

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL: SB 212

INTRODUCER: Senator Gaetz

SUBJECT: Recovery Care Services

DATE: January 14, 2016

REVISED: _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	Pre-meeting
2.			AHS	
3.			AP	

I. Summary:

SB 212 amends s. 395.002, F.S., to allow patients in an ambulatory surgical center (ASC) to stay in the center for up to 24 hours. Current law requires that patients in an ASC be discharged on the same working day and restricts patients from staying overnight in an ASC.

The bill also creates the recovery care center (RCC) license. The bill defines “recovery care center” and “recovery care services” to limit a patient’s stay in an RCC to 72 hours and to restrict RCCs to only admitting patients for whom an acute care hospitalization is not required and an uncomplicated recovery is reasonably expected.

The bill specifies requirements that must be met before a patient can be admitted to an RCC, including emergency care transfer protocols, a referral or admission agreement with at least one hospital, and procedures for discharge planning and discharge protocols. The Agency for Healthcare Administration (AHCA) may adopt rules to implement these standards.

The bill requires the AHCA to adopt rules to establish:

- A panel that will conduct an annual review of recovery care center policies and protocols governing licensure, utilization, patient safety, pharmacy services, infection control, and medical and nursing practices; and
- Fair and reasonable minimum standards to ensure that RCCs have a dietetic department, procedures to ensure the proper administration of medications, and pharmacy services on the premises or under contract.

The bill also makes conforming changes in multiple sections of the Florida Statutes to reflect the new RCC license type.

II. Present Situation:

Ambulatory Surgical Centers

An ASC is a facility, that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.¹

In Florida, ambulatory procedures are performed in two settings, hospital-based outpatient facilities and freestanding ASCs. Currently, there are 431 licensed ASCs in Florida.² Of these, 413 are Medicare and/or Medicaid certified and 381 are accredited by either the Accreditation Association for Ambulatory Health Care (AAAHC) or by the Joint Commission.³ In 2008, Medicare paid for 39.1 percent of all procedures performed in ASCs while Medicaid paid for 5.6 percent and commercial payors paid for 46.6 percent.

Between April 2014 and March 2015, there were 2,933,433 visits to ASCs in Florida.⁴ Hospital outpatient facilities accounted for 31 percent and free standing ASCs accounted for 59 percent of the total number of visits. Freestanding ASC average charges range from \$2,930 to \$7,333 and hospital based ASC average charges range from \$7,727 to \$26,034 for the same time period.⁵ Two of the most popular procedures to have performed on adults at an ASC include cataract procedures with 249,184 performed and colonoscopies with 218,745 performed, also during the same time period.⁶

ASC Licensure

ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.⁷ Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including the:

- Affidavit of compliance with fictitious name;
- Registration of articles of incorporation; and
- ASC's zoning certificate or proof of compliance with zoning requirements.⁸

¹ Section 395.002(3), F.S., defines "Ambulatory surgical center" or "mobile surgical facility" to mean a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003, F.S. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.

² See AHCA presentation on Ambulatory Surgical Centers, slide 10, presented to the Health Policy Committee on June 10, 2015, (on file with the Senate Committee on Health Policy).

³ Id.

⁴ Agency for Health Care Administration, Florida Health Finder Search, <http://www.floridahealthfinder.gov/CompareCare/CompareFacilities.aspx> (last viewed January 14, 2016).

⁵ Id.

⁶ Id.

⁷ Sections 395.001-395.1065, F.S., and Part II, Chapter 408, F.S.

⁸ Rule 59A-5.003(4), F.A.C.

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

- Governing body bylaws, rules and regulations;
- Roster of registered nurses and licensed practical nurses with current license numbers;
- Fire plan; and
- Comprehensive Emergency Management Plan.⁹

Rules for ASCs

Pursuant to s. 395.1055, F.S., AHCA is authorized to adopt rules for hospitals and ASCs. Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals, but the rules for all hospitals and ASCs must include minimum standards for ensuring that:

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

AHCA rule ch. 59A-5, F.A.C., implements the minimum standards for ASCs. Those rules also require policies and procedures to ensure the protection of patient rights.

