By the Committees on Appropriations; and Health Policy; and
Senator Gaetz

576-04250-16 2016212c2

1 A bill to be entitled
2 An act relating to health care; creating s. 381.4019,
3 F.S.; establishing a joint local and state dental care
4 access account initiative, subject to the availability
5 of funding; authorizing the creation of dental care
6 access accounts; specifying the purpose of the
7 initiative; defining terms; providing criteria for the
8 selection of dentists for participation in the
9 initiative; providing for the establishment of
10 accounts; requiring the Department of Health to
11 implement an electronic benefit transfer system;
12 providing for the use of funds deposited in the
13 accounts; requiring the department to distribute state
14 funds to accounts, subject to legislative
15 appropriations; authorizing the department to accept
16 contributions from a local source for deposit in a
17 designated account; limiting the number of years that
18 an account may remain open; providing for the
19 immediate closing of accounts under certain
20 circumstances; authorizing the department to transfer
21 state funds remaining in a closed account at a
22 specified time and to return unspent funds from local
23 sources; requiring a dentist to repay funds in certain
24 circumstances; authorizing the department to pursue
25 disciplinary enforcement actions and to use other
26 legal means to recover funds; requiring the department
27 to establish by rule application procedures and a
28 process to verify the use of funds withdrawn from a
29 dental care access account; requiring the department
30 to give priority to applications from dentists
31 practicing in certain areas; requiring the Department

32 of Economic Opportunity to rank dental health
33 professional shortage areas and medically underserved
34 areas; requiring the Department of Health to develop a
35 marketing plan in cooperation with certain dental
36 colleges and the Florida Dental Association; requiring
37 the Department of Health to annually submit a report
38 with certain information to the Governor and the
39 Legislature; providing rulemaking authority to require
40 the submission of information for such reporting;
41 amending s. 395.002, F.S.; revising the definition of
42 the term “ambulatory surgical center” or “mobile
43 surgical facility”; amending s. 395.003, F.S.;
44 requiring, as a condition of licensure and license
45 renewal, that ambulatory surgical centers provide
46 services to specified patients in at least a specified
47 amount; requiring ambulatory surgical centers to
48 report certain data; defining a term; requiring
49 ambulatory surgical centers to comply with certain
50 building and lifesafety codes in certain
51 circumstances; creating s. 624.27, F.S.; defining
52 terms; specifying that a direct primary care agreement
53 does not constitute insurance and is not subject to
54 ch. 636, F.S., relating to prepaid limited health
55 service organizations and discount medical plan
56 organizations, or any other chapter of the Florida
57 Insurance Code; specifying that entering into a direct
58 primary care agreement does not constitute the
59 business of insurance and is not subject to ch. 636,
60 F.S., or any other chapter of the code; providing that

61 certain certificates of authority and licenses are not
62 required to market, sell, or offer to sell a direct
63 primary care agreement; specifying requirements for a
64 direct primary care agreement; providing a short
65 title; amending s. 409.967, F.S.; requiring a managed
66 care plan to establish a process by which a
67 prescribing physician may request an override of
68 certain restrictions in certain circumstances;
69 providing the circumstances under which an override
70 must be granted; defining the term "fail-first
71 protocol"; creating s. 627.42392, F.S.; requiring an
72 insurer to establish a process by which a prescribing
73 physician may request an override of certain
74 restrictions in certain circumstances; providing the
75 circumstances under which an override must be granted;
76 defining the term "fail-first protocol"; amending s.
77 641.31, F.S.; prohibiting a health maintenance
78 organization from requiring that a health care
79 provider use a clinical decision support system or a
80 laboratory benefits management program in certain
81 circumstances; defining terms; providing for
82 construction; creating s. 641.394, F.S.; requiring a
83 health maintenance organization to establish a process
84 by which a prescribing physician may request an
85 override of certain restrictions in certain
86 circumstances; providing the circumstances under which
87 an override must be granted; defining the term "fail-
88 first protocol"; amending s. 766.1115, F.S.; revising
89 the definitions of the terms "contract" and "health

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90 care provider"; deleting an obsolete date; extending
91 sovereign immunity to employees or agents of a health
92 care provider that executes a contract with a
93 governmental contractor; clarifying that a receipt of
94 specified notice must be acknowledged by a patient or
95 the patient's representative at the initial visit;
96 requiring the posting of notice that a specified
97 health care provider is an agent of a governmental
98 contractor; amending s. 768.28, F.S.; revising the
99 definition of the term "officer, employee, or agent"
100 to include employees or agents of a health care
101 provider as it applies to immunity from personal
102 liability in certain actions; providing effective
103 dates.
104
105 Be It Enacted by the Legislature of the State of Florida:
106
107 Section 1. Section 381.4019, Florida Statutes, is created
108 to read:
109 381.4019 Dental care access accounts.—Subject to the
110 availability of funds, the Legislature establishes a joint local
111 and state dental care access account initiative and authorizes
112 the creation of dental care access accounts to promote economic
113 development by supporting qualified dentists who practice in
114 dental health professional shortage areas or medically
115 underserved areas or who treat a medically underserved
116 population. The Legislature recognizes that maintaining good
117 oral health is integral to overall health status and that the
118 good health of residents of this state is an important

