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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/26/2016	.	
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The Committee on Appropriations (Gaetz) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 381.4019, Florida Statutes, is created to read:

381.4019 Dental care access accounts.—Subject to the availability of funds, the Legislature establishes a joint local and state dental care access account initiative and authorizes the creation of dental care access accounts to promote economic

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development by supporting qualified dentists who practice in dental health professional shortage areas or medically underserved areas or who treat a medically underserved population. The Legislature recognizes that maintaining good oral health is integral to overall health status and that the good health of residents of this state is an important contributing factor in economic development. Better health, including better oral health, enables workers to be more productive, reduces the burden of health care costs, and enables children to improve in cognitive development.

(1) As used in this section, the term:

(a) "Dental health professional shortage area" means a geographic area so designated by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(b) "Department" means the Department of Health.

(c) "Medically underserved area" means a geographic area so designated by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(d) "Public health program" means a county health department, the Children's Medical Services Network, a federally qualified community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program as designated by the department.

(2) The department shall develop and implement a dental care access account initiative to benefit dentists licensed to practice in this state who demonstrate, as required by the department by rule:

(a) Active employment by a public health program located in

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a dental health professional shortage area or a medically underserved area; or

(b) A commitment to opening a private practice in a dental health professional shortage area or a medically underserved area, as demonstrated by the dentist residing in the designated area, maintaining an active Medicaid provider agreement, enrolling in one or more Medicaid managed care plans, expending sufficient capital to make substantial progress in opening a dental practice that is capable of serving at least 1,200 patients, and obtaining financial support from the local community in which the dentist is practicing or intending to open a practice.

(3) The department shall establish dental care access accounts as individual benefit accounts for each dentist who satisfies the requirements of subsection (2) and is selected by the department for participation. The department shall implement an electronic benefit transfer system that enables each dentist to spend funds from his or her account for the purposes described in subsection (4).

(4) Funds contributed from state and local sources to a dental care access account may be used for one or more of the following purposes:

(a) Repayment of dental school student loans.

(b) Investment in property, facilities, or equipment necessary to establish and operate a dental office consisting of no fewer than two operatories.

(c) Payment of transitional expenses related to the relocation or opening of a dental practice which are specifically approved by the department.

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(5) Subject to legislative appropriation, the department shall distribute state funds as an award to each dental care access account. An individual award must be in an amount not more than $100,000 and not less than $10,000, except that a state award may not exceed 3 times the amount contributed to an account in the same year from local sources. If a dentist qualifies for a dental care access account under paragraph (2)(a), the dentist's salary and associated employer expenditures constitute a local match and qualify the account for a state award if the salary and associated expenditures do not come from state funds. State funds may not be included in a determination of the amount contributed to an account from local sources.

(6) The department may accept contributions of funds from a local source for deposit in the account of a dentist designated by the donor.

(7) The department shall close an account no later than 5 years after the first deposit of state or local funds into that account or immediately upon the occurrence of any of the following:

(a) Termination of the dentist's employment with a public health program, unless, within 30 days after such termination, the dentist opens a private practice in a dental health professional shortage area or medically underserved area.

(b) Termination of the dentist's practice in a designated dental health professional shortage area or medically underserved area.

(c) Termination of the dentist's participation in the Florida Medicaid program.

(d) Participation by the dentist in any fraudulent activity.

(8) Any state funds remaining in a closed account may be awarded and transferred to another account concurrent with the distribution of funds under the next legislative appropriation for the initiative. The department shall return to the donor on a pro rata basis unspent funds from local sources which remain in a closed account.

(9) If the department determines that a dentist has withdrawn account funds after the occurrence of an event specified in subsection (7), has used funds for purposes not authorized in subsection (4), or has not remained eligible for a dental care access account for a minimum of 2 years, the dentist shall repay the funds to his or her account. The department may recover the withdrawn funds through disciplinary enforcement actions and other methods authorized by law.

