**May 2019**

Dear Health Law Section Members:

The Health Law Section (“HLS”) website has been updated with March through April 2019 articles on significant developments in the health law arena that may be of interest to you in your practice. This particular edition primarily focuses on recent Florida and Federal legislative and regulatory updates.

These summaries are presented to HLS members for general information only and do not constitute legal advice from The Florida Bar or its Health Law Section. HLS thanks the following volunteers who have generously donated their time to prepare these summaries for our members:

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**FRAUD & ABUSE UPDATES**

**Florida’s Fee-Splitting Statute and Implications on Florida’s Physicians and Physician Practice Management Companies**

Florida’s fee-splitting statute provides that the following are grounds for either denial of a license by the Florida Board of Medicine (the “Board”), or disciplinary action by the Board against a licensee: “. . . paying or receiving any commission, bonus, kickback, or rebate, or engaging in any split fee arrangement in any form whatsoever with a physician, organization, agency, or person, either directly or indirectly, for patients referred to providers of health care goods and services . . .”[[1]](#endnote-1) These prohibitions are very broad and have triggered a long line of declaratory statements, case law, and Board of Medicine findings prohibiting and allowing various types of split-fee arrangements.[[2]](#endnote-2) As a result, Florida’s fee-splitting statute is “selectively enforced,” causing unclear guidelines and inconsistent enforcement principles for physicians, physician practice groups, and physician practice management companies (“PPMCs”).[[3]](#endnote-3)

Under Section 456.072, Florida Statutes, the Board has authority to discipline health care professionals for prohibited conduct[[4]](#endnote-4) as well as authority to interpret and promulgate rules relating to the practice and business of medicine.[[5]](#endnote-5) In these instances, the Board’s discretionary power allows it to regulate the PPMC industry and more broadly, employment arrangements within the health care sphere. The various split Board rulings and declaratory statements could potentially force PPMCs with percentage-fee-based arrangements and referral network provisions to renegotiate or terminate their agreements with physicians.[[6]](#endnote-6) In turn, physicians also could advantageously demand more favorable contracts with PPMCs or stop using management companies altogether.[[7]](#endnote-7)

Historically, the Board has held that there needs to be a close nexus between the making of the referral and the payment for the making of that referral.[[8]](#endnote-8) In the seminal case *Practice Management Associates, Inc. v. Orman*, Florida’s Second District Court of Appeal upheld the decision that a chiropractor’s payment of a 10 percent management fee to Practice Management Associates, Inc., for marketing and consulting activities was a percentage-fee arrangement that was not unlawful, and did not violate either the Illinois fee-splitting statute or the Florida chiropractic fee-splitting statute.[[9]](#endnote-9) The court reinforced that the marketing efforts of Practice Management Associates did not amount to a referral of patients in Florida.[[10]](#endnote-10) The court distinguished compensation paid for the division of services from the division of fees paid for mere patient referrals in a companion case.[[11]](#endnote-11) The chiropractic fee-splitting statute is identical to the Florida fee-splitting statute applicable to physicians.[[12]](#endnote-12) This case was ground breaking in that it was upheld as strong precedent for a line of cases that subsequently followed in similar favor.[[13]](#endnote-13) *Orman* provided much needed guidance for physicians and PPMCs to understand the parameters of illegal split-fee arrangements as to managed care.

Percentage-based revenue sharing arrangements, such as those mentioned above, align the incentives of physicians and PPMCs to positively affect one another.[[14]](#endnote-14) Both sides seek a greater share of the managed care market, which is a critical tool to have given the endless amounts of network technologies and databases currently available in the health care industry.15

Although alternatives such as flat-fee arrangements may not align the goals of all parties or create an environment to work together efficiently and successfully, fee-splitting prohibitions, such as Florida’s, must be continually interpreted to reflect the different and dynamic types of arrangements prevalent in the healthcare industry today, specifically between physicians and PPMCs. As such, legislative changes are paramount to address the new and unique relations existing in the emergent and evolving health care industry in Florida.

**Submitted by: Amanda Hessein, Esq., Rutledge Ecenia, P.A.**

**LEGISLATIVE UPDATES**

**CMS Finalizes New Rule Addressing Telehealth Benefits in Medicare Advantage Health Plans**

On April 16, 2019, the Centers for Medicare & Medicaid Services (“CMS”) published its final rule implementing certain provisions of the Bipartisan Budget Act of 2018.[[15]](#endnote-15) One of the various notable issues articulated in this new rule is the expansion of coverage for telehealth benefits under Medicare Advantage plans.