119 contributing factor in economic development. Better health,
120 including better oral health, enables workers to be more
121 productive, reduces the burden of health care costs, and enables
122 children to improve in cognitive development.
123 (1) As used in this section, the term:
124 (a) “Dental health professional shortage area” means a
125 geographic area so designated by the Health Resources and
126 Services Administration of the United States Department of
127 Health and Human Services.
128 (b) “Department” means the Department of Health.
129 (c) “Medically underserved area” means a geographic area so
130 designated by the Health Resources and Services Administration
131 of the United States Department of Health and Human Services.
132 (d) “Public health program” means a county health
133 department, the Children’s Medical Services Network, a federally
134 qualified community health center, a federally funded migrant
135 health center, or other publicly funded or nonprofit health care
136 program as designated by the department.
137 (2) The department shall develop and implement a dental
138 care access account initiative to benefit dentists licensed to
139 practice in this state who demonstrate, as required by the
140 department by rule:
141 (a) Active employment by a public health program located in
142 a dental health professional shortage area or a medically
143 underserved area; or
144 (b) A commitment to opening a private practice in a dental
145 health professional shortage area or a medically underserved
146 area, as demonstrated by the dentist residing in the designated
147 area, maintaining an active Medicaid provider agreement,

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148 enrolling in one or more Medicaid managed care plans, expending
149 sufficient capital to make substantial progress in opening a
150 dental practice that is capable of serving at least 1,200
151 patients, and obtaining financial support from the local
152 community in which the dentist is practicing or intending to
153 open a practice.
154 (3) The department shall establish dental care access
155 accounts as individual benefit accounts for each dentist who
156 satisfies the requirements of subsection (2) and is selected by
157 the department for participation. The department shall implement
158 an electronic benefit transfer system that enables each dentist
159 to spend funds from his or her account for the purposes
160 described in subsection (4).
161 (4) Funds contributed from state and local sources to a
162 dental care access account may be used for one or more of the
163 following purposes:
164 (a) Repayment of dental school student loans.
165 (b) Investment in property, facilities, or equipment
166 necessary to establish and operate a dental office consisting of
167 no fewer than two operatories.
168 (c) Payment of transitional expenses related to the
169 relocation or opening of a dental practice which are
170 specifically approved by the department.
171 (5) Subject to legislative appropriation, the department
172 shall distribute state funds as an award to each dental care
173 access account. An individual award must be in an amount not
174 more than $100,000 and not less than $10,000, except that a
175 state award may not exceed 3 times the amount contributed to an
176 account in the same year from local sources. If a dentist

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177 qualifies for a dental care access account under paragraph
178 (2)(a), the dentist's salary and associated employer
179 expenditures constitute a local match and qualify the account
180 for a state award if the salary and associated expenditures do
181 not come from state funds. State funds may not be included in a
182 determination of the amount contributed to an account from local
183 sources.
184 (6) The department may accept contributions of funds from a
185 local source for deposit in the account of a dentist designated
186 by the donor.
187 (7) The department shall close an account no later than 5
188 years after the first deposit of state or local funds into that
189 account or immediately upon the occurrence of any of the
190 following:
191 (a) Termination of the dentist's employment with a public
192 health program, unless, within 30 days after such termination,
193 the dentist opens a private practice in a dental health
194 professional shortage area or medically underserved area.
195 (b) Termination of the dentist's practice in a designated
196 dental health professional shortage area or medically
197 underserved area.
198 (c) Termination of the dentist's participation in the
199 Florida Medicaid program.
200 (d) Participation by the dentist in any fraudulent
201 activity.
202 (8) Any state funds remaining in a closed account may be
203 awarded and transferred to another account concurrent with the
204 distribution of funds under the next legislative appropriation
205 for the initiative. The department shall return to the donor on

206 a pro rata basis unspent funds from local sources which remain
207 in a closed account.
208 (9) If the department determines that a dentist has
209 withdrawn account funds after the occurrence of an event
210 specified in subsection (7), has used funds for purposes not
211 authorized in subsection (4), or has not remained eligible for a
212 dental care access account for a minimum of 2 years, the dentist
213 shall repay the funds to his or her account. The department may
214 recover the withdrawn funds through disciplinary enforcement
215 actions and other methods authorized by law.
216 (10) The department shall establish by rule:
217 (a) Application procedures for dentists who wish to apply
218 for a dental care access account. An applicant may demonstrate
219 that he or she has expended sufficient capital to make
220 substantial progress in opening a dental practice that is
221 capable of serving at least 1,200 patients by documenting
222 contracts for the purchase or lease of a practice location and
223 providing executed obligations for the purchase or other
224 acquisition of at least 30 percent of the value of equipment or
225 supplies necessary to operate a dental practice. The department
226 may limit the number of applicants selected and shall give
227 priority to those applicants practicing in the areas receiving
228 higher rankings pursuant to subsection (11). The department may
229 establish additional criteria for selection which recognize an
230 applicant’s active engagement with and commitment to the
231 community providing a local match.
232 (b) A process to verify that funds withdrawn from a dental
233 care access account have been used solely for the purposes
234 described in subsection (4).

