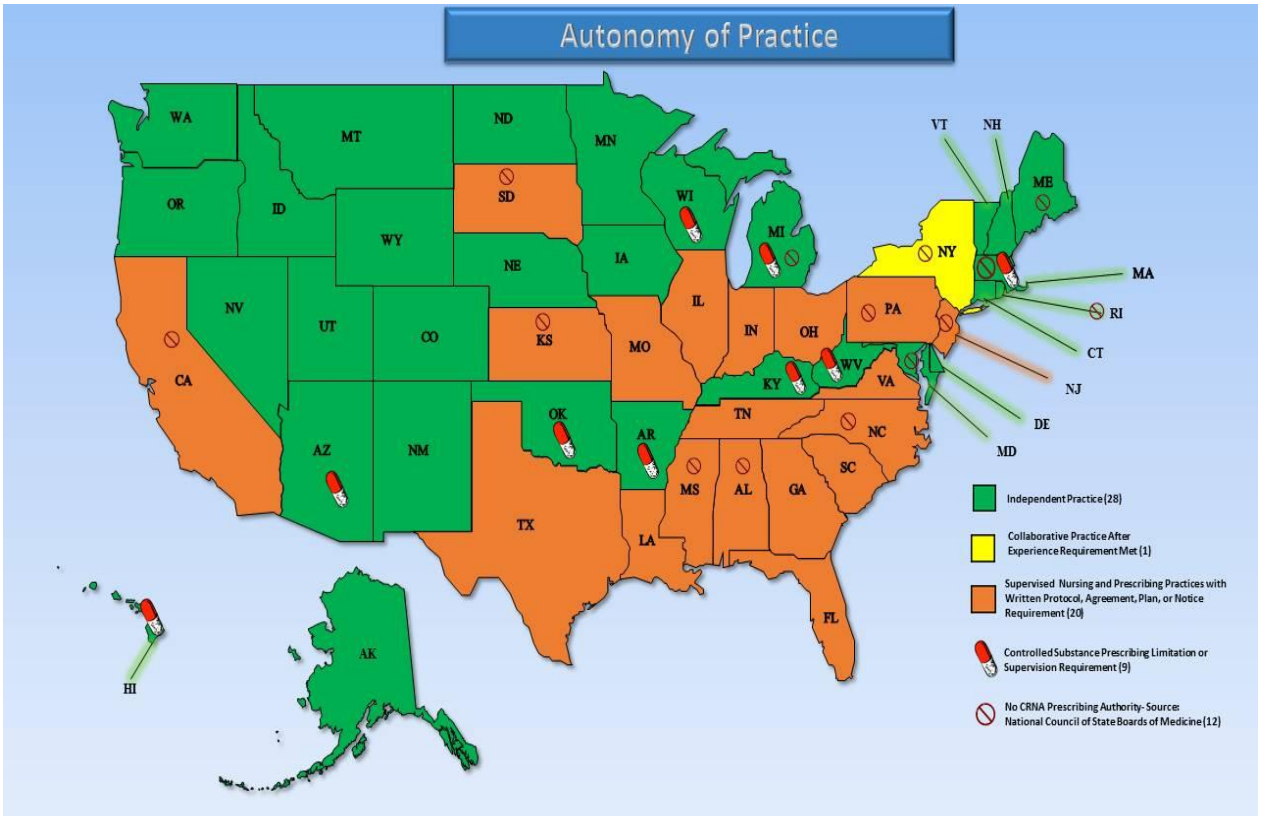
Pursuant to s. 456.048, F.S., all ARNPs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for certification is required to submit proof of coverage or financial responsibility within sixty days of certification and prior to each biennial certification renewal. The ARNP must have professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 or an unexpired irrevocable letter of credit in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the ARNP as beneficiary.[36] By comparison, physicians are required by Florida law to establish some method of financial responsibility with the same coverage amounts, and can choose one of three options for doing so: malpractice insurance, an escrow account, or a letter of credit. However, physicians who agree to pay adverse judgments, up to certain statutory limits, are exempt from this requirement, but must notify patients that they have chosen not to carry malpractice insurance.[37]

Autonomy of Practice

APN autonomy of practice varies by state. Generally, states align with three types of autonomy:

1. Independent nursing practice;
2. Collaborative nursing practice that requires physician collaboration without a specific requirement for a written agreement; or
3. Supervised nursing practice that requires physician supervision with a written agreement, protocol, notice, or plan signed by the physician, who has discretion as to what practices are authorized, including controlled substance prescribing.[38]

[35] Rule 64B9-4.002(3), F.A.C.
[36] Rule 64B9-4.002, F.A.C. DOH Form DH-MQA 1186, 01/09, "Financial Responsibility," is incorporated into the rule by reference. Certain licensees, such as those who practice exclusively for federal or state governments, only practice in conjunction with a teaching position, or can demonstrate no malpractice exposure in this state are exempt from the financial responsibility requirements.
[37] If allopathic and osteopathic physicians meet certain eligibility criteria and post signage at their medical office disclosing to the public that they do not carry medical malpractice insurance, they are exempt from medical malpractice or proof of financial responsibility requirements provided in ss. 458.320 and 459.0085, F.S., respectively.
[38] Findings based on research conducted by professional staff of the Health and Human Services Committee.



APN Autonomy in Veterans Health Administration Facilities

The U.S. Department of Veterans Affairs (VA) adopted a rule in December 2016, which amended its regulations to permit full practice authority of its APNs.[39] Under the rule, an APN working within the scope of his or her VA employment is authorized to perform specified services within the scope of his or her training, education, and certification without the clinical oversight of a physician, regardless of state law restrictions. However, the rule expressly provides that the full practice of an APN is subject to state law with regard to the prescribing or administration of controlled substances. The provisions of the rule are limited to CNPs, CNMs, and clinical nurse specialists, and do not apply to CRNAs. In Florida, there are 58 VHA medical centers and health care clinics that are affected by this policy change.[40]

APN Autonomy in Florida

Florida is a supervisory state. Under s. 464.012(3), F.S., APNs may only perform nursing practices delineated in a written physician protocol filed with the Board.[41]

Florida law allows a physician providing primary health care services to supervise APNs in up to four medical offices,[42] in addition to the physician's primary practice location. If the physician provides

[39] U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Grants Full Practice Authority to Advanced Practice Registered Nurses," (December 14, 2016), available at https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847 (last visited on April 11, 2017). The final rule can be found at https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf (last visited on April 11, 2017).
[40] U.S. Department of Veterans Affairs, Veterans Health Administration, "Locations: Florida," available at: http://www.va.gov/directory/guide/state.asp?STATE=FL&dnum=1 (last visited April 11, 2017).
[41] Allopathic and osteopathic physicians are also required to provide notice of the written protocol and the supervisory relationship to the Board of Medicine or Board of Osteopathic Medicine, respectively. Sections 458.348 and 459.025, F.S.
[42] The supervision limitations do not apply in certain facilities such as hospitals, colleges of medicine or nursing, nonprofit family-planning clinics, rural and federally qualified health centers, nursing homes, assisted living facilities, continuing care facilities, retirement communities, clinics providing anesthesia services, rural health clinics, community-based health care settings, student health care centers, school health clinics, or other government facilities. Sections 458.348(4)(e), and 459.025(3)(e), F.S.

specialty health care services, then only two medical offices in addition to the physician's primary practice location may be supervised.[43] Furthermore, a special limitation applies to dermatology services. If the physician offers services primarily related to dermatologic or skin care services (including aesthetic skin care services other than plastic surgery), at a medical office that is not the physician's primary practice location, then the physician may only supervise one medical office.[44]

Scope of Practice

State laws vary as to the scope within which an APN may practice, which is often determined by whether the APN is a CNP, CNM, or CRNA, and often relates to the authority to prescribe drugs and sign documents.

Twenty of the 29 independent practice states authorize an APN to prescribe controlled substances to a patient without physician supervision. Two of the 29 independent practice states, Kentucky and Michigan, require APNs to enter into a collaboration or delegation agreement with a physician in order to prescribe controlled substances.[45] In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APNs in Florida to prescribe controlled substances beginning January 2017. [46] The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,[47] as well as required continuing education related to controlled substances prescribing. Ten states specifically prohibit CRNAs from prescribing drugs, and 17 authorize CRNAs to prescribe pursuant to a written protocol with a physician or under the supervision of physician.[48] The map on p. 18 illustrates the varying controlled substance prescribing requirements throughout the U.S.

At least 12 states grant APNs have broad-based signature authority laws.[49] This authority is often referred to as "global signature authority." Many states specify in law the types of things an APN may sign, such as death certificates, handicapped license designations, and advanced directives.[50]

Nineteen states statutorily recognize APNs as "primary care providers."[51] Recognizing APNs as primary care providers assists them with being able to directly bill public or private payers for services provided, order certain tests, and establish independent primary care practices.[52] Insurers may be unwilling to contract directly with a provider who is supervised by another provider.

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[43] Sections 458.348, and 459.025, F.S.
[44] *Id*.
[45] *Supra* note 38. The remaining states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.
[46] Chapter 2016-224, L.O.F.
[47] Pursuant to s. 893.03(2), a schedule II substance has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. In Florida, an APN may only prescribe a 7-day supply of a schedule II controlled substance, except the limitation does not apply to certain psychiatric prescribing psychiatric medications.
[48] National Council of State Boards of Nursing, *CRNA Independent Prescribing Map*, (August 2016), available at https://www.ncsbn.org/5408.htm (last visited on April 11, 2017).
[49] American Association of Nurse Practitioners, *Issue-At-A-Glance: Signature Authority*, (April 2016), available at https://www.aanp.org/images/documents/policy-toolbox/signatureauthorityissue.pdf (last visited on April 11, 2017). Those states include Colorado, Georgia, Hawaii, Maine, Massachusetts, New Mexico, North Carolina, Rhode Island, Vermont, Virginia, Washington, and West Virginia.
[50] *Id*.
[51] Office of Program Policy Analysis & Government Accountability, "States Vary in Their Treatment of Advanced Registered Nurse Practitioners as Primary Care Providers," October 2013, on file with the Health and Human Services Committee.
[52] National Nursing Centers Consortium, "Insurers' contracting policies on nurse practitioners as primary care providers: the current landscape and what needs to change," *Policy, Politics & Nursing Practice, 7*(3), 216-226, August 2006, *available at*: http://journals.sagepub.com/doi/pdf/10.1177/1527154406294339 (last visited on April 11, 2017).