(10) The department shall establish by rule:

(a) Application procedures for dentists who wish to apply for a dental care access account. An applicant may demonstrate that he or she has expended sufficient capital to make substantial progress in opening a dental practice that is capable of serving at least 1,200 patients by documenting contracts for the purchase or lease of a practice location and providing executed obligations for the purchase or other acquisition of at least 30 percent of the value of equipment or supplies necessary to operate a dental practice. The department may limit the number of applicants selected and shall give priority to those applicants practicing in the areas receiving higher rankings pursuant to subsection (11). The department may

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establish additional criteria for selection which recognize an applicant's active engagement with and commitment to the community providing a local match.

(b) A process to verify that funds withdrawn from a dental care access account have been used solely for the purposes described in subsection (4).

(11) The Department of Economic Opportunity shall rank the dental health professional shortage areas and medically underserved areas of the state based on the extent to which limited access to dental care is impeding the areas' economic development, with a higher ranking indicating a greater impediment to development.

(12) The department shall develop a marketing plan for the dental care access account initiative in cooperation with the University of Florida College of Dentistry, the Nova Southeastern University College of Dental Medicine, the Lake Erie College of Osteopathic Medicine School of Dental Medicine, and the Florida Dental Association.

(13)(a) By January 1 of each year, beginning in 2018, the department shall issue a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which must include:

1. The number of patients served by dentists receiving funding under this section.

2. The number of Medicaid recipients served by dentists receiving funding under this section.

3. The average number of hours worked and patients served in a week by dentists receiving funding under this section.

4. The number of dentists in each dental health

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professional shortage area or medically underserved area receiving funding under this section.

5. The amount and source of local matching funds received by the department.

6. The amount of state funds awarded to dentists under this section.

7. A complete accounting of the use of funds by categories identified by the department, including, but not limited to, loans, supplies, equipment, rental property payments, real property purchases, and salary and wages.

(b) The department shall adopt rules to require dentists to report information to the department which is necessary for the department to fulfill its reporting requirement under this subsection.

Section 2. Subsection (3) of section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.—As used in this chapter:

(3) "Ambulatory surgical center" or "mobile surgical facility" means 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 24 hours ~~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

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ambulatory surgical center pursuant to s. 395.003. 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.

Section 3. Present subsections (6) through (10) of section 395.003, Florida Statutes, are redesignated as subsections (7) through (11), respectively, a new subsection (6) is added to that section, and present subsections (9) and (10) of that section are amended, to read:

395.003 Licensure; denial, suspension, and revocation.—

(6) An ambulatory surgical center, as a condition of initial licensure and license renewal, must provide services to Medicare patients, Medicaid patients, and patients who qualify for charity care in an amount equal to or greater than the applicable district average among licensed providers of similar services. For the purposes of this subsection, "charity care" means uncompensated care delivered to uninsured patients with incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures.

(10) ~~(9)~~ A hospital licensed as of June 1, 2004, shall be exempt from subsection (9) ~~subsection (8)~~ as long as the hospital maintains the same ownership, facility street address, and range of services that were in existence on June 1, 2004. Any transfer of beds, or other agreements that result in the establishment of a hospital or hospital services within the intent of this section, shall be subject to subsection (9)

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~~subsection (8)~~. Unless the hospital is otherwise exempt under subsection (9) ~~subsection (8)~~, the agency shall deny or revoke the license of a hospital that violates any of the criteria set forth in that subsection.

(11) ~~(10)~~ The agency may adopt rules implementing the licensure requirements set forth in subsection (9) ~~subsection (8)~~. Within 14 days after rendering its decision on a license application or revocation, the agency shall publish its proposed decision in the Florida Administrative Register. Within 21 days after publication of the agency's decision, any authorized person may file a request for an administrative hearing. In administrative proceedings challenging the approval, denial, or revocation of a license pursuant to subsection (9) ~~subsection (8)~~, the hearing must be based on the facts and law existing at the time of the agency's proposed agency action. Existing hospitals may initiate or intervene in an administrative hearing to approve, deny, or revoke licensure under subsection (9) ~~subsection (8)~~ based upon a showing that an established program will be substantially affected by the issuance or renewal of a license to a hospital within the same district or service area.