235 (11) The Department of Economic Opportunity shall rank the
236 dental health professional shortage areas and medically
237 underserved areas of the state based on the extent to which
238 limited access to dental care is impeding the areas' economic
239 development, with a higher ranking indicating a greater
240 impediment to development.
241 (12) The department shall develop a marketing plan for the
242 dental care access account initiative in cooperation with the
243 University of Florida College of Dentistry, the Nova
244 Southeastern University College of Dental Medicine, the Lake
245 Erie College of Osteopathic Medicine School of Dental Medicine,
246 and the Florida Dental Association.
247 (13)(a) By January 1 of each year, beginning in 2018, the
248 department shall issue a report to the Governor, the President
249 of the Senate, and the Speaker of the House of Representatives
250 which must include:
251 1. The number of patients served by dentists receiving
252 funding under this section.
253 2. The number of Medicaid recipients served by dentists
254 receiving funding under this section.
255 3. The average number of hours worked and patients served
256 in a week by dentists receiving funding under this section.
257 4. The number of dentists in each dental health
258 professional shortage area or medically underserved area
259 receiving funding under this section.
260 5. The amount and source of local matching funds received
261 by the department.
262 6. The amount of state funds awarded to dentists under this
263 section.

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264 7. A complete accounting of the use of funds by categories
265 identified by the department, including, but not limited to,
266 loans, supplies, equipment, rental property payments, real
267 property purchases, and salary and wages.
268 (b) The department shall adopt rules to require dentists to
269 report information to the department which is necessary for the
270 department to fulfill its reporting requirement under this
271 subsection.
272 Section 2. Subsection (3) of section 395.002, Florida
273 Statutes, is amended to read:
274 395.002 Definitions.—As used in this chapter:
275 (3) "Ambulatory surgical center" or "mobile surgical
276 facility" means a facility the primary purpose of which is to
277 provide elective surgical care, in which the patient is admitted
278 to and discharged from such facility within 24 hours ~~the same~~
279 ~~working day and is not permitted to stay overnight~~, and which is
280 not part of a hospital. However, a facility existing for the
281 primary purpose of performing terminations of pregnancy, an
282 office maintained by a physician for the practice of medicine,
283 or an office maintained for the practice of dentistry shall not
284 be construed to be an ambulatory surgical center, provided that
285 any facility or office which is certified or seeks certification
286 as a Medicare ambulatory surgical center shall be licensed as an
287 ambulatory surgical center pursuant to s. 395.003. Any structure
288 or vehicle in which a physician maintains an office and
289 practices surgery, and which can appear to the public to be a
290 mobile office because the structure or vehicle operates at more
291 than one address, shall be construed to be a mobile surgical
292 facility.

293 Section 3. Present subsections (6) through (10) of section
294 395.003, Florida Statutes, are redesignated as subsections (7)
295 through (11), respectively, a new subsection (6) is added to
296 that section, and present subsections (9) and (10) of that
297 section are amended, to read:
298 395.003 Licensure; denial, suspension, and revocation.—
299 (6) An ambulatory surgical center, as a condition of
300 initial licensure and license renewal, must provide services to
301 Medicare patients, Medicaid patients, and patients who qualify
302 for charity care in an amount equal to or greater than the
303 applicable district average among licensed providers of similar
304 services. Ambulatory surgical centers shall report the same
305 financial, patient, postoperative surgical infection, and other
306 data pursuant to s. 408.061 as reported by hospitals to the
307 Agency for Health Care Administration or otherwise published by
308 the agency. For the purposes of this subsection, “charity care”
309 means uncompensated care delivered to uninsured patients with
310 incomes at or below 200 percent of the federal poverty level
311 when such services are preauthorized by the licensee and not
312 subject to collection procedures. An ambulatory surgical center
313 that keeps patients later than midnight on the day of the
314 procedure must comply with the same building codes and
315 lifesafety codes as a hospital.
316 (10) ~~(9)~~ A hospital licensed as of June 1, 2004, shall be
317 exempt from subsection (9) ~~subsection (8)~~ as long as the
318 hospital maintains the same ownership, facility street address,
319 and range of services that were in existence on June 1, 2004.
320 Any transfer of beds, or other agreements that result in the
321 establishment of a hospital or hospital services within the