Section 50323 of the Bipartisan Budget Act of 2018 created a new section of the Social Security Act that gives Medicare Advantage health plans the ability to provide “additional telehealth benefits” to Medicare enrollees starting in plan year 2020. Importantly, the new telehealth rule states that these additional telehealth benefits will be treated as “basic benefits” in the health plan.

The new rule also clearly reflects that the Medicare enrollees’ ability to choose how they receive care is a priority. To that effect, CMS states that “MA additional telehealth benefits will increase access to patient centered care by giving enrollees more control to determine when, where, and how they access benefits.”

Significantly, the new telehealth rule likely will expand Medicare enrollees’ ability to access telehealth services from home and offer additional flexibility with new telehealth services being covered as “basic benefits” under their plans. In the past, some Medicare Advantage health plans offered certain telehealth services as supplemental benefits, which were accompanied with extra costs when utilized by Medicare enrollees. As drafted, the new telehealth rule is intended to provide Medicare enrollees more choices for the delivery of services and care and more access to new healthcare technology, while attempting to keep healthcare costs down.

**Submitted by: Maria D. Garcia, Esq., Kozyak Tropin & Throckmorton**

**Congress Re-Introduces Legislation to Increase Access to Substance Use**

**Disorder Records**

In April 2019, Congress revived its bipartisan effort to provide greater flexibility in disclosing substance use disorder (“SUD”) patient records, while still recognizing the unique need to protect the confidentiality of those records. The proposed legislation seeks to, among other things, align the heightened confidentiality protections for SUD patient records under 42 C.F.R. Part 2[[16]](#endnote-16) with the disclosure standards under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Health Information Technology for Economic and Clinical Health Act (“HITECH”).[[17]](#endnote-17)

Under HIPAA, covered entities can disclose PHI without patient consent when done for the purposes of treatment, payment, and health care operations.[[18]](#endnote-18) However, Part 2 limits disclosures of SUD patient records to medical emergencies, research, or audit and evaluation.[[19]](#endnote-19) The heightened privacy protections for SUD records under Part 2 were originally motivated by an understanding that the general stigma or fear of adverse consequences in criminal or domestic proceedings might deter persons with SUD from entering or participating in treatment. The restrictions apply to any information disclosed by a covered program that “would identify a patient as having or having has a [SUD].”[[20]](#endnote-20)

Stakeholders supporting the legislation argue that the Part 2 regulations limit the flow of information between providers, preventing coordination of care and case management. These impediments, they argue, can lead to doctors prescribing opioid medications to patients with SUD without knowing of their addiction and treatment history.[[21]](#endnote-21) Opponents of the legislation, however, argue that relaxing restrictions under Part 2 would prevent individuals with SUD from seeking treatment.[[22]](#endnote-22)

Both bills await further action in Congress. The Senate bill has been introduced and referred to the Committee on Health, Education, Labor, and Pensions, while the House bill has been referred to the House Committee on Energy and Commerce.

**Submitted by: Sam Winikoff, Esq., Beighley, Myrick, Udell, & Lynne, P.A.**

**Florida Eliminates the Certificate of Need Process for General Hospitals and Tertiary Services**

Under current law, hospitals, nursing homes and hospices are required to obtain a certificate of need (“CON”) from the Agency for Health Care Administration (“AHCA”) before they can build new facilities, add additional beds to existing facilities or add certain specialized services. The applicant has to show that the facility and/or services proposed will fill a community need in order to obtain the necessary certificate. Specialized or “tertiary services” that are restricted under the CON program include pediatric cardiac catheterization laboratories, pediatric open-heart surgery programs, organ transplant programs, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature so that they are not yet commonly accepted in the course of diagnosis or treatment.

Florida first enacted its CON laws in 1973 as a way of regulating the number of beds, ensuring effective utilization of tertiary services, and avoiding costly duplication of programs and services.

Opponents of the CON process, including the Trump administration, argue that CON regulations stifle the free market and are anti-competitive. In April 2019, the Trump administration again urged the 35 states with such laws to scale them back or eliminate them all together.