Section 4. Section 624.27, Florida Statutes, is created to read:

624.27 Application of code as to direct primary care agreements.—

(1) As used in this section, the term:

(a) "Direct primary care agreement" means a contract between a primary care provider and a patient, the patient's legal representative, or an employer which meets the requirements specified under subsection (4) and does not

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indemnify for services provided by a third party.

(b) "Primary care provider" means a health care practitioner licensed under chapter 458, chapter 459, chapter 460, or chapter 464, or a primary care group practice that provides medical services to patients which are commonly provided without referral from another health care provider.

(c) "Primary care service" means the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

(2) A direct primary care agreement does not constitute insurance and is not subject to chapter 636 or any other chapter of the Florida Insurance Code. The act of entering into a direct primary care agreement does not constitute the business of insurance and is not subject to chapter 636 or any other chapter of the Florida Insurance Code.

(3) A primary care provider or an agent of a primary care provider is not required to obtain a certificate of authority or license under chapter 636 or any other chapter of the Florida Insurance Code to market, sell, or offer to sell a direct primary care agreement.

(4) For purposes of this section, a direct primary care agreement must:

(a) Be in writing.

(b) Be signed by the primary care provider or an agent of the primary care provider and the patient, the patient's legal representative, or an employer.

(c) Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The

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agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.

(d) Describe the scope of primary care services that are covered by the monthly fee.

(e) Specify the monthly fee and any fees for primary care services not covered by the monthly fee.

(f) Specify the duration of the agreement and any automatic renewal provisions.

(g) Offer a refund to the patient of monthly fees paid in advance if the primary care provider ceases to offer primary care services for any reason.

(h) Contain in contrasting color and in not less than 12-point type the following statements on the same page as the applicant's signature:

1. The agreement is not health insurance and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by the agreement.

2. The agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the Patient Protection and Affordable Care Act, 26 U.S.C. s. 5000A.

Section 5. The amendments made by this act to ss. 409.967, 627.42392, 641.31, and 641.394, Florida Statutes, may be known as the "Right Medicine Right Time Act."

Section 6. Effective January 1, 2017, paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

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409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to

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accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2.a. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

b. If a managed care plan restricts the use of prescribed drugs through a fail-first protocol, it must establish a clear and convenient process that a prescribing physician may use to request an override of the restriction from the managed care plan. The managed care plan shall grant an override of the protocol within 24 hours if:

(I) Based on sound clinical evidence, the prescribing provider concludes that the preferred treatment required under the fail-first protocol has been ineffective in the treatment of the enrollee's disease or medical condition; or

(II) Based on sound clinical evidence or medical and scientific evidence, the prescribing provider believes that the preferred treatment required under the fail-first protocol:

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(A) Is likely to be ineffective given the known relevant physical or mental characteristics and medical history of the enrollee and the known characteristics of the drug regimen; or

(B) Will cause or is likely to cause an adverse reaction or other physical harm to the enrollee.

If the prescribing provider follows the fail-first protocol recommended by the managed care plan for an enrollee, the duration of treatment under the fail-first protocol may not exceed a period deemed appropriate by the prescribing provider. Following such period, if the prescribing provider deems the treatment provided under the protocol clinically ineffective, the enrollee is entitled to receive the course of therapy that the prescribing provider recommends, and the provider is not required to seek approval of an override of the fail-first protocol. As used in this subparagraph, the term "fail-first protocol" means a prescription practice that begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and custody of the Department of Children and Families shall ~~must~~ maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing

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comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department are ~~shall be~~ the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 7. Effective January 1, 2017, section 627.42392, Florida Statutes, is created to read:

627.42392 Fail-first protocols.—If an insurer restricts the use of prescribed drugs through a fail-first protocol, it must establish a clear and convenient process that a prescribing physician may use to request an override of the restriction from the insurer. The insurer shall grant an override of the protocol within 24 hours if:

(1) Based on sound clinical evidence, the prescribing provider concludes that the preferred treatment required under the fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(2) Based on sound clinical evidence or medical and scientific evidence, the prescribing provider believes that the preferred treatment required under the fail-first protocol:

(a) Is likely to be ineffective given the known relevant physical or mental characteristics and medical history of the

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insured and the known characteristics of the drug regimen; or

(b) Will cause or is likely to cause an adverse reaction or other physical harm to the insured.