322 intent of this section, shall be subject to subsection (9)
323 ~~subsection (8)~~. Unless the hospital is otherwise exempt under
324 subsection (9) ~~subsection (8)~~, the agency shall deny or revoke
325 the license of a hospital that violates any of the criteria set
326 forth in that subsection.
327 (11) ~~(10)~~ The agency may adopt rules implementing the
328 licensure requirements set forth in subsection (9) ~~subsection~~
329 ~~(8)~~. Within 14 days after rendering its decision on a license
330 application or revocation, the agency shall publish its proposed
331 decision in the Florida Administrative Register. Within 21 days
332 after publication of the agency's decision, any authorized
333 person may file a request for an administrative hearing. In
334 administrative proceedings challenging the approval, denial, or
335 revocation of a license pursuant to subsection (9) ~~subsection~~
336 ~~(8)~~, the hearing must be based on the facts and law existing at
337 the time of the agency's proposed agency action. Existing
338 hospitals may initiate or intervene in an administrative hearing
339 to approve, deny, or revoke licensure under subsection (9)
340 ~~subsection (8)~~ based upon a showing that an established program
341 will be substantially affected by the issuance or renewal of a
342 license to a hospital within the same district or service area.
343 Section 4. Section 624.27, Florida Statutes, is created to
344 read:
345 624.27 Application of code as to direct primary care
346 agreements.—
347 (1) As used in this section, the term:
348 (a) "Direct primary care agreement" means a contract
349 between a primary care provider and a patient, the patient's
350 legal representative, or an employer which meets the

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351 requirements specified under subsection (4) and does not
352 indemnify for services provided by a third party.
353 (b) “Primary care provider” means a health care
354 practitioner licensed under chapter 458, chapter 459, chapter
355 460, or chapter 464, or a primary care group practice that
356 provides medical services to patients which are commonly
357 provided without referral from another health care provider.
358 (c) “Primary care service” means the screening, assessment,
359 diagnosis, and treatment of a patient for the purpose of
360 promoting health or detecting and managing disease or injury
361 within the competency and training of the primary care provider.
362 (2) A direct primary care agreement does not constitute
363 insurance and is not subject to chapter 636 or any other chapter
364 of the Florida Insurance Code. The act of entering into a direct
365 primary care agreement does not constitute the business of
366 insurance and is not subject to chapter 636 or any other chapter
367 of the Florida Insurance Code.
368 (3) A primary care provider or an agent of a primary care
369 provider is not required to obtain a certificate of authority or
370 license under chapter 636 or any other chapter of the Florida
371 Insurance Code to market, sell, or offer to sell a direct
372 primary care agreement.
373 (4) For purposes of this section, a direct primary care
374 agreement must:
375 (a) Be in writing.
376 (b) Be signed by the primary care provider or an agent of
377 the primary care provider and the patient, the patient’s legal
378 representative, or an employer.
379 (c) Allow a party to terminate the agreement by giving the

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380 other party at least 30 days’ advance written notice. The
381 agreement may provide for immediate termination due to a
382 violation of the physician-patient relationship or a breach of
383 the terms of the agreement.
384 (d) Describe the scope of primary care services that are
385 covered by the monthly fee.
386 (e) Specify the monthly fee and any fees for primary care
387 services not covered by the monthly fee.
388 (f) Specify the duration of the agreement and any automatic
389 renewal provisions.
390 (g) Offer a refund to the patient of monthly fees paid in
391 advance if the primary care provider ceases to offer primary
392 care services for any reason.
393 (h) Contain in contrasting color and in not less than 12-
394 point type the following statements on the same page as the
395 applicant’s signature:
396 1. The agreement is not health insurance and the primary
397 care provider will not file any claims against the patient’s
398 health insurance policy or plan for reimbursement of any primary
399 care services covered by the agreement.
400 2. The agreement does not qualify as minimum essential
401 coverage to satisfy the individual shared responsibility
402 provision of the Patient Protection and Affordable Care Act, 26
403 U.S.C. s. 5000A.
404 Section 5. The sections created and amendments made by this
405 act to ss. 409.967, 627.42392, 641.31, and 641.394, Florida
406 Statutes, may be known as the “Right Medicine Right Time Act.”
407 Section 6. Effective January 1, 2017, paragraph (c) of
408 subsection (2) of section 409.967, Florida Statutes, is amended

409 to read:
410 409.967 Managed care plan accountability.—
411 (2) The agency shall establish such contract requirements
412 as are necessary for the operation of the statewide managed care
413 program. In addition to any other provisions the agency may deem
414 necessary, the contract must require:
415 (c) *Access.*—
416 1. The agency shall establish specific standards for the
417 number, type, and regional distribution of providers in managed
418 care plan networks to ensure access to care for both adults and
419 children. Each plan must maintain a regionwide network of
420 providers in sufficient numbers to meet the access standards for
421 specific medical services for all recipients enrolled in the
422 plan. The exclusive use of mail-order pharmacies may not be
423 sufficient to meet network access standards. Consistent with the
424 standards established by the agency, provider networks may
425 include providers located outside the region. A plan may
426 contract with a new hospital facility before the date the
427 hospital becomes operational if the hospital has commenced
428 construction, will be licensed and operational by January 1,
429 2013, and a final order has issued in any civil or
430 administrative challenge. Each plan shall establish and maintain
431 an accurate and complete electronic database of contracted
432 providers, including information about licensure or
433 registration, locations and hours of operation, specialty
434 credentials and other certifications, specific performance
435 indicators, and such other information as the agency deems
436 necessary. The database must be available online to both the
437 agency and the public and have the capability to compare the