During the most recent Florida legislative session, the House of Representatives quickly approved HB 21, a sweeping repeal of all CON laws, but ran into strong opposition in the Senate. Finally, after a committee compromise, on Monday, April 29, 2019, the Senate approved an amended version of HB 21 that leaves the CON process in place for nursing homes and hospices, but agrees to repeal the CON process for general hospitals and tertiary services. In addition, the law repeals the CON process for all hospitals, including pediatric hospitals, as of July 1, 2021. The House passed the amended version of HB21, which is now sent to Governor DeSantis for signing and implementation.

**Submitted by: Trish Calhoun, Esq., Carlton Fields LLP**

**Legislative Limitations to Restrictive Covenants**

**in Physicians’ Employment Contracts**

In the 2019 legislative session, the Florida Legislature passed a bill, House Bill 843 (“HB 843”), which contains language that is likely to impact hospitals’, physician practice groups’, and other healthcare entities’ ability to restrict competition when retaining highly specialized physicians. HB 843 contains language that voids out restrictive covenants contained in physicians’ employment contracts if the entity that is hiring the physician, directly or indirectly, is the only entity in the county that provides the specialized service offered by the physician. Specifically, if enacted, HB 843 creates Section 542.336, Florida Statutes, which states:

Invalid restrictive covenants.—A restrictive covenant entered into with a physician who is licensed under chapter 458 or chapter 459 and who practices a medical specialty in a county wherein one entity employs or contracts with, either directly or through related or affiliated entities, all physicians who practice such specialty in that county is not supported by a legitimate business interest. The Legislature finds that such covenants restrict patient access to physicians, increase costs, and are void and unenforceable under current law. Such restrictive covenants shall remain void and unenforceable for 3 years after the date on which a second entity that employs or contracts with, either directly or through related or affiliated entities, one or more physicians who practice such specialty begins offering such specialty services in that county.

HB 843 is currently pending review by Governor Ron DeSantis. If HB 843 is enacted, pursuant to the Governor’s approval, it will go into effect on July 1, 2019.

When analyzing the bill’s possible impact on existing hospitals, physician practice groups, or other healthcare entities, there is concern that the language at issue would void out the restrictive covenants in any physician’s contract that is employed by a hospital, physician practice group, or any other healthcare entity that is the sole provider in its county of a specialty that the physician specializes in. While this would not impact the majority of physicians’ employment contracts, it could void out the restrictive covenants for the most specialized, and therefore most expensive and most difficult to recruit, physicians. Accordingly, this could have an impact on healthcare entities’ ability to retain physicians or control physician staffing costs for those physicians who cannot be bound by a restrictive covenant clause in their employment contract.

**Submitted by: Angelina Gonzalez, Esq., Panza Maurer**

**Thinking of Selling or Buying a Medical Practice?**

**New Antitrust Legislation May Add a Speed Bump[[23]](#endnote-23)**

Florida has been at the forefront of some very interesting healthcare mergers and acquisitions activity in the past year, including an influx of private equity, payor acquisition of provider groups, and consistent growth in not-for-profit vertical integration acquisitions. However, waves of reform are underway. If the Florida House gets its way, the pace of healthcare transactions in Florida may hit a speed bump.

The Florida House’s bipartisan momentum takes direct aim to slow provider consolidation in the State. In a striking [video](https://www.youtube.com/watch?v=-nssT0RTP10&feature=youtu.be), the Florida House promises the 2019 legislative session will bring “more affordab[ility], more choices, more practitioners, more access, more quality, and more value” to the State’s health care market. In the video, the Florida House promises to end “government protection for hospital monopolies” and increase “enforcement against providers who violate antitrust laws.”

On April 11, 2019, the Florida House demonstrated its palpable commitment to these values by unanimously voting to pass Florida House Bill 1243 (“HB 1243” or “Bill”), sponsored by Rep. Colleen Burton (R). The Bill’s unanimous passage, only a month after being introduced, sends a strong signal that the Florida legislature is committed to ensuring antitrust law is followed and enforced in Florida hospital physician transactions.

If enacted into law, HB 1243 would require each party of any transaction involving a group practice, hospital, or hospital system that results in a “material change”[[24]](#endnote-24) to another group practice of four or more physicians, the group practice, hospital, or hospital system to provide written notice to the Florida Office of Attorney General (“OAG”) at least 90 days before the effective date of such a transaction. A party’s failure to provide proper written notice would subject such entity to potential civil penalties of up to $500,000.00.