If the prescribing provider follows the fail-first protocol recommended by the insurer for an insured, the duration of treatment under the fail-first protocol may not exceed a period deemed appropriate by the prescribing provider. Following such period, if the prescribing provider deems the treatment provided under the protocol clinically ineffective, the insured is entitled to receive the course of therapy that the prescribing provider recommends, and the provider is not required to seek approval of an override of the fail-first protocol. As used in this section, the term "fail-first protocol" means a prescription practice that begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary.

Section 8. Effective January 1, 2017, subsection (44) is added to section 641.31, Florida Statutes, to read:

641.31 Health maintenance contracts.—

(44) A health maintenance organization may not require a health care provider, by contract with another health care provider, a patient, or another individual or entity, to use a clinical decision support system or a laboratory benefits management program before the provider may order clinical laboratory services or in an attempt to direct or limit the provider's medical decisionmaking relating to the use of such services. This subsection may not be construed to prohibit any

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prior authorization requirements that the health maintenance organization may have regarding the provision of clinical laboratory services. As used in this subsection, the term:

(a) "Clinical decision support system" means software designed to direct or assist clinical decisionmaking by matching the characteristics of an individual patient to a computerized clinical knowledge base and providing patient-specific assessments or recommendations based on the match.

(b) "Clinical laboratory services" means the examination of fluids or other materials taken from the human body, which examination is ordered by a health care provider for use in the diagnosis, prevention, or treatment of a disease or in the identification or assessment of a medical or physical condition.

(c) "Laboratory benefits management program" means a health maintenance organization protocol that dictates or limits health care provider decisionmaking relating to the use of clinical laboratory services.

Section 9. Effective January 1, 2017, section 641.394, Florida Statutes, is created to read:

641.394 Fail-first protocols.—If a health maintenance organization restricts the use of prescribed drugs through a fail-first protocol, it must establish a clear and convenient process that a prescribing physician may use to request an override of the restriction from the health maintenance organization. The health maintenance organization shall grant an override of the protocol within 24 hours if:

(1) Based on sound clinical evidence, the prescribing provider concludes that the preferred treatment required under the fail-first protocol has been ineffective in the treatment of

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the subscriber's disease or medical condition; or

(2) Based on sound clinical evidence or medical and scientific evidence, the prescribing provider believes that the preferred treatment required under the fail-first protocol:

(a) Is likely to be ineffective given the known relevant physical or mental characteristics and medical history of the subscriber and the known characteristics of the drug regimen; or

(b) Will cause or is likely to cause an adverse reaction or other physical harm to the subscriber.

If the prescribing provider follows the fail-first protocol recommended by the health maintenance organization for a subscriber, the duration of treatment under the fail-first protocol may not exceed a period deemed appropriate by the prescribing provider. Following such period, if the prescribing provider deems the treatment provided under the protocol clinically ineffective, the subscriber is entitled to receive the course of therapy that the prescribing provider recommends, and the provider is not required to seek approval of an override of the fail-first protocol. As used in this section, the term "fail-first protocol" means a prescription practice that begins medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies only if necessary.

Section 10. Paragraphs (a) and (d) of subsection (3) and subsections (4) and (5) of section 766.1115, Florida Statutes, are amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.—

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(3) DEFINITIONS.—As used in this section, the term:

(a) "Contract" means an agreement executed in compliance with this section between a health care provider and a governmental contractor for volunteer, uncompensated services which allows the health care provider to deliver health care services to low-income recipients as an agent of the governmental contractor. ~~The contract must be for volunteer, uncompensated services, except as provided in paragraph (4)(g).~~ For services to qualify as volunteer, uncompensated services under this section, the health care provider, or any employee or agent of the health care provider, must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or a public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract, except as provided in paragraph (4)(g). A free clinic as described in subparagraph (d)14. may receive a legislative appropriation, a grant through a legislative appropriation, or a grant from a governmental entity or nonprofit corporation to support the delivery of contracted services by volunteer health care providers, including the employment of health care providers to supplement, coordinate, or support the delivery of such services. The appropriation or grant for the free clinic does not constitute compensation under this paragraph from the governmental contractor for services provided under the contract, nor does receipt or use of the appropriation or grant constitute the acceptance of compensation under this paragraph for the specific services provided to the low-income recipients covered by the contract.