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438 availability of providers to network adequacy standards and to
439 accept and display feedback from each provider's patients. Each
440 plan shall submit quarterly reports to the agency identifying
441 the number of enrollees assigned to each primary care provider.
442 2.a. Each managed care plan must publish any prescribed
443 drug formulary or preferred drug list on the plan's website in a
444 manner that is accessible to and searchable by enrollees and
445 providers. The plan must update the list within 24 hours after
446 making a change. Each plan must ensure that the prior
447 authorization process for prescribed drugs is readily accessible
448 to health care providers, including posting appropriate contact
449 information on its website and providing timely responses to
450 providers. For Medicaid recipients diagnosed with hemophilia who
451 have been prescribed anti-hemophilic-factor replacement
452 products, the agency shall provide for those products and
453 hemophilia overlay services through the agency's hemophilia
454 disease management program.
455 b. If a managed care plan restricts the use of prescribed
456 drugs through a fail-first protocol, it must establish a clear
457 and convenient process that a prescribing physician may use to
458 request an override of the restriction from the managed care
459 plan. The managed care plan shall grant an override of the
460 protocol within 24 hours if:
461 (I) Based on sound clinical evidence, the prescribing
462 provider concludes that the preferred treatment required under
463 the fail-first protocol has been ineffective in the treatment of
464 the enrollee's disease or medical condition; or
465 (II) Based on sound clinical evidence or medical and
466 scientific evidence, the prescribing provider believes that the

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467 preferred treatment required under the fail-first protocol:
468 (A) Is likely to be ineffective given the known relevant
469 physical or mental characteristics and medical history of the
470 enrollee and the known characteristics of the drug regimen; or
471 (B) Will cause or is likely to cause an adverse reaction or
472 other physical harm to the enrollee.
473
474 If the prescribing provider follows the fail-first protocol
475 recommended by the managed care plan for an enrollee, the
476 duration of treatment under the fail-first protocol may not
477 exceed a period deemed appropriate by the prescribing provider.
478 Following such period, if the prescribing provider deems the
479 treatment provided under the protocol clinically ineffective,
480 the enrollee is entitled to receive the course of therapy that
481 the prescribing provider recommends, and the provider is not
482 required to seek approval of an override of the fail-first
483 protocol. As used in this subparagraph, the term “fail-first
484 protocol” means a prescription practice that begins medication
485 for a medical condition with the most cost-effective drug
486 therapy and progresses to other more costly or risky therapies
487 only if necessary.
488 3. Managed care plans, and their fiscal agents or
489 intermediaries, must accept prior authorization requests for any
490 service electronically.
491 4. Managed care plans serving children in the care and
492 custody of the Department of Children and Families shall ~~must~~
493 maintain complete medical, dental, and behavioral health
494 encounter information and participate in making such information
495 available to the department or the applicable contracted

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496 community-based care lead agency for use in providing
497 comprehensive and coordinated case management. The agency and
498 the department shall establish an interagency agreement to
499 provide guidance for the format, confidentiality, recipient,
500 scope, and method of information to be made available and the
501 deadlines for submission of the data. The scope of information
502 available to the department are ~~shall be~~ the data that managed
503 care plans are required to submit to the agency. The agency
504 shall determine the plan's compliance with standards for access
505 to medical, dental, and behavioral health services; the use of
506 medications; and followup on all medically necessary services
507 recommended as a result of early and periodic screening,
508 diagnosis, and treatment.
509 Section 7. Effective January 1, 2017, section 627.42392,
510 Florida Statutes, is created to read:
511 627.42392 Fail-first protocols.—If an insurer restricts the
512 use of prescribed drugs through a fail-first protocol, it must
513 establish a clear and convenient process that a prescribing
514 physician may use to request an override of the restriction from
515 the insurer. The insurer shall grant an override of the protocol
516 within 24 hours if:
517 (1) Based on sound clinical evidence, the prescribing
518 provider concludes that the preferred treatment required under
519 the fail-first protocol has been ineffective in the treatment of
520 the insured's disease or medical condition; or
521 (2) Based on sound clinical evidence or medical and
522 scientific evidence, the prescribing provider believes that the
523 preferred treatment required under the fail-first protocol:
524 (a) Is likely to be ineffective given the known relevant