APN Scope of Practice in Florida

Within the framework of the written protocol, an APN may:

- Prescribe, dispense, administer, or order any drug;[53];
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by Board rule;
- Order diagnostic tests and physical and occupational therapy;
- Perform certain acts within his or her specialty; and
- Perform medical acts authorized by a joint committee.[54]

APNs in Florida are not authorized to sign certain documents; rather, Florida law requires them to be signed by a physician. For example, APNs are not authorized to sign a certificate to initiate the involuntary examination of a person under the Baker Act, to sign for the release of persons in receiving facilities under the Baker Act, or to sign death certificates.[55]

Reports and Studies Related to Advanced Practice Nurses

Patient Health Care Outcomes

Despite concerns that APNs provide a different quality of care than physicians,[56] a multitude of reports and studies suggest treatment by an APN is just as safe, if not safer, than treatment by a physician. In 2009, the Cochrane Collaboration published a review of the findings of 25 articles comparing physician and APN patient outcomes. The review found that, in general, there are no appreciable differences between physicians and APNs in health outcomes for patients, process of care, resource utilization, or cost.[57]

Similar to the Cochrane review, the National Governors Association performed a review of various studies to determine whether there were differences in the quality of care provided by CNPs compared to physicians. The studies measured quality of care components such as patient satisfaction, time spent with patients, and prescribing accuracy. The review of those studies found that CNPs provided at least equal quality of care to patients as compared to physicians and, in fact, CNPs were found to have equal or higher patient satisfaction rates and tended to spend more time with patients during clinical visits.[58]

A 2013 study, found that allowing CNPs to practice and prescribe drugs without physician oversight leads to increased primary health care utilization and improvements in health outcomes.[59]

[53] Controlled substances may only be prescribed or dispensed if the ARNP has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.
[54] Sections 464.012(3),(4), and 464.003, F.S.
[55] Sections 394.463(2) and 382.008, F.S.
[56] When 972 clinicians, including 467 nurse practitioners and 505 physicians, were surveyed in a study as to whether physicians provide a higher quality of examination and consultation, the respondents were diametrically opposed. Approximately 66.1% of physicians agreed with the statement and 75.3% of nurse practitioners disagreed with the statement. Donelan, K., Sc.D., DesRoches, C., Dr. P.H., Dittus, R., M.D., M.P.H., and Buerhaus, P., R.N., Ph.D.,"Perspectives of Physicians and Nurse Practitioners on Primary Care Practice," N. Engl. J. Med. 2013, 368:1898-1906, available at http://www.nejm.org/doi/full/10.1056/NEJMsa1212938 (last visited on April 11, 2017).
[57] Laurant, M., et al., The Cochrane Collaboration, "Substitution of doctors by nurses in primary care," October 18, 2004, *abstract* available at http://www.ncbi.nlm.nih.gov/pubmed/15846614 (last visited on April 11, 2017).
[58] National Governors Association, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," December 2012, *available at* http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf (last visited on April 11, 2017).
[59] Udalova, V., Traczynski, J., "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," May 4, 2014, *available at* http://www2.hawaii.edu/~jtraczyn/paperdraft_050414_ASHE.pdf (last visited on April 11, 2017).

Cost Savings

The rising cost of health care is a concern for individuals, families, businesses, government entities, and society as a whole. These rising costs will only be intensified by the increasing number of persons with health care coverage and the shortage of health care workers.[60]

In 2012, the Perryman Group conducted a study to determine whether Texas could achieve any cost-savings by increasing the utilization of APNs. A report of the study's findings concluded that greater utilization of APNs would improve patient outcomes, reduce overall health care costs, and increase access to health care. The estimated savings were $16.1 billion in total expenditures and $8 billion in output (gross product) each year. Additionally, it was estimated that 97,205 permanent jobs would be added to Texas' workforce. Finally, the report estimated that Texas would receive additional tax receipts of up to $483.9 million to the state and $233.2 million to local government entities each year.[61]

Another study found that states that allow APNs to practice and prescribe without physician supervision experience 16-35% increases in health care utilization, increases in care quality, and reductions in inappropriate emergency room use. The researchers concluded these advances were primarily due to elimination of supervision time (10%) and lower indirect costs (such as better appointment availability and lower patient travel costs).[62]

The U.S. Federal Trade Commission (FTC) has authored several letters to states regarding the negative effects of restrictive scope of practice laws for APNs. The main concern of the FTC is that scope of practice restrictions are anti-competitive and that they, in effect, reduce competitive market pressures, increase out-of-pocket prices, allow for more limited service hours, and reduce the distribution of services. The FTC poses that if such constraints were eliminated, not only would access to services be increased, but also there would be benefits to price competition that would help contain health care costs.[63]

Physician Assistants

Florida Licensure

Under Florida law, PAs are governed under the physician practice acts for medical doctors (MDs) and doctors of osteopathic medicine (DOs). PAs are regulated by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine (collectively, "boards) for PAs licensed under ch. 459, F.S. As of February 2017, there are 7,527 active licensed PAs.[64]

An applicant for a PA license must apply to the Department of Health (Department). The Department must issue a license to a person certified by the Council as having met all of the following requirements:

- At least 18 years of age;
- Satisfactorily passes the National Commission on Certification of Physician Assistants exam;
- Completes an application form and remit the registration fee;

[60] The Perryman Group, "The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in the Provision of Health Care in Texas," May 2012, available at http://c.ymcdn.com/sites/www.texasnp.org/resource/resmgr/Advocacy/Perryman%20APRN%20Ultilization%20Economic%20Impact%20Report%20May%202012.pdf (last visited on April 11, 2017).
[61] *Id*.
[62] *Supra* note 59.
[63] U.S. Federal Trade Commission, Office of Policy Planning, Bureau of Competition and Bureau of Economics, letters to the Illinois State Senate, Connecticut House of Representatives, and Texas State Senate, on file with committee staff.
[64] E-mail correspondence with the Department of Health, dated February 2, 2017, on file with the staff of the Health Quality Subcommittee.

- Completes an approved PA training program
- Provides an acknowledgement of any prior felony convictions;
- Provides an acknowledgement of any revocation or denial of licensure or certification in any state; and
- If the applicant wishes to apply for prescribing authority, submits of a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy.[65]

Licenses are renewed biennially.[66] A PA must complete 100 hours of continuing medical education (CME) during the two years prior to application for renewal or hold a current certificate issued by the National Commission on Certification of Physician Assistants.[67]

PA Practice in Florida

In Florida, a PA practices under the delegated authority of a supervising physician. A physician supervising a PA must be qualified in the medical area in which the PA is practicing and is responsible and liable for the performance, acts, and omissions of the PA.[68]

The Boards have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. Whether the supervision of a PA is adequate, is dependent upon the:

- Complexity of the task;
- Risk to the patient;
- Background, training and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.[69]

The supervising physician is required to periodically review the PA's performance.

A supervising physician may only delegate tasks and procedures to the PA which are within the supervising physician's scope of practice.[70] The decision to permit the PA to perform a task or procedure under direct or indirect supervision is made by the supervising physician based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[71]

A supervising physician may delegate the authority for a PA to:

- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the formulary established by the Council;[72]

[65] *See* s. 458.347 and s. 459.022, F.S.
[66] For timely renewed licenses, the renewal fee is $275 and the prescribing registration is $150. Additionally, at the time of renewal, the PA must pay an unlicensed activity fee of $5. *See* Rules 64B8-30.019 and 64B15-6.013, F.A.C.
[67] Sections 458.347(7)(b)-(c) and 459.022(7)(b)-(c), F.S.
[68] Sections 458.347(3), F.S., and 459.022(3), F.S.; and Rules 64B8-30.012, F.A.C., and 64B15-6.010, F.A.C.
[69] Rules 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.
[70] *Supra* note 65.
[71] "Direct supervision" refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed. "Indirect supervision" refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication. *Supra* fn. 78.
[72] Sections 458.347(4)(f), F.S., and 459.022(e), F.S., directs the Council to establish a formulary listing the medical drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C., prohibits PAs from prescribing controlled

- Order any medication for administration for administration to the supervising physician's patient in a facility licensed under chapter 395, F.S., or part II of chapter 400, F.S.;[73] and
- Any other services that are not expressly prohibited in ch. 458, ch. 459, or the rules adopted thereunder.[74]

Telehealth

There is no universally accepted definition of telehealth. In broad terms, telehealth is:

> The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment[75] and prevention of disease and injuries[76], research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.[77]

More specific definitions vary by state and occasionally by profession.[78] There are, however, common elements among the varied definitions of telehealth.

Telehealth generally consists of synchronous and/or asynchronous transmittal of information.[79] Synchronous refers to the live[80] transmission of information between patient and provider during the same time period.[81] Asynchronous telehealth is the transfer of data over a period of time, and typically in separate time frames.[82] This is commonly referred to as "store and forward." Definitions of telehealth also commonly contain restrictions related to the location where telehealth may be used. For example, the use of the "hub and spoke" model is a common location restriction. A hub site is the location from which specialty or consultative services originate, i.e., the provider.[83] A spoke site is a remote site where the patient is presented during the telehealth encounter.[84] Under this model, health services may be provided through telehealth only if the patient is located at a designated spoke site and the provider is located at a designated hub site.

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substances; general, spinal or epidural anesthetics; and radiographic contrast materials. However, the rules authorize physicians to delegate to PAs the authority to order controlled substances in facilities licensed under ch. 395, F.S..