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(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.

2. An ambulatory surgical center licensed under chapter 395.

3. A hospital licensed under chapter 395.

4. A physician or physician assistant licensed under chapter 458.

5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.

6. A chiropractic physician licensed under chapter 460.

7. A podiatric physician licensed under chapter 461.

8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.

9. A midwife licensed under chapter 467.

10. A health maintenance organization certificated under part I of chapter 641.

11. A health care professional association ~~and its employees~~ or a corporate medical group ~~and its employees~~.

12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.

13. A dentist or dental hygienist licensed under chapter 466.

14. A free clinic that delivers only medical diagnostic

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services or nonsurgical medical treatment free of charge to all low-income recipients.

15. A pharmacy or pharmacist licensed under chapter 465.

16.~~15.~~ Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

(4) CONTRACT REQUIREMENTS.—A health care provider that executes a contract with a governmental contractor to deliver health care services ~~on or after April 17, 1992,~~ as an agent of the governmental contractor, or any employee or agent of such health care provider, is an agent for purposes of s. 768.28(9), while acting within the scope of duties under the contract, if the contract complies with the requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider, or any employee or agent of such health care provider, shall continue to be an agent for purposes of s. 768.28(9) for 30 days after a determination of ineligibility to allow for treatment until the individual

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transitions to treatment by another health care provider. A health care provider, or any employee or agent of such health care provider, under contract with the state may not be named as a defendant in any action arising out of medical care or treatment ~~provided on or after April 17, 1992,~~ under contracts entered into under this section. The contract must provide that:

(a) The right of dismissal or termination of any health care provider delivering services under the contract is retained by the governmental contractor.

(b) The governmental contractor has access to the patient records of any health care provider delivering services under the contract.

(c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if the incidents and information pertain to a patient treated under the contract. The health care provider shall submit the reports required by s. 395.0197. If an incident involves a professional licensed by the Department of Health or a facility licensed by the Agency for Health Care Administration, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities under this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(d) Patient selection and initial referral must be made by

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the governmental contractor or the provider. Patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.

(e) If emergency care is required, the patient need not be referred before receiving treatment, but must be referred within 48 hours after treatment is commenced or within 48 hours after the patient has the mental capacity to consent to treatment, whichever occurs later.

(f) The provider is subject to supervision and regular inspection by the governmental contractor.

(g) ~~As an agent of the governmental contractor for purposes of s. 768.28(9), while acting within the scope of duties under the contract,~~ A health care provider licensed under chapter 466, as an agent of the governmental contractor for purposes of s. 768.28(9), may allow a patient, or a parent or guardian of the patient, to voluntarily contribute a monetary amount to cover costs of dental laboratory work related to the services provided to the patient within the scope of duties under the contract. This contribution may not exceed the actual cost of the dental laboratory charges.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

(5) NOTICE OF AGENCY RELATIONSHIP.—The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be

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acknowledged in writing at the initial visit, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to ~~the provisions of~~ s. 768.28. Thereafter, or with respect to any federally funded community health center, the notice requirements may be met by posting in a place conspicuous to all persons a notice that the health care provider, or federally funded community health center, is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to ~~the provisions of~~ s. 768.28.

Section 11. Paragraphs (a) and (b) of subsection (9) of section 768.28, Florida Statutes, is amended to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(9)(a) An ~~No~~ officer, employee, or agent of the state or of any of its subdivisions may not ~~shall~~ be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton

and willful disregard of human rights, safety, or property. However, such officer, employee, or agent shall be considered an adverse witness in a tort action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. The exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state or any of its subdivisions or constitutional officers is ~~shall be~~ by action against the governmental entity, or the head of such entity in her or his official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless such act or omission was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. The state or its subdivisions are ~~shall~~ not ~~be~~ liable in tort for the acts or omissions of an officer, employee, or agent committed while acting outside the course and scope of her or his employment or committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any health care provider, and its employees or agents, when providing services pursuant to s. 766.1115; any nonprofit independent college or university located and chartered in this state which owns or operates an accredited medical school, and its employees or agents, when providing patient services pursuant to paragraph (10)(f); ~~and~~ any public

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defender or her or his employee or agent, including~~, among others,~~ an assistant public defender or ~~and~~ an investigator; and any physician licensed in this state who is a medical director for or member of a child protection team, as defined in s. 39.01, when carrying out her or his duties as a team member.