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525 physical or mental characteristics and medical history of the
526 insured and the known characteristics of the drug regimen; or
527 (b) Will cause or is likely to cause an adverse reaction or
528 other physical harm to the insured.
529
530 If the prescribing provider follows the fail-first protocol
531 recommended by the insurer for an insured, the duration of
532 treatment under the fail-first protocol may not exceed a period
533 deemed appropriate by the prescribing provider. Following such
534 period, if the prescribing provider deems the treatment provided
535 under the protocol clinically ineffective, the insured is
536 entitled to receive the course of therapy that the prescribing
537 provider recommends, and the provider is not required to seek
538 approval of an override of the fail-first protocol. As used in
539 this section, the term “fail-first protocol” means a
540 prescription practice that begins medication for a medical
541 condition with the most cost-effective drug therapy and
542 progresses to other more costly or risky therapies only if
543 necessary.
544 Section 8. Effective January 1, 2017, subsection (44) is
545 added to section 641.31, Florida Statutes, to read:
546 641.31 Health maintenance contracts.—
547 (44) A health maintenance organization may not require a
548 health care provider, by contract with another health care
549 provider, a patient, or another individual or entity, to use a
550 clinical decision support system or a laboratory benefits
551 management program before the provider may order clinical
552 laboratory services or in an attempt to direct or limit the
553 provider’s medical decisionmaking relating to the use of such

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554 services. This subsection may not be construed to prohibit any
555 prior authorization requirements that the health maintenance
556 organization may have regarding the provision of clinical
557 laboratory services. As used in this subsection, the term:
558 (a) "Clinical decision support system" means software
559 designed to direct or assist clinical decisionmaking by matching
560 the characteristics of an individual patient to a computerized
561 clinical knowledge base and providing patient-specific
562 assessments or recommendations based on the match.
563 (b) "Clinical laboratory services" means the examination of
564 fluids or other materials taken from the human body, which
565 examination is ordered by a health care provider for use in the
566 diagnosis, prevention, or treatment of a disease or in the
567 identification or assessment of a medical or physical condition.
568 (c) "Laboratory benefits management program" means a health
569 maintenance organization protocol that dictates or limits health
570 care provider decisionmaking relating to the use of clinical
571 laboratory services.
572 Section 9. Effective January 1, 2017, section 641.394,
573 Florida Statutes, is created to read:
574 641.394 Fail-first protocols.—If a health maintenance
575 organization restricts the use of prescribed drugs through a
576 fail-first protocol, it must establish a clear and convenient
577 process that a prescribing physician may use to request an
578 override of the restriction from the health maintenance
579 organization. The health maintenance organization shall grant an
580 override of the protocol within 24 hours if:
581 (1) Based on sound clinical evidence, the prescribing
582 provider concludes that the preferred treatment required under

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583 the fail-first protocol has been ineffective in the treatment of
584 the subscriber's disease or medical condition; or
585 (2) Based on sound clinical evidence or medical and
586 scientific evidence, the prescribing provider believes that the
587 preferred treatment required under the fail-first protocol:
588 (a) Is likely to be ineffective given the known relevant
589 physical or mental characteristics and medical history of the
590 subscriber and the known characteristics of the drug regimen; or
591 (b) Will cause or is likely to cause an adverse reaction or
592 other physical harm to the subscriber.
593
594 If the prescribing provider follows the fail-first protocol
595 recommended by the health maintenance organization for a
596 subscriber, the duration of treatment under the fail-first
597 protocol may not exceed a period deemed appropriate by the
598 prescribing provider. Following such period, if the prescribing
599 provider deems the treatment provided under the protocol
600 clinically ineffective, the subscriber is entitled to receive
601 the course of therapy that the prescribing provider recommends,
602 and the provider is not required to seek approval of an override
603 of the fail-first protocol. As used in this section, the term
604 "fail-first protocol" means a prescription practice that begins
605 medication for a medical condition with the most cost-effective
606 drug therapy and progresses to other more costly or risky
607 therapies only if necessary.
608 Section 10. Paragraphs (a) and (d) of subsection (3) and
609 subsections (4) and (5) of section 766.1115, Florida Statutes,
610 are amended to read:
611 766.1115 Health care providers; creation of agency

612 relationship with governmental contractors.—
613 (3) DEFINITIONS.—As used in this section, the term:
614 (a) “Contract” means an agreement executed in compliance
615 with this section between a health care provider and a
616 governmental contractor for volunteer, uncompensated services
617 which allows the health care provider to deliver health care
618 services to low-income recipients as an agent of the
619 governmental contractor. ~~The contract must be for volunteer,~~
620 ~~uncompensated services, except as provided in paragraph (4)(g).~~
621 For services to qualify as volunteer, uncompensated services
622 under this section, the health care provider, or any employee or
623 agent of the health care provider, must receive no compensation
624 from the governmental contractor for any services provided under
625 the contract and must not bill or accept compensation from the
626 recipient, or a public or private third-party payor, for the
627 specific services provided to the low-income recipients covered
628 by the contract, except as provided in paragraph (4)(g). A free
629 clinic as described in subparagraph (d)14. may receive a
630 legislative appropriation, a grant through a legislative
631 appropriation, or a grant from a governmental entity or
632 nonprofit corporation to support the delivery of contracted
633 services by volunteer health care providers, including the
634 employment of health care providers to supplement, coordinate,
635 or support the delivery of such services. The appropriation or
636 grant for the free clinic does not constitute compensation under
637 this paragraph from the governmental contractor for services
638 provided under the contract, nor does receipt or use of the
639 appropriation or grant constitute the acceptance of compensation
640 under this paragraph for the specific services provided to the