Additionally, in counties where there is only one entity contracting with or employing any category of medical specialists, such entity’s restrictive covenants would be void and unenforceable until there is new market entry by a competitor entity for at least three years.[[25]](#endnote-25)

HB1243 is designed to provide the Florida OAG with an opportunity to scrutinize hospital and group practice health care transactions of all sizes, including transactions that might not otherwise have required a federal pre-merger notification, filing, and review under the Federal Hart-Scott-Rodino Act (“HSR”).

Under HSR, parties entering into certain multi-million dollar transactions must file a notification and report form with the Federal Trade Commission and Assistant Attorney General of the Department of Justice, and wait a certain period (typically, 30 days) during which time the regulatory agencies may request further information to help them assess whether the proposed transaction violates the antitrust laws of the United States or could cause an anti-competitive effect in the parties’ markets. HB1243 would impose reporting and notification requirements on parties that would otherwise not have been affected by HSR and force a longer waiting period (90 days) upon parties that will simultaneously be required under federal law to file notice and reporting under HSR.

If enacted into law, HB 1243 will significantly affect all parties contemplating entering into health care transactions in Florida and may influence potential health care investor interest in the State of Florida. Businesses contemplating entering into a health care transaction in Florida, will need to consider whether to expedite acquisitions, sales, and physician exit strategies before the Bill’s likely chilling effect on investor interest and unavoidable pre-transaction waiting period. While the Bill may not pass before the legislative session adjourns (Friday, May 3, 2019), the House’s commitment to health care transformation cannot be understated.

**Submitted by:** **Kathleen Premo, Esq., and Elizabeth Scarola, Esq., Epstein Becker Green, PC**

**REGULATORY UPDATES**

**CMS Announces New Voluntary, Risk-Based Primary Care Initiative[[26]](#endnote-26)**

Since enactment of the Patient Protection and Affordable Care Act, the Center for Medicare and Medicaid Innovation (the “CMS Innovation Center” or “CMMI”) has tested innovative payment and service delivery models that could potentially reduce Medicare, Medicaid, and Children’s Health Insurance Program expenditures and also improve the quality of care for these program beneficiaries.

On April 22, 2019, the CMS Innovation Center announced its newest voluntary opportunity: the launch of the Primary Care Initiative, set to begin in January 2020.

The Primary Care Initiative accommodates primary care practices at multiple stages of readiness to assume financial risk in exchange for performance-based payments with two main tracks: (1) Primary Care First (“PCF”) and (2) Direct Contracting (“DC”) via five payment model options:

* Primary Care First
* Primary Care First – High Need Populations
* Direct Contracting – Global
* Direct Contracting – Professional
* Direct Contracting – Geographic

All five payment models focus on care for chronically and seriously ill patients.

**Primary Care First**

The Primary Care First tracks will test whether sharing financial risk and tying provider payments to quality performance will reduce total Medicare spending, improve care quality, and advance patient outcomes via two payment models: PCF and PCF-High Need Populations.

Participating PCF practices will receive a monthly payment to treat patient populations with complex conditions and who are seriously ill. Each PCF payment model allows participating providers the opportunity to earn quarterly performance-based financial bonuses (up to 50 percent) for reducing unnecessary hospitalizations and reducing total cost of care; and, the risk of bearing financial responsibility for extra spending of up to 10 percent of their practice’s revenue. Under both models, to be eligible for a positive performance-based adjustment, the practice must meet standards that reflect quality care (e.g., experience of care survey, controlling high blood pressure, diabetes hemoglobin A1c poor control, colorectal cancer screening, and advance care planning).

PCF-High Need Population practices will receive a higher payment rate than PCF practices as PCF-High Need Population practices must demonstrate that they maintain a network of relationships with other care organizations in the community and offer care to high need patients (i.e., seriously ill patients).