[73] Chapter 395, F.S., provides for the regulation and the licensure of hospitals and trauma centers, part II of ch. 400, F.S., provides for the regulation and licensure of nursing home facilities.

[74] Sections 458.347(4) and 459.022(e), F.S.

[75] The University of Florida's Diabetes Institute utilizes telehealth to deliver treatment to children with diabetes and other endocrine problems who live in Volusia County. This allows the children to receive specialized treatment without the necessity of traveling from Volusia County to Gainesville. The Florida Department of Health's Children's Medical Services underwrites the program. *See* https://ufhealth.org/diabetes-center-excellence/telemedicine (last visited on April 11, 2017).

[76] The University of South Florida has partnered with American Well to provide health care services to the residents of the Villages via telehealth. The goal is to reduce hospital admissions, readmission rates, and pharmacy costs, while maintaining Medicare beneficiaries in their homes rather than long-term care settings. *See* http://hscweb3.hsc.usf.edu/blog/2012/06/22/usf-health-and-american-well-to-bring-telehealth-to-seniors-living-at-the-villages/ (last visited on April 11, 2017).

[77] World Health Organization, *Telemedicine: Opportunities and Developments in Member States, Global Observatory for Ehealth Series- Volume 2,* Section 1.2, page 9 (2010), *available at* http://www.who.int/goe/publications/goe_telemedicine_2010.pdf (last visited on April 11, 2017).

[78] Center for Connected Health Policy, The National Telehealth Policy Resource Center, *State Telehealth Laws and Medicaid Program Policies*, (August 2016)*, available at* http://www.cchpca.org/sites/default/files/resources/50%20STATE%20COMPLETE%20REPORT%20PASSWORD%20AUG%202016_1.pdf (last visited on April 11, 2017).

[79] The majority of telehealth definitions allow for both synchronous and asynchronous transmittal of information. Some definitions however omit asynchronous from the definition of telehealth.

[80] This is also referred to as "real time" or "interactive" telehealth.

[81] American Telemedicine Association, *Telemedicine Glossary*, available at http://hub.americantelemed.org/resources/telemedicine-glossary (last visited on April 11, 2017). The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

[82] *Id*. A common example of synchronous telehealth is the transfer of x-rays or MRI images from one health care provider to another health care provider for review in the future.

[83] *Id.*

[84] *Id.*

Telehealth includes telemedicine and telemonitoring. Telemedicine is focused on the delivery of traditional clinical services, like diagnosis and treatment. Telemonitoring is the process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patient from a distance.[85] Telehealth more broadly includes non-clinical services, such as patient and professional health-related education, public health, and health administration.[86]

Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.[87]

Telehealth, in its modern form,[88] started in the 1960s in large part driven by the military and space technology sectors.[89] Specifically, telehealth was used to remotely monitor physiological measurements of certain military and space program personnel. As this technology became more readily available to the civilian market, telehealth began to be used for linking physicians with patients in remote, rural areas. As advancements were made in telecommunication technology, the use of telehealth became more widespread to include not only rural areas but also urban communities. Due to recent technology advancements and general accessibility, the use of telehealth has spread rapidly and is now becoming integrated into the ongoing operations of hospitals, specialty departments, home health agencies, private physician offices as well as consumer's homes and workplaces.[90] In fact, there are currently an estimated 200 telehealth networks, with 3,500 service sites in the U.S.[91]

Telehealth is used to address several problems in the current health care system. Inadequate access to care is one of the primary obstacles to obtaining quality health care.[92] This occurs in both rural areas and urban communities.[93] Telehealth reduces the impact of this issue by providing a mechanism to deliver quality health care, irrespective of the location of a patient or a health care professional. Cost is another barrier to obtaining quality health care. This includes the cost of travel to and from the health care facility, as well as related loss of wages from work absences. Costs are reduced through telehealth by decreasing the time and distance required to travel to the health care professional. Two more issues addressed through telehealth are the reutilization of health care services and hospital readmission. These often occur due to a lack of proper follow-up care by the patient[94] or a chronic condition.[95] These issues however can potentially be avoided through the use of telehealth and telemonitoring.

Telehealth and Federal Law

Several federal laws and regulations apply to the delivery of health care services through telehealth.

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[85] *Id.*
[86] *Id.*
[87] U.S. Department of Health and Human Services, *Report to Congress: E-Health and Telemedicine*, (August 2016), available at https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf (last visited April 11, 2017).
[88] Historically, telehealth can be traced back to the mid to late 19th century with one of the first published accounts occurring in the early 20th century when electrocardiograph data were transmitted over telephone wires. See *supra* note 77.
[89] *Id.*
[90] American Telemedicine Association, *About Telemedicine*, available at http://www.americantelemed.org/about/about-telemedicine (last visited on April 11, 2017).
[91] American Telemedicine Association, *Telemedicine Frequently Asked Questions*, available at http://www.americantelemed.org/main/about/telehealth-faqs-, (last visited on April 11, 2017).
[92] American Telemedicine Association, *Telemedicine Benefits*, available at *http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-benefits*, (last visited January 9, 2017).
[93] *Id*.
[94] Post-surgical examination subsequent to a patient's release from a hospital is a prime example. Specifically, infection can occur without proper follow-up and ultimately leads to a readmission to the hospital.
[95] For example, diabetes is a chronic condition which can benefit by treatment through telehealth.

Prescribing Via the Internet

Federal law specifically prohibits prescribing controlled substances via the Internet without an in-person evaluation. The federal regulation under 21 CFR §829 specifically states:

> 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.

A valid prescription is further defined under the same regulation as one issued by a practitioner who has conducted an in-person evaluation. 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.[96] However, the Ryan Haight Online Pharmacy Consumer Protection Act,[97] signed into law in October 2008, created an exception for the in-person medical evaluation for telehealth practitioners. The practitioner is still subject to the requirement that all controlled substance prescriptions be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice.

Medicare Coverage

Specific telehealth[98] services delivered at designated sites are covered under Medicare. The Federal Centers for Medicare and Medicaid Services' regulations require both a distant site and a separate originating site (hub and spoke model) under their definition of telehealth. Asynchronous (store and forward) activities are only reimbursed under Medicare in federal demonstration projects.[99] To qualify for Medicare reimbursement, the originating site must be:

- Located in a federally defined rural county;
- Located in a health professional shortage area that is outside a Metropolitan Statistical Area (MSA)[100] or in a rural census tract; or
- Identified as a participant in a federal telemedicine demonstration project as of December 21, 2000.[101]

In addition, an originating site must be one of the following location types as further defined in federal law and regulation:

- The office of a physician or practitioner;
- A critical access hospital;
- A rural health clinic;
- A federally qualified health center;
- A hospital;
- A hospital-based or critical access hospital-based renal dialysis center (including satellites);
- A skilled nursing facility; or
- A community mental health center.[102]

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[96] 21 CFR §829(e)(2).
[97] Ryan Haight Online Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).
[98] Medicare covers a broader set of services using the term telehealth. Medicare defines telehealth as the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.
[99] Only two states have a federal demonstration project that meets these qualifications, Hawaii and Alaska.
[100] A metropolitan statistical (MSA) is a core area containing a substantial population nucleus, as well as adjacent communities that have a high degree of economic and social integration with that core. Each MSA has at least one urbanized area with a population of at least 50,000. *See* U.S. Census Bureau, *Metropolitan and Micropolitan*, available at https://www.census.gov/programs-surveys/metro-micro/about.html (last visited on January 9, 2017).
[101] See 42 U.S.C. sec. 1395(m)(m)(4)(C)(i).
[102] See 42 U.S.C. sec. 1395(m)(m)(4)(C)(ii).

Protection of Personal Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. Privacy rules were initially issued in 2000 by the U.S. Department of Health and Human Services and later modified in 2002.[103] These rules address the use and disclosure of an individual's personal health information as well as create standards for information security.
Only certain entities are subject to HIPAA's provisions. These "covered entities" include:[104]:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.

Covered entities are obligated to meet HIPAA's requirements to ensure privacy and confidentiality personal health information, regardless of the method in which the medical service is delivered.

In 2009, the Health Information Technology for Economic Clinical Health (HITECH) Act was enacted as part of American Recovery and Reinvestment Act (ARRA).[105] The HITECH Act promoted electronic exchange and use of health information by investing $20 billion in health information technology infrastructure and incentives to encourage doctors and hospitals to use health information technology.[106] HITECH was intended to strengthen existing HIPAA security and privacy rules.[107] It expanded HIPAA to entities not previously covered; specifically, "business associates" now includes Regional Health Information Organizations, and Health Information Exchanges.[108] Similarly, it made changes to the privacy rule to better protect personal health information held, transferred, or used by covered entities.[109]

Under the provisions of HIPAA and the HITECH Act, a health care provider or other covered entity participating in the electronic exchange of personal health information are subject to HIPAA and HITECH. These federal laws apply to covered entities in Florida, regardless of whether there is an express reference to them in Florida law.

National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) is a federal databank that serves as a repository of information about health care practitioners in the U.S.[110] Due to the perceived increase in medical malpractice litigation, Congress created the NPDB to improve the quality of medical care and restrict the ability of an incompetent physician or dentist to move from state to state without the disclosure or discovery of the physician's or dentist's previous damaging or incompetent performance.[111]

The information collected in the NPDB includes:

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[103] U.S. Department of Health and Human Services, *The Privacy Rule*, available at http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/ (last visited on April 11, 2017).
[104] U.S. Department of Health and Human Services, *For Covered Entities and Business Associates*, available at http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/ (last visited on April 11, 2017).
[105] U.S. Department of Health & Human Services, *HITECH Act Enforcement Interim Final Rule*, available at http://www.hhs.gov/hipaa/for-professionals/special-topics/HITECH-act-enforcement-interim-final-rule/index.html (last visited April 11, 2017).
[106] *Id*.
[107] *Id*.
[108] *Id*.
[109] *Id*.
[110] U.S. Department of Health and Human Services, National Practitioner Data Bank, *About Us*, available at https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp (last visited on April 11, 2017).
[111] U.S. Department of Health and Human Services, *NPDB Guidebook*, (April 2015), available at https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf (last visited on April 11, 2017).