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641 low-income recipients covered by the contract.
642 (d) "Health care provider" or "provider" means:
643 1. A birth center licensed under chapter 383.
644 2. An ambulatory surgical center licensed under chapter
645 395.
646 3. A hospital licensed under chapter 395.
647 4. A physician or physician assistant licensed under
648 chapter 458.
649 5. An osteopathic physician or osteopathic physician
650 assistant licensed under chapter 459.
651 6. A chiropractic physician licensed under chapter 460.
652 7. A podiatric physician licensed under chapter 461.
653 8. A registered nurse, nurse midwife, licensed practical
654 nurse, or advanced registered nurse practitioner licensed or
655 registered under part I of chapter 464 or any facility which
656 employs nurses licensed or registered under part I of chapter
657 464 to supply all or part of the care delivered under this
658 section.
659 9. A midwife licensed under chapter 467.
660 10. A health maintenance organization certificated under
661 part I of chapter 641.
662 11. A health care professional association ~~and its~~
663 ~~employees~~ or a corporate medical group ~~and its employees~~.
664 12. Any other medical facility the primary purpose of which
665 is to deliver human medical diagnostic services or which
666 delivers nonsurgical human medical treatment, and which includes
667 an office maintained by a provider.
668 13. A dentist or dental hygienist licensed under chapter
669 466.

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670 14. A free clinic that delivers only medical diagnostic
671 services or nonsurgical medical treatment free of charge to all
672 low-income recipients.
673 15. A pharmacy or pharmacist licensed under chapter 465.
674 16.~~15.~~ Any other health care professional, practitioner,
675 provider, or facility under contract with a governmental
676 contractor, including a student enrolled in an accredited
677 program that prepares the student for licensure as any one of
678 the professionals listed in subparagraphs 4.-9.
679
680 The term includes any nonprofit corporation qualified as exempt
681 from federal income taxation under s. 501(a) of the Internal
682 Revenue Code, and described in s. 501(c) of the Internal Revenue
683 Code, which delivers health care services provided by licensed
684 professionals listed in this paragraph, any federally funded
685 community health center, and any volunteer corporation or
686 volunteer health care provider that delivers health care
687 services.
688 (4) CONTRACT REQUIREMENTS.—A health care provider that
689 executes a contract with a governmental contractor to deliver
690 health care services ~~on or after April 17, 1992,~~ as an agent of
691 the governmental contractor, or any employee or agent of such
692 health care provider, is an agent for purposes of s. 768.28(9),
693 while acting within the scope of duties under the contract, if
694 the contract complies with the requirements of this section and
695 regardless of whether the individual treated is later found to
696 be ineligible. A health care provider, or any employee or agent
697 of such health care provider, shall continue to be an agent for
698 purposes of s. 768.28(9) for 30 days after a determination of

699 ineligibility to allow for treatment until the individual
700 transitions to treatment by another health care provider. A
701 health care provider, or any employee or agent of such health
702 care provider, under contract with the state may not be named as
703 a defendant in any action arising out of medical care or
704 treatment ~~provided on or after April 17, 1992,~~ under contracts
705 entered into under this section. The contract must provide that:
706 (a) The right of dismissal or termination of any health
707 care provider delivering services under the contract is retained
708 by the governmental contractor.
709 (b) The governmental contractor has access to the patient
710 records of any health care provider delivering services under
711 the contract.
712 (c) Adverse incidents and information on treatment outcomes
713 must be reported by any health care provider to the governmental
714 contractor if the incidents and information pertain to a patient
715 treated under the contract. The health care provider shall
716 submit the reports required by s. 395.0197. If an incident
717 involves a professional licensed by the Department of Health or
718 a facility licensed by the Agency for Health Care
719 Administration, the governmental contractor shall submit such
720 incident reports to the appropriate department or agency, which
721 shall review each incident and determine whether it involves
722 conduct by the licensee that is subject to disciplinary action.
723 All patient medical records and any identifying information
724 contained in adverse incident reports and treatment outcomes
725 which are obtained by governmental entities under this paragraph
726 are confidential and exempt from the provisions of s. 119.07(1)
727 and s. 24(a), Art. I of the State Constitution.