Eligible PCF applicants include primary care practices that:

* include primary care practitioners (M.D., D.O., C.N.S., N.P., and P.A.), certified in internal medicine, general medicine, geriatric medicine, family medicine, and hospice and palliative medicine;
* provide primary care health services to a minimum of 125 attributed Medicare beneficiaries at any one particular location;
* are located in one of the selected PCF regions: Alaska (statewide), Arkansas (statewide), California (statewide), Colorado (statewide), Delaware (statewide), Florida (statewide), Greater Buffalo region (New York), Greater Kansas City region (Kansas and Missouri), Greater Philadelphia region (Pennsylvania), Hawaii (statewide), Louisiana (statewide), Maine (statewide), Massachusetts (statewide), Michigan (statewide), Montana (statewide), Nebraska (statewide), New Hampshire (statewide), New Jersey (statewide), North Dakota (statewide), North Hudson-Capital region (New York), Ohio and Northern Kentucky region (statewide in Ohio and partial state in Kentucky), Oklahoma (statewide), Oregon (statewide), Rhode Island (statewide), Tennessee (statewide), and Virginia (statewide);
* have primary care services account for at least 70 percent of the practices’ collective billing based on revenue;
* have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to fee-for-service payments such as full or partial capitation;
* use 2015 Edition Certified Electronic Health Record Technology (“CEHRT”), support data exchange with other providers and health systems via Application Programming Interface (“API”) and connect to their regional health information exchange (“HIE”);
* can attest to a limited set of advanced primary care delivery capabilities, such as 24/7 access to a practitioner or nurse call line and empanelment of patients to a practitioner or care team; and
* can meet the requirements of the PCF Participation Agreement.

**Direct Contracting**

Large provider organizations with advanced, risk-based contract experience such as sophisticated risk contracting Medicare Advantage provider groups, MSOs, and ACOs, should consider the DC track payment model for Medicare fee-for-service (“FFS”) beneficiaries. This model will offer primary care providers a risk-adjusted per beneficiary per month payment (which CMS refers to as a population-based payment (“PBP”)) that ranges from a portion of expected primary care costs to the total cost of care. Two model options have been announced, and a third one is proposed with a request for public comments: (i) Professional PBP; (ii) Global PBP; and the potential (iii) Geographic PBP.

The PBP will include the costs of enhanced benefits and additional services that participating providers can offer to increase beneficiary engagement and improve quality and outcomes. Under the Professional model, the PBP will prospectively cover the costs of enhanced primary care services, and providers will share risk with CMS (50 percent savings or losses). Participants in the Global option will receive a PBP for all services provided by the participant and contract partners, and in turn will bear full financial risk (i.e., 100% accountability for savings and losses). Finally, the even more ambitious Geographic option would create a total cost of care model, allowing providers to assume financial and clinical responsibility for all health needs of all Medicare FFS beneficiaries in a defined geographic area.

Beneficiary enrollment in these programs and participation in enhanced benefits is voluntary, and beneficiaries retain all rights of traditional Medicare. This voluntary participation may present logistical challenges for providers, who will likely serve both participating and non-participating Medicare beneficiaries, and need to develop separate billing workflows in addition to attending to the differing treatment options and processes for each set of patients.

This opportunity builds on a variety of models that CMMI has created to incentivize enhancements to primary care, but is the first context in which primary care physicians will be permitted to assume risk with traditional Medicare patient’s risk without an ACO structure. One very significant advantage for providers who are large and sophisticated enough to participate in the Global and Geographic options will be the ability to bypass the traditional claims processing and denials and appeals processes, yielding considerable savings in administrative costs. CMS will also offer a reduced set of mandatory quality measures. In turn, providers will need a large enough beneficiary pool to spread risk adequately (the RFI for the Geographic model currently suggests that the geographic area will be required to include a minimum of 75,000 beneficiaries), and will need the administrative sophistication to implement MSO or ACO-like functions to manage that risk appropriately, particularly with regard to agreements with contracted providers under the Geographic option.

CMS has stated they will post a letter of intent (“LOI”) for interested providers in Spring 2019. Submission of an LOI will not be binding but will be required for eventual participation. Participation agreements will be created in late 2019, and an initial start-up year will begin in 2020, with actual payments under the new models beginning on January 1, 2021.

CMS has issued a [Request for Information](https://innovation.cms.gov/Files/x/dc-geographicpbp-rfi.pdf) on the Geographic Population-Based Payment Model for Direct Contracting to seek public comments on the design parameters for this model. Responses to the RFI are due by **May 23, 2019** and can be submitted to DPC@cms.hhs.gov.