- Medical malpractice payments;
- Adverse licensing actions;
- Adverse actions related to clinical privileges;
- Adverse actions taken by the Drug Enforcement Administration (DEA) against a practitioners controlled substance registration;
- Exclusions from participation in Medicare, Medicaid, and other federal health care programs;
- Negative actions or findings by peer review and private accreditation organizations;
- Actions taken by certain state agencies, such as law enforcement, Medicaid Fraud Control Units, or state agencies administering state health care programs; and
- Health-care related criminal convictions and civil judgments.[112]

Certain entities are required to submit the above-referenced actions to the NDPB. These include medical malpractice payers, hospitals and other health care entities, state licensing agencies, health plans, peer review and private accreditation organizations, federal government agencies, federal and state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering state health care programs.[113]

The information in the NPDB is not available to the general public and is limited to certain entities. Entities that may access the NPDB include:

- Hospitals and other health care entities;
- State licensing and certification authorities;
- State Medicaid Fraud Control Units;
- State agencies administering or supervising the administration of state health care programs;
- Agencies administering federal health care programs;
- Health plans;
- Medical malpractice payers;
- Health care practitioner or entities requesting information on themselves; and
- State and federal law enforcement agencies.[114]

Although, the database initially only contained information related to physicians and dentists, it now includes many other types of health care practitioners.[115]

As a part of the licensure process, DOH queries the database at the time of initial licensure and at each biennial renewal.[116]

Telehealth Barriers

There are several barriers which impede the use of telehealth. These barriers include:[117]

- Lack of a standard definition for telehealth;
- Lack of standard regulations for the practice of telehealth;
- Licensure requirements which prohibit cross-state practice; and
- Restrictions on the location where telehealth services may be provided.

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[112] *Id.*
[113] *Id* at E-1.
[114] *Id* at C-2 – C-6. In a medical malpractice action, and under certain circumstances, an attorney may request information from NPDB for use in litigation against a hospital.
[115] *Id.*
[116] Telephone conversation with DOH staff on February 20, 2017.
[117] Center for Connected Health Policy, The National Telehealth Policy Resource Center, *State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia*, (March 2016), available at http://www.cchpca.org/sites/default/files/resources/50%20State%20FINAL%20April%202016.pdf (last visited on April 11, 2017).

Standardized Definition

Lack of a standard definition[118] presents a barrier to the use of telehealth. As previously noted, there is no universally accepted definition. A health care professional is left to speculate as to whether the service he or she is providing constitutes telehealth. This can have far-reaching consequences which range from a denial of reimbursement for the services provided to an inquiry as to whether the services provided equate to the unlicensed practice of medicine. Florida law does not define telehealth.

Standardized Regulations

The absence of a uniform regulatory structure governing the use of telehealth presents another barrier to its use. Currently, seven states[119] do not have any statutory structure for the delivery of health care services through telehealth.[120] This absence places the burden upon individual professionals to determine what is appropriate, and invites health professional licensing boards to fill the regulatory gap. This can lead to inconsistent regulation of telehealth amongst the varying health care professions and impede the use of telehealth.

For example, a common telehealth regulation is the requirement that a health care professional conduct an in-person examination of the patient prior to providing services via telehealth.[121] Many times an exception is expressly contained within the regulation which allows the in-person requirement to be met through telehealth.[122] This exception, however, can vary by profession in the absence of a uniform regulation. For example, an audiologist may be authorized to conduct the initial evaluation through telehealth while a physical therapist is required to perform an in-person physical examination prior to providing services through telehealth. There may not be any reasonable justification for this disparate treatment.

Licensure

Licensure requirements present one of the greatest barriers to the use of telehealth. Currently, 30 states prohibit a health care professional from using telehealth to provide health care services unless the professional is licensed in the state where the patient is located.[123] Most states have exceptions to this requirement, applicable only in certain limited circumstances, which include: [124]

- Physician-to-physician consultations (not between practitioner and patient);
- Educational purposes;
- Residency training;
- Licensure in a border state;
- U.S. Military;
- Public health services; and
- Medical emergencies (Good Samaritan) or natural disasters.

Nine states require out-of-state licensed health care professionals to acquire a special telehealth license or certificate to provide health care services through telehealth to patients in those states.[125]

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[118] *Id*. No two states define telehealth exactly alike, although some similarities in language exist between certain states.
[119] Florida currently has no statutory framework for regulating health care services provided via telehealth. However, the Board of Medicine has promulgated rules establishing standards for telemedicine practice (see below).
[120] Even amongst states with telehealth statutory regulations, no two states regulate telehealth in exactly the same manner. *Supra* note 117.
[121] *Id*.
[122] *Id*.
[123] *Id*. This includes Florida.
[124] Telehealth Resource Centers, *Cross-State Licensure*, http://www.telehealthresourcecenter.org/toolbox-module/licensure-and-scope-practice (last visited on April 11, 2017).
[125] These states are Alabama, Louisiana, Maine, New Mexico, Ohio, Oklahoma, Oregon, Tennessee, and Texas. Additionally, there are 12 states who have adopted the Interstate Medical Licensure Compact which allows for expedited licensure for licensed physicians

Two of these states (Tennessee and Texas), however, only offer the telehealth license to physicians who are board-eligible or board-certified specialists.

In the absence of an exception or a state regulation authorizing otherwise, it appears that a health care professional must be licensed in the state where the patient is located to provide health care services through telehealth. Requiring health care professionals to obtain multiple state licenses to provide health care services through telehealth may be burdensome and may inhibit the use of telehealth across state borders.

Location Restrictions

Generally, states impose two types of location restrictions. The first is a geographical restriction which limits the use of telehealth to certain designated areas within a state. For example, only individuals in areas designated as a rural area or a medically underserved area may be authorized to receive health care services through telehealth.

The second restriction relates to limitations on the specific location where telehealth services may be provided. The most common example of this type of limitation is the hub and spoke model.[126] Under this model, "hub" refers to the location to where the health care professional must be located while "spoke" refers to the location where the patient must be located.

The two types of restrictions are not mutually exclusive and are commonly used in conjunction. This presents a significant obstacle to access to care by placing arbitrary restrictions on the use of telehealth which inhibits the effectiveness, as well as the use of telehealth to deliver health care services.

Telehealth in Florida

Florida does not have a statutory structure for the delivery of health care services through telehealth.[127] References to telehealth in the Florida Administrative Code relate to the Board of Medicine,[128] the Board of Osteopathic Medicine,[129] the Child Protection Team program,[130] and the Florida Medicaid program.[131]

Florida Board of Medicine

In 2003, the Florida Board of Medicine (Board) adopted Rule 64B8-9.014, F.A.C., "Standards for Telemedicine Prescribing Practice" (Rule).[132] The Rule sets forth requirements and restrictions for physicians and physician assistants prescribing medications.[133] The Rule also states that telemedicine "shall include, but is not limited to, prescribing legend drugs to patients through the following modes of communication: (a) Internet; (b) Telephone; and (c) Facsimile."[134] The Rule, however, fails to fully

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whose state is a member of the compact. Those states are Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, Wisconsin, and Wyoming. *Supra* note 117.

[126] Florida's Department of Health's Children's Medical Services Program (CMS) currently uses the hub and spoke model to provide services via telehealth to children enrolled in the program.

[127] The only references to telehealth in the Florida Statutes are in ss. 364.0135, 381.885, and 394.453, F.S. Section 364.0135, F.S., relates to broadband internet services and does not define or regulate telehealth in any manner. Section 381.885, F.S., relates to epinephrine auto-injectors and expressly states that consultation for the use of the auto-injector through electronic means does not constitute the practice of telemedicine. Section 394.453, F.S., provides legislative intent for the Florida Mental Health Act, in which 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.

[128] Rule 64B8-9.0141, F.A.C.

[129] Rule 64B15-14.0081, F.A.C.

[130] Rule 64C-8.003, F.A.C.

[131] Rule 59G-1.057, F.A.C.

[132] The current telemedicine rules and regulations for the Board of Medicine and the Board of Osteopathic Medicine are virtually identical. Rules 64B8-9.0141 and 64B15-14.0081, F.A.C.

[133] Rule 64B8-9.0141, F.A.C.

[134] *Id*.

define telemedicine and does not regulate its use in any other way. The Board only regulates allopathic physicians, so this rule does not apply to any other profession.[135]

In 2014, the Board adopted a new rule[136] setting forth standards for telemedicine.[137] The new rule defines telemedicine as 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.[138] The definition could be interpreted to limit the use of telemedicine to physicians and physician assistants; however, the Board does not have the authority to regulate other professions.[139] The new rule provides that: [140]

- The standard of care is the same as that required for services provided in person;
- A physician-patient relationship may be established through telemedicine;
- A physician or physician assistant is responsible for the quality and safety of the equipment and used to provide services through telemedicine; and
- The same patient confidentiality and record-keeping requirements applicable to in-person services are applicable to services provided through telemedicine.

The new rule prohibits physicians and physician's assistants from providing treatment recommendations, including issuing a prescription, through telemedicine unless the following has occurred:[141]

- A documented patient evaluation, including history and physical examination to establish the diagnosis for which any legend drug is prescribed;
- A discussion between the physician or the physician assistant and the patient regarding treatment options and the risks and benefits of treatment; and
- Contemporaneous medical records are maintained.