Section 12. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2016.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to health care; creating s. 381.4019, F.S.; establishing a joint local and state dental care access account initiative, subject to the availability of funding; authorizing the creation of dental care access accounts; specifying the purpose of the initiative; defining terms; providing criteria for the selection of dentists for participation in the initiative; providing for the establishment of accounts; requiring the Department of Health to implement an electronic benefit transfer system; providing for the use of funds deposited in the accounts; requiring the department to distribute state funds to accounts, subject to legislative appropriations; authorizing the department to accept contributions from a local source for deposit in a designated account; limiting the number of years that

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an account may remain open; providing for the immediate closing of accounts under certain circumstances; authorizing the department to transfer state funds remaining in a closed account at a specified time and to return unspent funds from local sources; requiring a dentist to repay funds in certain circumstances; authorizing the department to pursue disciplinary enforcement actions and to use other legal means to recover funds; requiring the department to establish by rule application procedures and a process to verify the use of funds withdrawn from a dental care access account; requiring the department to give priority to applications from dentists practicing in certain areas; requiring the Department of Economic Opportunity to rank dental health professional shortage areas and medically underserved areas; requiring the Department of Health to develop a marketing plan in cooperation with certain dental colleges and the Florida Dental Association; requiring the Department of Health to annually submit a report with certain information to the Governor and the Legislature; providing rulemaking authority to require the submission of information for such reporting; amending s. 395.002, F.S.; revising the definition of the term "ambulatory surgical center" or "mobile surgical facility"; amending s. 395.003, F.S.; requiring, as a condition of licensure and license renewal, that ambulatory surgical centers provide services to specified patients in at least a specified

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amount; defining a term; creating s. 624.27, F.S.; defining terms; specifying that a direct primary care agreement does not constitute insurance and is not subject to ch. 636, F.S., relating to prepaid limited health service organizations and discount medical plan organizations, or any other chapter of the Florida Insurance Code; specifying that entering into a direct primary care agreement does not constitute the business of insurance and is not subject to ch. 636, F.S., or any other chapter of the code; providing that certain certificates of authority and licenses are not required to market, sell, or offer to sell a direct primary care agreement; specifying requirements for a direct primary care agreement; providing a short title; amending s. 409.967, F.S.; requiring a managed care plan to establish a process by which a prescribing physician may request an override of certain restrictions in certain circumstances; providing the circumstances under which an override must be granted; defining the term "fail-first protocol"; creating s. 627.42392, F.S.; requiring an insurer to establish a process by which a prescribing physician may request an override of certain restrictions in certain circumstances; providing the circumstances under which an override must be granted; defining the term "fail-first protocol"; amending s. 641.31, F.S.; prohibiting a health maintenance organization from requiring that a health care provider use a clinical decision support system or a

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laboratory benefits management program in certain circumstances; defining terms; providing for construction; creating s. 641.394, F.S.; requiring a health maintenance organization to establish a process by which a prescribing physician may request an override of certain restrictions in certain circumstances; providing the circumstances under which an override must be granted; defining the term "fail-first protocol"; amending s. 766.1115, F.S.; revising the definitions of the terms "contract" and "health care provider"; deleting an obsolete date; extending sovereign immunity to employees or agents of a health care provider that executes a contract with a governmental contractor; clarifying that a receipt of specified notice must be acknowledged by a patient or the patient's representative at the initial visit; requiring the posting of notice that a specified health care provider is an agent of a governmental contractor; amending s. 768.28, F.S.; revising the definition of the term "officer, employee, or agent" to include employees or agents of a health care provider as it applies to immunity from personal liability in certain actions, to include licensed physicians who are medical directors for or members of a child protection team, in certain circumstances; providing effective dates.