**Primary Care Initiative Value Based Model Participation**

CMS projects that 25 percent of primary care practitioners will elect to participate in either PCF or DC models.

CMS will host webinars on the following dates for interested PCF stakeholders:

* **Thursday, May 16, 12 p.m. EDT**[**Register here**](https://cmslearningeventscqpub.cosocloud.com/content/connect/c1/7/en/events/event/shared/default_template_simple/event_landing.html?connect-session=breezbreezbw4bmwk25rsc9m27&sco-id=1466290&_charset_=utf-8)
* **Thursday, May 16, 3 p.m. EDT**  [**Register here**](https://cmslearningeventscqpub.cosocloud.com/content/connect/c1/7/en/events/event/shared/default_template_simple/event_landing.html?connect-session=breezbreezbw4bmwk25rsc9m27&sco-id=1466322&_charset_=utf-8)

**Submitted by: Kathleen Premo, Esq., Elizabeth Scarola, Esq., and David Shillcut, Esq., Epstein Becker Green, PC**

**Enrollment Moratoria for Home Health Agencies and Non-Emergency Ground Ambulance Suppliers Expires**

The Centers for Medicare & Medicaid Services (“CMS”) lifted the Medicare enrollment moratoria for home health agencies in Florida, Illinois, Michigan, and Texas and non-emergency ground ambulance providers in Pennsylvania and New Jersey, effective January 30, 2019, when it permitted the moratoria to expire. Previously, CMS extended the Medicare enrollment moratoria for home health agencies in Florida, Illinois, Michigan, and Texas and non-emergency ground ambulance providers in Pennsylvania and New Jersey effective July 29, 2018 for six (6) additional months.

Section 6401 of the Patient Protection and Affordable Care Act authorized CMS to impose temporary moratoria on the initial enrollment or establishment of new practice locations if the Secretary of CMS determined that such moratorium was necessary to prevent or combat fraud, waste, or abuse respecting a particular provider or supplier types, particular geographic areas, or a combination of both. In 2013, CMS exercised this authority and imposed moratoria preventing enrollment of new home health agencies and branches in Miami-Dade County, Florida, and Cook County, Illinois, and the surrounding counties.[[27]](#endnote-27) Simultaneously, CMS imposed a moratorium on enrollment of Medicare Part B ground ambulance suppliers in Harris County, Texas, and the surrounding counties.

CMS now will accept supplier enrollment applications for home health agencies, including applications for new branches and subunits, and Medicare Part B ground ambulance providers. To enroll in Medicare, home health agencies should complete CMS Form 855A and ground ambulance suppliers should complete CMS Form 855B. It is important to note that CMS requires home health agencies or ground ambulance suppliers to be licensed by the state in which they are located before submitting the Medicare enrollment application. Even though the Medicare enrollment moratoria is lifted, certain states still impose new provider enrollment moratoria or require new providers prove the need for a new provider through the certificate of need process, both of which can be additional roadblocks for companies seeking to establish a new home health agency or Medicare Part B ground ambulance provider.