The new rule prohibits prescribing controlled substances through telemedicine except for the treatment of psychiatric disorders.[142] However, the new rule does not preclude physicians from ordering controlled substances through the use of telemedicine for patients hospitalized in a facility licensed pursuant to 395, F.S.[143]

Telehealth Advisory Council

In 2016, the Legislature passed House Bill 7087,[144] which created a 15-member Telehealth Advisory Council to make recommendations to increase the use and accessibility of services provided via telehealth, as well as any implementation or access barriers, to the Legislature and the Governor. The recommendations are to be based on a report prepared by the Agency for Healthcare Administration (AHCA), along with the Department of Health (DOH), and the Office of Insurance Regulation (OIR) regarding telehealth utilization and coverage. The bill required the agencies to conduct a survey of health care practitioners, health care facilities, and insurers to collect the following information:

- The types of health care services provided via telehealth;
- The extent to which telehealth is used by telehealth is used by health care practitioners and health care facilities nationally and in the state;

[135] The Board of Osteopathic Medicine rule only applies to osteopathic physicians.
[136] The Board of Medicine and the Board of Osteopathic Medicine rules for telemedicine are virtually identical.
[137] Rule 64B8-9.0141, F.A.C.
[138] *Id*.
[139] The Board of Osteopathic Medicine definition only applies to osteopathic physicians.
[140] *Supra* note 137.
[141] *Id*.
[142] *Id.*
[143] *Id*.
[144] Chapter 2016-240, Laws of Fla.

- The estimated costs and cost savings to health care entities, health care practitioners, and the state associated with the use of telehealth to provide health care services; and
- Which health care insurers, health maintenance organizations, and managed care organizations cover health care services provide to patients in this state via telehealth, whether the coverage is restricted or limited, ad how such coverage compares to that insurer's coverage for services provided in person.

In December 2016, AHCA issued a report on the results of the surveys conducted that addressed accessibility and usage of telehealth services in this state, as well as research findings.[145] Of the 11,900 health care facilities surveyed by AHCA, 49 percent responded to the survey; all of the 54 health plans surveyed by OIR responded to the survey; and DOH received 26,579 responses to its survey.

Among health care facilities surveyed by AHCA, approximately 45% of hospitals responding to the survey offer telehealth services through their facilities.[146] The facilities indicated that the benefits of providing services using telehealth included patient convenience, better care coordination, better patient outcomes, and better access to specialists. Health care facilities use telehealth most often to diagnose and treat patients, provide emergency care, or to provide or obtain a second opinion. The health care facilities also identified the greatest barriers to services using telehealth. The ongoing challenges for offering telehealth include, among other things, lack of health insurance reimbursement for services provided using telehealth, lack of funding for telehealth equipment, and an inability to determine the return on investment.

Although a national survey of health care executives in 2016 reported 63 percent of health care practitioners provide some services via telehealth, the survey conducted by DOH found that only six percent of the responding health care practitioners in Florida use telehealth to provide health care services.[147] The health care practitioners indicated that the major factors in adopting the use of telehealth in their private practice include the lack of insurance reimbursement for services provided using telehealth, lack of funding for telehealth equipment, and inability to determine return on investment.[148]

OIR found that 43 percent of Florida health insurers cover some form of telehealth services.[149] However, that coverage is usually very limited. Unlike 29 other states, Florida does not have any statutory requirements that coverage and reimbursement for telehealth services be covered the same as face-to-face services. The surveyed health plans indicated that the greatest barriers to covering and reimbursing for services provided using telehealth include government regulation,[150] concerns with liability, costs of the still evolving technology, and a need to significantly change payment and reimbursement guidelines.

The final report of the Telehealth Advisory Council' recommendations is due to the Governor and Legislature on or before October 31, 2017.

Child Protection Teams

A Child Protection Team (CPT) is a medically directed multi-disciplinary group that works with local sheriffs' offices and the Department of Children and Families to supplement investigative activities in

[145] Agency for Health Care Administration, *Florida Report on Telehealth Utilization and Accessibility*, (December 2016), available at http://www.ahca.myflorida.com/SCHS/telehealth/docs/Telehealth_Report_Final.pdf (last visited on April 12, 2017).
[146] *Id*.
[147] *Id*.
[148] *Id*.
[149] *Id*.
[150] *Id*. This includes issues of interstate practice since each state is responsible for licensing the health care practitioners that provide services in its state.

cases of child abuse and neglect.[151] The CPT program within the Children's Medical Services (CMS) program utilizes a telehealth network to perform child assessments. The use of telemedicine[152] under this program requires the presence of a CMS approved physician or advanced registered nurse practitioner at the hub site and a registered nurse at the remote site to facilitate the evaluation.[153] In 2014, CPT telehealth services were available at nine sites and 667 children were provided medical or other assessments via telehealth technology.[154]

Florida Emergency Trauma Telemedicine Network

Various designated trauma centers participate in the Florida Emergency Trauma Telemedicine Network (FETTN). Coordinated by the Department of Health (DOH), the FETTN facilitates the treatment of trauma patients between trauma centers and community or rural hospitals.[155]

Tuberculosis Physician's Network

The DOH utilizes tele-radiology through the Tuberculosis Physician's Network.[156] The ability to read electronic chest X-Rays remotely can lead to a faster diagnosis, treatment and a reduction in the spread of the disease, according to DOH. This service is not currently reimbursed by Medicaid.

Florida Medicaid Program

Under the Medicaid Medical Assistance (MMA) Program implemented in 2014, the vast majority of Medicaid recipients are covered through managed care. Florida Medicaid, in its fee-for-service delivery system, reimburses for telehealth services using interactive telecommunications equipment that includes, at a minimum audio and video equipment that permits two-way, real time, interactive communication between a patient and a practitioner.[157] Not only may MMA plans use telehealth for behavioral health, dental, and physician services as before, but upon approval by AHCA, may also use telehealth to provide other covered services.[158]

Jurisdiction and Venue

A Florida court has jurisdiction over a resident health care practitioner due to his or her presence in the state. For a nonresident health care profession, a Florida patient must establish in court that:

- The health care practitioner subjected himself or herself to jurisdiction through Florida's long-arm statute; and
- The health care practitioner had sufficient minimum contacts with the state so that he or she could reasonably anticipate being haled into court in Florida.[159]

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[151] Florida Department of Health, *Child Protection Teams*, available at http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html (last visited on April 13, 2017).
[152] Rule 64C-8.001(5), F.A.C., defines telemedicine as "the use of telecommunication and information technology to provide clinical care to individuals at a distance and to transmit the information needed to provide that care."
[153] Rule 64C-8.003(3), F.A.C.
[154] Florida Department of Health, *Maternal and Child Health Block Grant Narrative for 2014,* available at http://www.floridahealth.gov/healthy-people-and-families/womens-health/pregnancy/mch-fl-2013-1narrative.pdf, p.21, (last visited on April 13, 2017).
[155] Florida Department of Health, 2014 Agency Legislative Bill Analysis of HB 167, (October 21, 2013), on file with the Health and Human Services committee.
[156] *Id*.
[157] Rule 59G-1.057, F.A.C.
[158] Agency for Health Care Administration, Model Contract, Attachment II, Exhibit II A, Medicaid Managed Medical Assistance Program, (November 2016), available at http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2017-02-01/02-01-17_EXHIBIT_II-A_MMA.pdf (last viewed on April 13, 2017).
[159] *Venetian Salami Co. v. Parthenais*, 554 So.2d 499, 501 (Fla. 1989).

Under the long-arm statute, any health care practitioner (irrespective of whether he or she is a resident of the state) who commits certain enumerated acts is subject to the jurisdiction of the courts of Florida.[160] Such acts include:

- Operating, conducting, engaging in, or carrying on a business or business venture in this state or having an office or agency in this state;
- Committing a tortious act within this state;
- Causing injury to persons or property within this state arising out of an act or omission by the defendant outside this state, if, at or about the time of the injury, the health care practitioner was engaged in solicitation or service activities in this state; and
- Breaching a contract in this state by failing to perform act required by the contract to be performed in this state.[161]

"Venue" refers to the geographical area, that is the county or district, where a cause may be heard or tried.[162] For Florida residents, actions may be brought in the county where the defendant resides, where the cause of action accrued, or where the property in litigation is located.[163] An action against a nonresident may be brought in any county of the state.[164]

Service of process on a person outside of the state may be made by any officer authorized to serve process in the state where the person is served.[165]

Insurance Premium Tax and Credits

Florida's insurance premium tax was established in 1895 as an annual tax of 1% of gross receipts of insurance premiums (except for life insurance) on each insurance company doing business within the state.[166] Today, the insurance premium tax is set at 1.75% on insurance premiums written in Florida and paid by insurance companies to the Department of Revenue (DOR).[167] It is estimated that DOR will collect $739.5 million in insurance premium tax in FY 2016-17.[168] This revenue is distributed to general revenue and various trust funds:[169]

Receipts			**Distributions†**			
Fiscal Year	Collections	Annual Change	General Revenue	Insurance Regulatory Trust Fund	Police & Firefighters Premium Tax Trust Fund	Emergency Management Preparedness & Assistance Trust Fund
2017-18*	$777,900,000	4.53%	$523,500,00	$41,000.000	$193,000,000	$14,800,000
2016-17*	$744,200,000	5.72%	$507,900,000	$39,800,000	$186,100,000	$14,500,000
2015-16	$703,914,531	2.18%	$471,500,000	$37,500,000	$175,900,000	$14,500,000
2014-15	$688,898,528	-3.23%	$466,500,000	$36,700,000	$169,700,000	$13,900,000
2013-14	$711,866,203	1.43%	$470,500,000	$39,700,000	$173,100,000	$13,600,000
* Estimate † Distributions do not equal collections due to beginning and ending cash balances and refunds.						

[160] Section 48.193(1), F.S.
[161] *Id*.
[162] *Metnick & Levy, P.A. v. Seuling*, 123 So.3d 639 (Fla. 4th DCA 2013).
[163] Section 47.011, F.S.
[164] *Supra* note 162. This is subject to the doctrine of forum non conveniens.
[165] Section 48.194, F.S.
[166] Chapter 4322, Laws of Fla., codified as Title VI, ch. 1, s. 464, F.S.
[167] Section 624.509, F.S.
[168] Florida Revenue Estimating Conference, "2017 Florida Tax Handbook," p. 112, available at http://edr.state.fl.us/Content/revenues/reports/tax-handbook/taxhandbook2017.pdf (last visited on April 13, 2017).
[169] *Id*.