728 (d) Patient selection and initial referral must be made by
729 the governmental contractor or the provider. Patients may not be
730 transferred to the provider based on a violation of the
731 antidumping provisions of the Omnibus Budget Reconciliation Act
732 of 1989, the Omnibus Budget Reconciliation Act of 1990, or
733 chapter 395.
734 (e) If emergency care is required, the patient need not be
735 referred before receiving treatment, but must be referred within
736 48 hours after treatment is commenced or within 48 hours after
737 the patient has the mental capacity to consent to treatment,
738 whichever occurs later.
739 (f) The provider is subject to supervision and regular
740 inspection by the governmental contractor.
741 (g) ~~As an agent of the governmental contractor for purposes~~
742 ~~of s. 768.28(9), while acting within the scope of duties under~~
743 ~~the contract,~~ A health care provider licensed under chapter 466<u>,</u>
744 <u>as an agent of the governmental contractor for purposes of s.</u>
745 <u>768.28(9),</u> may allow a patient, or a parent or guardian of the
746 patient, to voluntarily contribute a monetary amount to cover
747 costs of dental laboratory work related to the services provided
748 to the patient <u>within the scope of duties under the contract</u>.
749 This contribution may not exceed the actual cost of the dental
750 laboratory charges.
751
752 A governmental contractor that is also a health care provider is
753 not required to enter into a contract under this section with
754 respect to the health care services delivered by its employees.
755 (5) NOTICE OF AGENCY RELATIONSHIP.—The governmental
756 contractor must provide written notice to each patient, or the

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757 patient's legal representative, receipt of which must be
758 acknowledged in writing at the initial visit, that the provider
759 is an agent of the governmental contractor and that the
760 exclusive remedy for injury or damage suffered as the result of
761 any act or omission of the provider or of any employee or agent
762 thereof acting within the scope of duties pursuant to the
763 contract is by commencement of an action pursuant to ~~the~~
764 ~~provisions of~~ s. 768.28. Thereafter, or with respect to any
765 federally funded community health center, the notice
766 requirements may be met by posting in a place conspicuous to all
767 persons a notice that the health care provider, or federally
768 funded community health center, is an agent of the governmental
769 contractor and that the exclusive remedy for injury or damage
770 suffered as the result of any act or omission of the provider or
771 of any employee or agent thereof acting within the scope of
772 duties pursuant to the contract is by commencement of an action
773 pursuant to ~~the provisions of~~ s. 768.28.
774 Section 11. Paragraphs (a) and (b) of subsection (9) of
775 section 768.28, Florida Statutes, are amended to read:
776 768.28 Waiver of sovereign immunity in tort actions;
777 recovery limits; limitation on attorney fees; statute of
778 limitations; exclusions; indemnification; risk management
779 programs.—
780 (9)(a) An ~~No~~ officer, employee, or agent of the state or of
781 any of its subdivisions may not ~~shall~~ be held personally liable
782 in tort or named as a party defendant in any action for any
783 injury or damage suffered as a result of any act, event, or
784 omission of action in the scope of her or his employment or
785 function, unless such officer, employee, or agent acted in bad

786 faith or with malicious purpose or in a manner exhibiting wanton
787 and willful disregard of human rights, safety, or property.
788 However, such officer, employee, or agent shall be considered an
789 adverse witness in a tort action for any injury or damage
790 suffered as a result of any act, event, or omission of action in
791 the scope of her or his employment or function. The exclusive
792 remedy for injury or damage suffered as a result of an act,
793 event, or omission of an officer, employee, or agent of the
794 state or any of its subdivisions or constitutional officers is
795 ~~shall be~~ by action against the governmental entity, or the head
796 of such entity in her or his official capacity, or the
797 constitutional officer of which the officer, employee, or agent
798 is an employee, unless such act or omission was committed in bad
799 faith or with malicious purpose or in a manner exhibiting wanton
800 and willful disregard of human rights, safety, or property. The
801 state or its subdivisions are ~~shall~~ not ~~be~~ liable in tort for
802 the acts or omissions of an officer, employee, or agent
803 committed while acting outside the course and scope of her or
804 his employment or committed in bad faith or with malicious
805 purpose or in a manner exhibiting wanton and willful disregard
806 of human rights, safety, or property.
807 (b) As used in this subsection, the term:
808 1. “Employee” includes any volunteer firefighter.
809 2. “Officer, employee, or agent” includes, but is not
810 limited to, any health care provider, and its employees or
811 agents, when providing services pursuant to s. 766.1115; any
812 nonprofit independent college or university located and
813 chartered in this state which owns or operates an accredited
814 medical school, and its employees or agents, when providing

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815 patient services pursuant to paragraph (10)(f); and any public
816 defender or her or his employee or agent, including~~, among~~
817 ~~others,~~ an assistant public defender or ~~and~~ an investigator.
818 Section 12. Except as otherwise expressly provided in this
819 act, this act shall take effect July 1, 2016.

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