**Submitted by: Timothy Wombles, Esq., Nelson Mullins Broad and Cassel**

1. Fla. Stat. § 458.331(1)(i) (2016). [↑](#endnote-ref-1)
2. Allen R. Grossman; R. Andrew Rock, *Fee Splitting and the Management of Medical Practices: A History of Board of Medicine Declaratory Statements*, 72 Fla. B.J. 48 (1998). [↑](#endnote-ref-2)
3. *Id*. *See also* David Winker et al., *The Role of the Florida Board of Medicine and the Bakarania Decision*, 7 U. Miami Bus. L. Rev. 450, 451 (1999). [↑](#endnote-ref-3)
4. Fla. Stat. § 456.072 (2016). [↑](#endnote-ref-4)
5. *See supra*, note 3. [↑](#endnote-ref-5)
6. *Physician Group Deals*, American Health Lawyers Association, PAPERS P11199807. [↑](#endnote-ref-6)
7. *Id*. [↑](#endnote-ref-7)
8. *Practice Mgmt. Ass’n, Inc. v. Orman*, 614 So.2d 1135 (Fla. 2d DCA 1993). [↑](#endnote-ref-8)
9. *Id.; see generally* Fla. Stat. § 460.413. [↑](#endnote-ref-9)
10. *See supra,* note 8. [↑](#endnote-ref-10)
11. *Practice Mgmt. Ass’n, Inc. v. Blickensderfer*, 630 So.2d 1147, 1148 (Fla. 2d DCA 1993). [↑](#endnote-ref-11)
12. Fla. Stat. § 460.413(1)(k). [↑](#endnote-ref-12)
13. *See* *Practice Mgmt. Ass’n, Inc. v. Wakefield*, 615 So. 2d 846, 847 (Fla. 2d DCA 1993); *Practice Mgmt. Ass’n, Inc. v. Ruhe*, 620 So. 2d 265 (Fla. Dist. Ct. App. 1993). [↑](#endnote-ref-13)
14. Allen R. Grossman & R. Andrew Rock, *Fee Splitting and the Management of Medical Practices: A History of Board of Medicine Declaratory Statements*, 72 Fla. B.J. 48, 52 (1998). [↑](#endnote-ref-14)
15. 84 Fed. Reg. 73 (Apr. 16, 2019). [↑](#endnote-ref-15)
16. The Part 2 regulations implement title 42, section 290dd–2 of the United States Code pertaining to the Confidentiality of Substance Use Disorder Patient Records held by federally assisted SUD treatment programs. *See* 42 CFR § 2.1. [↑](#endnote-ref-16)
17. In the House, Representatives Earl Blumenauer (D-OR) and Markwayne Mullin (R-OK) introduced the Overdose Prevention and Patient Safety (“OPPS”) Act, H.R. 2062, 116th Congress (2019), and in the Senate, Senators Shelley Moore Capito (R-WV) and Joe Manchin (D-WV) introduced identical legislation, the Protecting Jessica Grubb's Legacy Act, S. 1012, 116th Congress (2019). [↑](#endnote-ref-17)
18. 45 C.F.R. § 164.502(a)(1)(ii). [↑](#endnote-ref-18)
19. 42 C.F.R. § 2.51-2.53. [↑](#endnote-ref-19)
20. 42 C.F.R. § 2.12(a). [↑](#endnote-ref-20)
21. *See e.g.*,Partnership to Amend 42 C.F.R. Part 2, *Stakeholders Agree: Modernize the Privacy Laws to Combat Opioid Epidemic* (April 3, 2019), *available at* https://www.asam.org/docs/default-source/advocacy/letters-and-comments/partnership-part-2-introduction-press-release.pdf?sfvrsn=5b5d4ac2\_2. Stakeholders include the American Society of Addiction Medicine, American Psychiatric Association, National Association of Addiction Treatment Providers, American Health Information Management Association, American Hospital Association, and America’s Health Insurance Plans. [↑](#endnote-ref-21)
22. *Congress Affirms that Addiction Treatment Confidentiality Protections Remain Essential*, Legal Action Ctr. (Sept. 26, 2018), *available at* https://lac.org/congress-affirms-that-addiction-treatment-confidentiality-protections-remain-essential. [↑](#endnote-ref-22)
23. HLS Editors’ Note: This Bill was indefinitely postponed and withdrawn from consideration on May 3, 2019. However, we thought it would be important to include this submission, as it may emerge in subsequent Florida legislative sessions. [↑](#endnote-ref-23)
24. “Material change” is defined as: “(i) a merger, consolidation, or affiliation; (ii) the employment of all or substantially all of the physicians of a group practice; or (iii) the acquisition of all or substantially all of: (a) the properties and assets of a group practice; (b) the capital stock, membership interests, or other equity interests of a group practice; or (c) one or more insolvent group practices.” [↑](#endnote-ref-24)
25. Specifically, restrictive covenants entered into with physicians who practice a medical specialty in a county where one entity employs or contracts with, either directly or through related or affiliated entities, all restrictive covenants entered into with physicians who practice such specialty in that county would be void and unenforceable until three years after another entity enters the market and begins offering the medical specialty to the patients of that county. [↑](#endnote-ref-25)
26. HLS Editors’ Note: Although the HLS Updates are typically shorter in length, the HLS Editors thought this particular submission should be included in its full length in this Edition, which is primarily focused on significant regulatory and legislative updates on both the Federal and Florida levels. [↑](#endnote-ref-26)
27. 78 Fed. Reg. 46,339 (July 31, 2013). [↑](#endnote-ref-27)