Section 624.5091, F.S., requires out of state insurance to pay retaliatory taxes to the state.[170] These retaliatory taxes are levied in almost every state[171] and help ensure a level playing field by preventing companies from choosing to locate in one state in order to lower their insurance premium taxes.[172] Insurance companies are permitted to receive an employees' salary credit and corporate income tax credit against insurance premium taxes.[173,174]

Florida Employee Salaries Credit

In 1985, the U.S. Supreme Court ruled in *Metropolitan Life Insurance Company v. Ward*[175] that a domestic preference provision in Alabama's insurance tax law similar to the preference provision in Florida at the time violated the Equal Protection Clause. Florida and other states looked for ways to provide tax breaks to their domestic insurance companies that would pass constitutional muster, and the Florida Legislature responded by repealing its own domestic preference provision and replacing it with an employees' salary credit equal to 15% of the amount of salaries paid to employees located in Florida.[176]

In FY 2016-17 the employees' salary credit is estimated to reduce insurance premium tax revenue to DOR by $297.38 million.[177]

Corporate Income Tax and Credit

Florida imposes a 5.5% tax on the taxable income of all corporations doing business in the state.[178] The determination of taxable income for Florida tax purposes begins with the taxable income used for federal income tax purposes.[179] This means that a corporation paying taxes in Florida generally receives the same benefits from deductions allowed in determining its federal taxable income. With federal taxable income as a starting point, Florida law then requires a variety of additions and subtractions to reflect Florida-specific policies to determine Florida taxable income. The Florida corporate income tax uses a three-factor apportionment formula consisting of property, payroll, and sales (which is double-weighted) to measure the portion of a multistate corporation's business activities attributable to Florida.[180] Income that is apportioned to Florida using this formula is then subject to the Florida income tax.

Corporate income taxes paid by any insurer are credited against the liability for insurance premium tax for the annual period in which such tax payments are made.[181] The total of the credit granted for corporate income taxes[182] and the Florida employees salary credit may not exceed 65 percent of the insurance premium tax due after deducting taxes paid by the insurer for certain pension funds and assessments.[183]

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[170] Section 624.5091, F.S.
[171] *Supra* note 168, at 115.
[172] Office of Program Analysis and Government Accountability, *The Corporate Income Tax Credit Scholarship Program Saves the State Dollars*, Report No. 08-68, December 2008, available at http://www.oppaga.state.fl.us/reports/pdf/0868rpt.pdf (last visited on April 13, 2017).
[173] Section 624.509(4), F.S.
[174] Section 624.509(5), F.S.
[175] 470 U.S. 869, 105 S.Ct. 1676.
[176] *Supra* note 174.
[177] *Supra* note 168, at 115.
[178] Section 220.11, F.S.
[179] Sections 220.12 and 220.13, F.S.
[180] s. 220.15, F.S.
[181] Florida Senate Committee on Finance and Tax, *An Overview of Florida's Insurance Premium Tax*, October 2006, available at http://archive.flsenate.gov/data/Publications/2007/Senate/reports/interim_reports/pdf/2007-122ftlong.pdf (last visited on April 11, 2017).
[182] Section 624.509(4), F.S.
[183] *Id*.

In FY 2016-17, the corporate income tax credit is estimated to reduce insurance premium tax revenue by $157.6 million.[184]

Effect of Proposed Changes

Advanced Practice Registered Nurses

The bill changes the term "advanced registered nurse practitioner" to "advanced practice registered nurse" (APRN) throughout Florida Statutes. The bill also authorizes an APRN to certify a person for involuntary examination under the Baker Act.[185]

Independent Advanced Practice Registered Nurses

The bill authorizes an APRN who meets certain eligibility criteria to register as an "Independent Advanced Practice Registered Nurse." The bill establishes title protection for this new title.

To register as an Independent Advanced Practice Registered Nurse (IAPRN), the applicant must hold an active and unencumbered APRN certificate under s. 464.012, F.S., pay an application fee set by the Board (not to exceed $100), and must have:

- Completed, in any U.S. jurisdiction, at least 4,000 clinical practice hours supervised by an actively licensed physician;
- Completed at least 2,000 clinical practice hours within the 3-year period immediately before submission of the application. If these hours are supervised, they may count toward meeting the requirement of completing 4,000 clinical practice hours supervised, as indicated above.
- Not been subject to any disciplinary action during the five years immediately preceding the application; and
- Completed a graduate level course in pharmacology.

To maintain their registration, IAPRNs must complete at least 10 hours of continuing education approved by the Board in pharmacology for each biennial renewal. [186] The IAPRN registration renewal will coincide with the his or her licensure renewal period. APRNs registered as IAPRNs must also ensure that their practitioner profiles created by the Department of Health reflect their registration as an IARPN.

IAPRNs are authorized to perform any act currently authorized for APRNs, but may perform such acts without the supervision of a physician or a written protocol. In addition to those acts, an IAPRN may independently and without supervision or a written protocol perform the following acts:

- Admit, discharge, or manage the care of a patient requiring the services of a health care facility.
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.
- Certify causes of death and sign, correct, and file death certificates.
- Act as a patient's primary care provider.
- Execute a certificate to subject a person to involuntary examination under the Baker Act.
- Examine, and approve the release of, a person admitted into a receiving facility under the Baker Act, if the IAPRN holds a national certification as a psychiatric-mental health advanced practice nurse.

[184] *Supra* note 168, at 115.
[185] The Baker Act is also titled the "Florida Mental Health Act" under s. 394.451, F.S.
[186] The bill provides an exception to the 10 hours of continuing education in pharmacology for an IAPRN whose biennial renewal is due before January 1, 2018. However, this requirement must be met during the subsequent biennial renewal periods.

- Perform certain physical examinations currently reserved to physicians and physician assistants by Florida law, such as examinations of pilots, law enforcement officers, and suspected child abuse victims.

The bill imposes safeguards to ensure IAPRNs safely prescribe controlled substances and are held accountable if they do otherwise. Specifically, IAPRNs:

- Must report adverse incidents attributable to the prescription of a controlled substance. Adverse incidents are only those events that require the transfer of a patient to a hospital or cause permanent physical injury or death.
- May be administratively disciplined for several delineated prohibited acts related to inappropriate prescribing practices.
- Are required to register as prescribers of controlled substances for chronic nonmalignant pain, if they prescribe such substances, and must meet statutory requirements related to treatment plans, recordkeeping, patient examinations, written agreements, and referrals.
- Must comply with the prescribing and dispensing requirements and limitations under the Florida Comprehensive Drug Abuse Prevention and Control Act.[187]

In addition, the bill provides for several other accountability measures for IAPRNs by:

- Requiring IAPRNs to maintain malpractice insurance or prove financial responsibility as provided by Board rule to ensure claims due to malpractice are covered;
- Authorizing the Board to administratively discipline IAPRNs for several delineated prohibited acts related to relationships with patients, business practices, and nursing practices; and
- Subjecting IAPRNs to accountability provisions included in the Florida Patient's Bill of Rights and Responsibilities.[188]

Physician Assistants

The bill expands the scope of practice for PAs to authorize them to:

- Perform physical examinations to detect child abuse or neglect and for purposes of pilot certification;
- Certify a person for involuntary examination under the Baker Act; and
- File death certificates and certify a cause of death.

The bill also requires PAs to comply the Florida Patient's Bill of Rights and Responsibilities Act.

The bill also authorizes PAs to participate in the Public School Volunteer Health Care Practitioner Program. This program allows any participating health care practitioner who agrees to provide his or her services, without compensation, in a public school for at least 80 hours a year for each school year during the biennial licensure period to be eligible for waiver of the biennial license renewal fee for an active license and fulfillment of a maximum of 25 percent of the continuing education hours required for license renewal under s. 456.013(9), F.S.

Telehealth

The bill creates s. 456.47, F.S., relating to the use of telehealth to provide health care services.

[187] Chapter 893, F.S.
[188] Section 381.026, F.S., requires health care providers to provide patients with certain information related to qualifications, diagnosis, treatment, grievance procedures, and service charges. Also, health care providers are prohibited from discriminating against a patient for specified reasons and must respect a patient's privacy under this law.

"Telehealth" is defined in the bill to mean the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services including, but not limited to, patient assessment, diagnosis, consultation, and treatment, monitoring transfer of medical data, patient and professional health-related education, public health services, and health administration. The definition of telehealth does not include audio-only telephone calls, e-mail messages, or facsimile transmissions. Thus, health care professionals can use telehealth to provide services to patients through both "live" and "store and forward" methods. It also authorizes the use of telemonitoring. The definition does not place any additional limitations on the type of technology that can be used in telehealth. However, both HIPAA and HITECH continue to apply to covered entities.

Telehealth Providers

The bill defines "telehealth provider" as any person who provides health care related services using telehealth and who is licensed in Florida or is an out-of-state health care registered and is in compliance with the requirements of this bill. Florida licensed telehealth provides must be one of the following professionals:[189]

- Behavior analyst;
- Acupuncturist;
- Allopathic physician;
- Osteopathic physician;
- Chiropractor;
- Podiatrist;
- Optometrist;
- Nurse;
- Pharmacist;
- Dentist;
- Dental Hygienist;
- Midwife;
- Speech therapist;
- Occupational therapist;
- Radiology technician;
- Electrologist;
- Orthotist;
- Pedorthist;
- Prosthetist;
- Medical physicist;
- Emergency Medical Technician;
- Paramedic;
- Massage therapist;
- Optician;
- Hearing aid specialist;
- Clinical laboratory personnel;
- Respiratory therapist;
- Physical therapist;
- Psychologist;
- Psychotherapist;
- Dietician/Nutritionist;
- Athletic trainer;

[189] These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part III, part IV, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

- Clinical social worker;
- Marriage and family therapist; or
- Mental health counselor.

Out-of-state telehealth providers must register biennially with DOH or the applicable board to provide telehealth services, within the relevant scope of practice established by Florida law and rule, to patients in this state. To register or renew registration as an out-of-state telehealth provider, the health care professional must:

- Submit an application to DOH;
- Pay a $150 registration fee;
- Hold an active unencumbered license, consistent with the definition of "telehealth provider" listed above, in a U.S. state or jurisdiction and against whom no disciplinary action has been taken during the five years before submission of the application;[190] and
- Never have had a license revoked in any U.S. state or jurisdiction.