Staff and Personnel Rules

ASCs are required to have written policies and procedures for surgical services, anesthesia services, nursing services, pharmaceutical services, laboratory services, and radiologic services. In providing these services, ACSs are required to have certain professional staff available, including:

- A qualified person responsible for the daily functioning and maintenance of the surgical suite;
- An anesthesiologist, physician, a certified registered nurse anesthetist under the on-site medical direction of a licensed physician, or an anesthesiologist assistant under the direct supervision of an anesthesiologist who must be in the ASC during the anesthesia and post-anesthesia recovery period until all patients are alert or discharged;
- A registered professional nurse who is responsible for coordinating and supervising all nursing services;
- A registered professional circulating nurse for a patient during that patient's surgical procedure; and
- A registered professional nurse who must be in the recovery area at all times when a patient is present.¹⁰

⁹ Rule 59A-5.003(5), F.A.C.

¹⁰ Rule 59A-5.0085, F.A.C.

Infection Control Rules

ASCs are required to establish an infection control program involving members of the medical, nursing, and administrative staff. The program must include written policies and procedures reflecting the scope of the infection control program. The written policies and procedures must be reviewed at least every 2 years by the infection control program members. The infection control program must include:

- Surveillance, prevention, and control of infection among patients and personnel;
- A system for identifying, reporting, evaluating and maintaining records of infections;
- Ongoing review and evaluation of aseptic, isolation and sanitation techniques employed by the ASC; and
- Development and coordination of training programs in infection control for all personnel.¹¹

Emergency Management Plan Rules

ASCs are required to develop and adopt a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency. The ASC must review the plan and update it annually.¹²

Accreditation

ASCs may seek voluntary accreditation by the Joint Commission or the AAAHC. The AHCA is required to conduct an annual licensure inspection survey for non-accredited ASCs. The AHCA is authorized to accept survey reports of accredited ASCs from accrediting organizations if the standards included in the survey report are determined to document that the ASC is in substantial compliance with state licensure requirements. The AHCA is required to conduct annual validation inspections on a minimum of 5 percent of the ASCs which were inspected by an accreditation organization.¹³

AHCA is required to conduct annual life safety inspections of all ASCs to ensure compliance with life safety codes and disaster preparedness requirements. However, the life-safety inspection may be waived if an accreditation inspection was conducted on an ASC by a certified life safety inspector and the ASC was found to be in compliance with the life safety requirements.¹⁴

Medicare Requirements

ASCs are required to have an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare. ASCs are also required to comply with specific conditions for coverage. CMS defines “ASC” as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.¹⁵

¹¹ Rule 59A-5.011, F.A.C.

¹² Rule 59A-5.018, F.A.C.

¹³ Rule 59A-5.004, F.A.C.

¹⁴ Id.

¹⁵ 42 C.F.R. §416.2

CMS may deem an ASC to be in compliance with all of the conditions for coverage if the ASC is accredited by a national accrediting body, or licensed by a state agency, and CMS determines that such accreditation or licensure provides reasonable assurance that the conditions for coverage are met.¹⁶ All of the CMS conditions for coverage requirements are specifically required in AHCA rule ch. 59A-5, F.A.C., and apply to all ASCs in Florida. The conditions for coverage require ASCs to have a:

- Governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation;
- Quality assessment and performance improvement program;
- Transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- Disaster preparedness plan;
- Organized medical staff;
- Fire control plan;
- Sanitary environment;
- Infection control program; and
- Procedure for patient admission, assessment and discharge.

Recovery Care Centers

RCCs are entities that provide short-term nursing care, support, and pain control for patients that do not require acute hospitalization.¹⁷ RCC patients are typically healthy persons that have had elective surgery and RCCs are typically restricted from accepting patients with a higher risk for complications after surgery. RCCs can be either freestanding or attached to an ASC or hospital.¹⁸ In practice, RCCs typically provide care to patients transferred from ASCs following surgery, which can allow ASCs to perform more complex procedures.¹⁹

RCCs are not eligible for Medicare reimbursement.²⁰ One 1999 survey noted that RCCs received payment in the following breakdown: 41 percent from managed care plans, 29 percent from self-pay, 16 percent from indemnity plans, and 9 percent from workers' compensation.²¹

Three states, Arizona, Connecticut, and Illinois, have specific licenses for "recovery care centers."²² California also had a demonstration project for recovery care centers from 1987 to 2000 which has expired.²³ Other states may license RCCs as nursing facilities or hospitals.²⁴

¹⁶ 42 C.F.R. §416.26(a)(1)

¹⁷ MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: MEDICARE PAYMENT FOR POST-SURGICAL RECOVERY CARE CENTERS, at pg. 3 (2000).