The bill prohibits an out-of-state telehealth provider from opening an office in Florida and from providing in-person health care services to patients located in Florida.

The bill requires out-of-state telehealth providers to notify the applicable board or DOH of restrictions placed on the health care professional's license to practice or disciplinary actions taken against the health care practitioner within 5 days after such occurrence.

The bill authorizes a board, or DOH if there is no board, to revoke an out-of-state telehealth provider's registration if the registrant:

- Fails to notify DOH of any adverse actions taken against his or her license within 5 days after such adverse action;
- Has restrictions placed on or disciplinary action taken against his or her license in any state or jurisdiction; or
- Violates any of the requirements for the registration of out-of-state telehealth providers.

The bill requires DOH to publish on its website the name of each registered out-of-state telehealth provider. It must also include the following background information, to the extent applicable, for each registrant:

- Health care occupation;
- Completed health care training and education, including completion dates and any certificates or degrees obtained;
- Out-of-state health care license with license number;
- Florida telehealth provider registration number;
- Specialty;
- Board certification;
- 5 year disciplinary history, including sanctions and board actions; and
- Medical malpractice insurance provider and policy limits, including whether the policy covers claims which arise in this state.

Telehealth Provider Standards

The bill establishes that the standard of care for telehealth providers is the same as the standard of care for health care practitioners or health care providers providing in-person health care services to

[190] The bill requires DOH to consult the National Practitioner Data Bank to verify whether adverse information is available for the registrant.

patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services.

Under the bill a telehealth provider is not required to research a patient's medical history or conduct a physical examination of the patient before providing telehealth services to the patient if the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth. The bill also allows the evaluation to be performed using telehealth.

The bill provides that a patient receiving telehealth services may be in any location at the time that the telehealth services are rendered and that a telehealth provider may be in any location when providing telehealth services to a patient.

The bill allows health care providers who are authorized to prescribe a controlled substance to use telehealth to prescribe controlled substances. Telehealth may not be used to prescribe a controlled substance to treat chronic nonmalignant pain, unless ordered by a physician for inpatient treatment at a facility licensed under ch. 395, F.S., prescribed for a patient receiving hospice services as defined under s. 400.601, F.S., or prescribed for a resident of a nursing home facility as defined under s. 400.021(12), F.S.

The bill requires that a telehealth provider document the telehealth services rendered in the patient's medical records according to the same standard as that required for in-person services. The bill requires that such medical records be kept confidential consistent with ss. 395.3025(4) and 456.057, F.S. Section 456.057, F.S., relates to all licensed health care professionals while s. 395.3025(4), F.S., relates to all health care facilities licensed under ch. 395 (hospitals, ambulatory surgical centers, and mobile surgical centers). Thus, the same confidentiality requirements placed upon health care facilities and health care practitioners for medical records generated as part of in-person treatment apply to any medical records generated as part of treatment rendered through telehealth.

The bill provides that a non-physician telehealth provider using telehealth and acting within the applicable scope of practice, as established under Florida law, may not be interpreted as practicing medicine without a license.

The bill establishes, for jurisdictional purposes, that any act that constitutes the delivery of health care services shall be deemed to occur at the place where the patient is located at the time the act is performed. This will assist a patient in establishing jurisdiction and venue in Florida in the event he or she pursues a legal action against the telehealth provider.

The bill provides exceptions to the registration requirement for emergencies or for consultations between health care practitioners.

The bill requires a registered telehealth provider, who is a pharmacist, to use a pharmacy holding a Florida permit, a nonresident pharmacy registered in Florida, or a nonresident pharmacy or outsourcing facility holding a nonresident sterile compounding permit to dispense medicinal drugs to Florida patients.

The bill authorizes DOH or an applicable board to adopt rules to administer the requirements related to telehealth set forth in the bill.

Telehealth Tax Credit

For tax years beginning on or after January 1, 2018, the bill creates a telehealth tax credit for any health insurer or health maintenance organization (HMO) that cover services provided by telehealth. The tax credit maybe taken against any corporate income tax or insurance premium tax liability incurred by a health insurer or HMO. The tax credit is one tenth of one percent of the total insurance premiums

received on accident or health insurance policy or plans issued in Florida that provide medical, major medical, or similar comprehensive coverage. The Office of Insurance Regulation (OIR) must confirm the coverage to the Department of Revenue (DOR). The bill authorizes an unused tax credit or portion thereof to be carried forward for a period not to exceed five years.

The bill authorizes DOR, in addition to its existing audit and investigation authority, additional authority to perform financial and technical audits and investigations to verify eligibility for the telehealth tax credit. Such audits and investigations may include examining the accounts, books, and records of the health insurer or HMO. The bill also directs OIR to provide technical assistance upon request by DOR on any audits or investigations it performs. If DOR discover that a health insurer or health maintenance organization received a telehealth tax credit for which it was not entitle, DOR is authorized to pursue recovery of the funds in accordance to the law.

The bill authorizes a health insurer or HMO to transfer a telehealth tax credit in whole or in part to another insurer by written agreement. To perfect the transfer, the transferor must provide a written statement to DOR that states:

- The transferor's intent to transfer the tax credit to the transferee;
- The date the transfer is effective;
- The transferee's name, address, and federal taxpayer identification number;
- The tax period; and
- The amount the tax credit to be transferred.

Upon receipt of the transfer statement, DOR will issue a certificate reflecting the transferred credit amount, a copy of which must be attached to each tax return for which the transferee seeks to apply the credit.

An insurer that claims the telehealth tax credit is not required to pay any additional retaliatory tax, as a result of claiming such a credit.

DOR and OIR are authorized to adopt rules to administer the telehealth tax credit, including rules regarding implementation and administration of the tax credit and forms needed to claim the telehealth tax credit.

The bill provides an effective date of July 1, 2017, except as otherwise expressly provided in the bill.

B. SECTION DIRECTORY:

Section 1: Creates s. 456.47, F.S., relating to the use of telehealth to provide services.
Section 2: Provides an appropriation.
Section 3: Creates s. 220.197, F.S., relating to the telehealth tax credit.
Section 4: Amends s. 624.509, F.S., relating to the premium tax; rate and computation.
Section 5: Amends s. 464.003, F.S., relating to definitions.
Section 6: Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners; fees; and controlled substance prescribing.
Section 7: Creates s. 464.0125, F.S., relating to registration of independent advanced practice registered nurses and fees.
Section 8: Amends s. 464.015, F.S., relating to titles and abbreviations; restrictions; and penalty.
Section 9: Creates s. 464.0155, F.S., relating to reports of adverse incidents by independent advanced practice registered nurses.
Section 10: Amends s. 464.016, F.S., relating to violations and penalties.
Section 11: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 12: Amends s. 39.303, F.S., relating to child protection teams; services; and eligible cases.
Section 13: Amends s. 39.304, F.S., relating to photographs, medical examinations, X rays, and medical treatment of abused, abandoned, or neglected child.

Section 14: Amends s. 90.503, F.S., relating to psychotherapist-patient privilege.
Section 15: Amends s. 110.12315, F.S., relating to the prescription drug program.
Section 16: Amends s. 112.0455, F.S., relating to the Drug-Free Workplace Act.
Section 17: Amends s. 121.0515, F.S., relating to Special Risk Class.
Section 18: Amends s. 252.515, F.S., relating to the Postdisaster Relief Assistance Ac; immunity from civil liability.
Section 19: Amends s. 310.071, F.S., relating to deputy pilot certification.
Section 20: Amends s. 310.073, F.S., relating to state pilot licensing.
Section 21: Amends s. 310.081, F.S., relating to department to examine and license state pilots and certificate deputy pilots; vacancies.
Section 22: Amends s. 320.0848, F.S., relating to persons who have disabilities, issuance of disabled parking permits, temporary permits, and permits for certain providers of transportation services to persons who have disabilities.
Section 23: Amends s. 381.00315, F.S., relating to public health advisories, public health emergencies; isolation and quarantines.
Section 24: Amends s. 381.00593, F.S., relating to public school volunteer health care practitioner program.
Section 25: Amends s. 381.026, F.S., relating to Florida Patient's Bill of Rights and Responsibilities.
Section 26: Amends s. 382.008, F.S., relating to death and fetal death registration.
Section 27: Amends s. 383.14, F.S., relating to screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
Section 28: Amends s. 383.141, F.S., relating to prenatally diagnosed conditions; patient to be provided information; definitions; information clearinghouse; and advisory council.
Section 29: Amends s. 384.27, F.S., relating to physical examination and treatment.
Section 30: Amends s. 390.0111, F.S., relating to termination of pregnancies.
Section 31: Amends s. 390.012, F.S., relating to powers of agency; rules; and disposal of fetal remains.
Section 32: Amends s. 394.455, F.S., relating to definitions.
Section 33: Amends s. 394.463, F.S., relating to involuntary examination.
Section 34: Amends s. 395.0191, F.S., relating to staff membership and clinical privileges.
Section 35: Amends s. 395.602, F.S., relating to rural hospitals.
Section 36: Amends s. 395.605, F.S., relating to emergency care hospitals.
Section 37: Amends s. 397.311, F.S., relating to definitions.
Section 38: Amends s. 397.405, F.S., relating to exemptions from licensure.
Section 39: Amends s. 397.427, F.S., relating to medication-assisted treatment service providers; rehabilitation program; needs assessment and provision of services; persons authorized to issue takeout medication; unlawful operation; and penalty.
Section 40: Amends s. 397.501, F.S., relating to rights of individuals.
Section 41: Amends s. 397.679, F.S., relating to emergency admission; circumstances justifying.
Section 42: Amends s. 397.6793, F.S., relating to professional's certificate for emergency admission.
Section 43: Amends s. 400.021, F.S., relating to definitions.
Section 44: Amends s. 400.0255, F.S., relating to resident transfer or discharge; requirements and procedures; and hearings.
Section 45: Amends s. 400.172, F.S., relating to respite care provided in nursing home facilities.
Section 46: Amends s. 400.462, F.S., relating to definitions.
Section 47: Amends s. 400.487, F.S., relating to home health service agreements; physician's, physician assistants, and advanced registered nurse practitioner's treatment orders; patient assessment; establishment and review of plan of care; provision of services, and orders not to resuscitate.
Section 48: Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; and penalties.
Section 49: Amends s. 400.9905, F.S., relating to definitions.
Section 50: Amends s. 400.9973, F.S., relating to client admission, transfer, and discharge.
Section 51: Amends s. 400.9974, F.S., relating to client comprehensive treatment plans; client services.

Section 52: Amends s. 400.9976, F.S., relating to administration of medication.
Section 53: Amends s. 400.9979, F.S., relating to restraint and seclusion; client safety.
Section 54: Amends s. 401.445, F.S., relating to emergency examination and treatment of incapacitated persons.
Section 55: Amends s. 409.905, F.S., relating to mandatory Medicaid services.
Section 56: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 57: Amends s. 409.9081, F.S., relating to copayments.
Section 58: Amends s. 409.973, F.S., relating to benefits.
Section 59: Amends s. 429.26, F.S., relating to appropriateness of placements and examinations of residents.
Section 60: Amends s. 429.918, F.S., relating to licensure designation as a specialized Alzheimer's services adult day care center.
Section 61: Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
Section 62: Amends s. 456.0391, F.S., relating to advanced registered nurse practitioners; information required for certification.
Section 63: Amends s. 456.0392, F.S., relating to prescription labeling.
Section 64: Amends s. 456.041, F.S., relating to practitioner profile and creation.
Section 65: Amends s. 456.048, F.S., relating to financial responsibility requirements for certain health care practitioners.
Section 66: Amends s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services.
Section 67: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; and enforcement.
Section 68: Amends s. 456.44, F.S., relating to controlled substance prescribing.
Section 69: Amends s. 458.3265, F.S., relating to pain-management clinics.
Section 70: Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 71: Amends s. 458.348, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 72: Amends s. 459.0137, F.S., relating to pain-management clinics.
Section 73: Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 74: Amends s. 459.025, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 75: Amends s. 464.004, F.S., relating to Board of Nursing; membership; appointment; and terms.
Section 76: Amends s. 464.0205, F.S., relating to retired volunteer nurse certificate.
Section 77: Amends s. 467.003, F.S., relating to definitions.
Section 78: Amends s. 480.0475, F.S., relating to massage establishments and prohibited practices.
Section 79: Amends s. 483.041, F.S., relating to definitions.
Section 80: Amends s. 483.181, F.S., relating to acceptance, collection, identification, and examination of specimens.
Section 81: Amends s. 483.801, F.S., relating to exemptions.
Section 82: Amends s. 486.021, F.S., relating to definitions.
Section 83: Amends s. 490.012, F.S., relating to violations; penalties; and injunction.
Section 84: Amends s. 491.0057, F.S., relating to dual licensure as a marriage and family therapist.
Section 85: Amends s. 491.012, F.S., relating to violations; penalty; and injunction.
Section 86: Amends s. 493.6108, F.S., relating to investigation of applicants by Department of Agriculture and Consumer Services.
Section 87: Amends s. 626.9707, F.S., relating to disability insurance; discrimination on basis of sickle-cell trait prohibited.
Section 88: Amends s. 627.357, F.S., relating to medical malpractice self-insurance.
Section 89: Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; and coinsurance and deductibles.
Section 90: Amends s. 627.6472, F.S., relating to exclusive provider organizations.

Section 91: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; and claims.
Section 92: Amends s. 633.412, F.S., relating to firefighters and qualifications for certification.
Section 93: Amends s. 641.3923, F.S., relating to discrimination against providers prohibited.
Section 94: Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
Section 95: Amends s. 744.2006, F.S., relating to Office of Public and Professional Guardians; appointment, notification.
Section 96: Amends s. 744.331, F.S., relating to procedures to determine incapacity.
Section 97: Amends s. 766.102, F.S., relating to medical negligence; standards of recovery; and expert witness.
Section 98: Amends s. 766.103, F.S., relating to Florida Medical Consent Law.
Section 99: Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
Section 100: Amends s. 766.1116, F.S., relating to health care practitioner; waiver of license renewal fees and continuing education requirements.
Section 101: Amends s. 766.118, F.S., relating to determination of noneconomic damages.
Section 102: Amends s. 768.135, F.S., relating to volunteer team physicians and immunity.
Section 103: Amends s. 782.071, F.S., relating to vehicular homicide.
Section 104: Amends s. 794.08, F.S., relating to female genital mutilation.
Section 105: Amends s. 893.02, F.S., relating to definitions.
Section 106: Amends s. 893.05, F.S., relating to practitioners and persons administering controlled substances in their absence.
Section 107: Amends s. 943.13, F.S., relating to officers' minimum qualifications for employment or appointment.
Section 108: Amends s. 945.603, F.S., relating to powers and duties of authority.
Section 109: Amends s. 948.03, F.S., terms and conditions of probation.
Section 110: Amends s. 960.28, F.S., relating to payment for victims' initial forensic physical examinations.
Section 111: Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
Section 112: Amends s. 1002.42, F.S., relating to private schools.
Section 113: Amends s. 1006.062, F.S., relating to administration of medication and provision of medical services by district school board personnel.
Section 114: Amends s. 1006.20, F.S., relating to athletics in public K-12 schools.
Section 115: Amends s. 1009.65, F.S., relating to Medical Education Reimbursement and Loan Repayment Program.
Section 116: Amends s. 1009.66, F.S., relating to Nursing Student Loan Forgiveness Program.
Section 117: Amends s. 1009.67, F.S., relating to nursing scholarship program.
Section 118: Provides an effective date of July 1, 2017, except as otherwise expressly provided in the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The Revenue Estimating Conference estimated that the tax provisions in the bill will have a recurring negative impact on General Revenue of $29 million in FY 2017-18 growing to $32.7 million in FY 2021-22.[191] The cash impacts on General Revenue begin in FY 2019-20 at $30.8 million and grow to $32.7 million in FY 2021-22.

[191] 2017 Revenue Estimating Conference, pp. 180-181, (February 24, 2017), available at http://edr.state.fl.us/Content/conferences/revenueimpact/archives/2017/_pdf/Impact0224.pdf (last visited April 13, 2017).

Applicants for registration as an IAPRN will have to pay an initial application fee, and registered IAPRNs will have to pay a biennial renewal fee, to the Department of Health. The total amount the Department of Health will receive from such fees is indeterminate, because the number of APRNs who choose to register as IAPRNs is not predictable.

The bill authorizes DOH to assess a $150 registration and registration renewal fee for out-of-state telehealth providers. The revenue generated is anticipated to be $765,000 biennially, assuming that the number of out-of-state registrants will be comparable to the experience of a similar program in Texas. Utilizing the Texas Medical Board experience of a 0.54% licensure rate would generate approximately 5,100 Florida telehealth registrants.[192]

2. Expenditures:

The bill requires out-of-state health care professionals to register with DOH prior to providing any health care services through telehealth to individuals located in Florida. The State of Texas offers a comparable telehealth license to physicians and physician's assistants out of state. There are currently 405 active telehealth licensed physicians in the state of Texas and a total 74,098 active-licensed physicians. Applying the ratio found in Texas of telehealth physicians compared to the total in-state physicians of 0.54% to the current active in-state physicians in the state of Florida, 56,060, an anticipated 303 physicians will seek telehealth licensure in Florida. Applying the same rate to the 820,248 additional medical professionals identified in the bill, an anticipated 4,743 will register as out-of-state telehealth providers in Florida. The Florida Medical Quality Assurance Division currently employs 570 positions to regulate 886,716 active in-state licenses.

The bill provides an appropriation of $261,389 recurring and $15,528 nonrecurring from the Medical Quality Assurance Trust Fund and four full time equivalent positions and $145,870 in salary rate to utilize the funds generated from the bill's $150 registration fee to offset the workload increase anticipated from an additional 4,743 registrations.

DOH, the affected regulatory boards within DOH, and the Department of Revenue may incur indeterminate, but nominal costs associated with rulemaking, which can be absorbed within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health insurers and health maintenance organizations that cover services provided by telehealth may be able to reduce their corporate income tax or insurance premium tax liability by utilizing the tax credit authorized in the bill.

Applicants for registration as an IAPRN will have to pay an application fee and IAPRNs renewing their registration will be subject to renewal fees. The bill authorizes the Board of Nursing to set the application and biennial renewal fees, but they may not exceed $100 and $50, respectively.

APRNs who have paid physicians in order to be supervised under a protocol may achieve some cost-savings if they register as an IAPRN and practice without a written protocol.

[192] Physician Statistics, Physicians In and Out of State Report, Texas Medical Board, September 2016, available at http://www.tmb.state.tx.us/dl/FA3E654D-B017-F10C-6F44-487DAE447A08 (last viewed February 2, 2017).

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides the Board of Nursing sufficient rule-making authority to implement the provisions of the bill relating to the independent practice of APRNs.

The bill provides DOH and the applicable boards with sufficient rulemaking authority to adopt rules relating the provision of telehealth services in this state.

The bill provides the Department of Revenue and the Office of Insurance Regulation sufficient rulemaking authority to adopt rules related to the implementation and administration of the telehealth tax credits.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 15, 2017, the Health Quality Subcommittee adopted an amendment that increased the experience requirement for an advanced practice registered nurse (APRN) to practice independently in this state from 2,000 hours of clinical practice while practicing as an APRN to 4,000 hours of clinical practice supervised by an actively licensed supervised physician. The amendment requires an APRN to have completed at least 2,000 clinical practice hours within the 3-year period immediately preceding the submission of the application; if these hours are supervised, they may count toward meeting the requirement of 4,000 hours of supervised clinical practice.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.