¹⁸ The most common practice seems to be attaching a RCC to an ASC, for example Illinois has 7 licensed RCCs all of which are attached. Phone conversation with Karen Singer, Division of Healthcare Facilities and Programs, Illinois Department of Public Health (June 5, 2015).

¹⁹ *Supra* n. 17 at pg. 4.

²⁰ See MEDICARE PAYMENT ADVISORY COMM'N, *supra* FN 17.

²¹ MEDICARE PAYMENT ADVISORY COMM'N, *supra* FN 17, at pg. 6 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

²² ARIZ. REV. STAT. ANN. §§ 36-448.51-36-448.55; CONN. AGENCIES REGS. § 19A-495-571; 210 ILL. COMP. STAT. ANN. 3/35.

²³ CAL. HSC. Code s. 128600. See also *Supra* n. 17 at p. 6.

²⁴ Sandra Lee Breisch, *Profits in Short Stays*, AM. ACAD. OF ORTHOPAEDIC SURGEONS BULLETIN (June, 1999), available at <http://www2.aaos.org/bulletin/jun99/asc.htm>. (Last visited January 14, 2016).

Of the three states that currently license RCCs, only Arizona has a continuing program with three currently licensed RCCs.²⁵ Illinois ended its RCC demonstration project in 2012 and currently is not licensing any new RCCs. Seven RCCs are still licensed in Illinois with between two and nine beds each. The main reason cited for ending the project was that the RCCs were underutilized due to not being Medicare reimbursable.²⁶ Connecticut’s RCC program is still active, however, there are currently no licensed RCCs in the state.²⁷ See the table below for a comparison of Arizona’s, Illinois’, and Connecticut’s RCC regulations.

Regulation	Arizona ²⁸	Connecticut ²⁹	Illinois ³⁰
Licensure Required	X	X	X
Written Policies	X	X	X
Maintain Medical Records	X	X	X
Patient’s Bill of Rights	X	X	X
Allows Freestanding Facility or Attached	Not Available.	X	X
Length of Stay	Not Available.	Expected 3 days Maximum 21 days	Expected 48 hours Maximum 72 hours
Emergency Care Transfer Agreement	Not Available.	With a hospital and an ambulance service.	With a hospital within 15 minutes travel time.
Prohibited Patients	Patients needing: Intensive care Coronary care Critical care	Patients needing: Intensive care Coronary care Critical care	Patients with chronic infectious conditions Children under age 3
Prohibited Services	Surgical Radiological Pediatric Obstetrical	Surgical Radiological Pre-adolescent pediatric Hospice Obstetrical services over 24 weeks gestation. Intravenous therapy for non-hospital based RCC	Blood administration (only blood products allowed)

²⁵ See Arizona Department of Health Provider and Facility Databases, available at <http://www.azdhs.gov/licensing/index.php#databases>, (last visited January 14, 2016)

²⁶ See supra n. 17.

²⁷ Phone conversation with staff of the Connecticut Department of Health on June 4, 2015.

²⁸ Ariz. Rev. Stat. Ann. §§ 36-448.51-36-448.55; Ariz. Admin. Code §§ R9-10-501-R9-10-518 (updated in 2013, formerly R9-10-1401-R9-10-1412).

²⁹ Conn. Agencies Regs. § 19a-495-571.

³⁰ 210 Ill. Comp. Stat. Ann. 3/35; Ill. Admin. Code tit. 77, §§ 210.2500 & 210.2800.

Regulation	Arizona ²⁸	Connecticut ²⁹	Illinois ³⁰
Required Services	Laboratory Pharmaceutical Food	Pharmaceutical Dietary Personal care Rehabilitation Therapeutic Social work	Laboratory Pharmaceutical Food Radiological
Bed Limitation	Not Available.	Not Available.	20
Required Staff	Governing authority Administrator	Governing body Administrator	Consulting committee
Required Medical Personnel	At least two physicians Director of nursing	Medical advisory board Medical director Director of nursing	Medical director Nursing supervisor
Required Personnel When Patients Are Present	Director of nursing 40 hours per week One registered nurse One other nurse	Two persons for patient care	One registered nurse One other nurse

III. Effect of Proposed Changes:

SB 212 amends the definition of “ambulatory surgical center” in s. 395.002, F.S., to allow a patient to be admitted and discharged from an ASC within 24 hours. Current law requires that patients be discharged from an ASC within the same working day and restricts patients from staying at an ASC overnight.

The bill also creates the RCC license type. The bill defines “recovery care center” as a facility that is not part of a hospital and which provides recovery care services to patients who are admitted and discharged from the facility within 72 hours. The bill defines “recovery care services” as postsurgical and post-diagnostic medical and general nursing care, including postsurgical rehabilitation services provided to patients for whom an acute care hospitalization is not required and an uncomplicated recovery is reasonably expected. The bill specifically excludes intensive care services, coronary care services, and critical care services from the definition of “recovery care services.”

The bill requires the AHCA to adopt rules to establish a panel comprised of a physician, a nurse, and a pharmacist who are licensed in Florida and who are not employed or receiving compensation from a recovery care center. The panel must annually review recovery care center policies and protocols governing licensure, utilization, patient safety, pharmacy services, infection control, and medical and nursing practices.

The bill specifies requirements that must be met before a patient can be admitted to an RCC. These requirements include:

- The patient must need recovery care services; and
- A physician must certify that the patient is medically stable and does not need acute care hospitalization.

Patients may be admitted to an RCC upon discharge from an ASC or a hospital or post-diagnosis and post-treatment for recovery care services.

The bill requires that an RCC have emergency care transfer protocols, a referral or admission agreement with at least one hospital, and procedures for discharge planning and discharge protocols. The bill allows the AHCA to adopt rules to implement these standards.

The bill requires the AHCA to adopt rules for fair and reasonable minimum standards to ensure that RCCs have:

- A dietetic department or service, on the premises or under contract, to ensure the provision of appropriate nutritional care and quality food service;
- Procedures to ensure the proper administration of medications including procedures for prescribing, ordering, preparing, and dispensing medications as well as the appropriate monitoring of the effects of such medications; and
- A pharmacy, pharmaceutical department, or service on the premises or under contract.

The bill also makes numerous conforming changes in multiple sections of the Florida Statutes to reflect the new RCC license type.

The bill exempts RCCs from certain licensure provisions in s. 408.810(7)-(10), F.S., related to proof of insurance, the applicant's financial ability to operate, and CON requirements in order to match the licensure requirements for ASCs and mobile surgical facilities.

The bill establishes an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 212 may have an indeterminate positive fiscal impact on patients in Florida who are able to have a surgical procedure performed in an ASC or recover in an RCC if the costs are less in these settings than in a hospital.

SB 212 may have an indeterminate negative fiscal impact on hospitals if more patients choose to have their procedures performed in an ASC or recover in a RCC rather than in a hospital.

C. Government Sector Impact:

SB 212 requires the AHCA to adopt rules for, license, and regulate RCCs. Such activity may have an indeterminate negative fiscal impact on the agency, however, RCC license fees should offset most, if not all, of such costs.

VI. Technical Deficiencies:

Line 136 authorizes the AHCA to adopt rules to implement “this subsection,” however it should authorize rulemaking for the entire section.

VII. Related Issues:

Lines 159-166 establish a panel that will annually review certain criteria regarding RCCs, however, the bill does not establish a requirement for the panel to generate a report or other summary of its findings.

Additionally, lines 159-160 require rules to be adopted on two separate issues: on the annual review of RCC policies and protocols and on minimum standards for RCCs. As written, the AHCA only have authority to adopt a single rule to address both issues, however, it may be advisable to grant the AHCA separate rulemaking authority for each issue individually.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.001, 395.002, 395.003, 395.1055, 395.10973, 395.301, 408.802, 408.820, 394.4787, and 409.975.

This bill creates section 395.0171 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.