HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 827 Recovery Care Services
SPONSOR(S): Stevenson
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 1 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill creates a new licensure category for a Recovery Care Center (RCC), defined as a facility the primary purpose of which is to provide recovery care services, to which a patient is admitted and discharged within 72 hours, and which is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission to a RCC. A patient may receive recovery care services in a RCC upon:

- Discharge from an Ambulatory Surgical Center (ASC) after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving out-patient medical treatment such as chemotherapy.

The new RCC license is modeled after the current licensing procedures for hospitals and ASCs, subjecting RCCs to similar regulatory standards, inspections, and rules. RCCs must have emergency care and transfer protocols, including transportation arrangements, and a referral or admission agreement with at least one hospital.

The bill has an indeterminate, negative fiscal impact on the Agency for Health Care Administration, which will be offset by fees authorized by linked PCB HMR 20-01.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Recovery Care Centers

Recovery care centers (RCCs) are entities that provide short-term nursing care, support, and pain control for patients that do not require acute hospitalization.[1] RCC patients are typically healthy persons that have had elective surgery. RCCs are not eligible for Medicare reimbursement.[2] However, RCCs may receive payments from Medicaid programs and commercial payers.

RCCs can be either freestanding or attached to an ambulatory surgical center (ASC) or hospital. In practice, RCCs typically provide care to patients transferred from an ASC following surgery, which allows the ASC to perform more complex procedures.[3]

There has been a steady increase in the complexity of cases performed in ASCs. Total joint arthroplasty is representative of procedures that have experienced transition from the inpatient to the ASC setting. From 2012 to 2015, elective total joint replacements in the outpatient setting increased by nearly 50 percent, and in the next decade outpatient total joint replacement is expected to increase 457 percent for total knee replacements and 633 percent for total hip replacements.[4]

In 2014, the Office of the Inspector General for the U.S. Department of Health and Human Services studied the cost efficiency associated with Medicare beneficiaries obtaining surgical services in an outpatient setting.[5] The OIG found that Medicare saved almost $7 billion during calendar years (CYs) 2007 through 2011 and could potentially save $12 billion from CYs 2012 through 2017 due primarily to the lower rates for surgical procedures done in ASCs.[6] The OIG also found that Medicare beneficiaries realized savings of $2 billion in the form of reduced co-payment obligations in the ASC setting.[7] In addition, Medicare could generate savings of as much as $15 billion for CYs 2012 through 2017 if CMS reduced hospital outpatient department payment rates for ASC-approved procedures to ASC payment levels.[8] Beneficiaries, in turn, would save $3 billion.[9]

A review of commercial medical claims data found that U.S. healthcare costs are reduced by more than $38 billion per year due to the availability of ASCs for outpatient procedures.[10] More than $5 billion of the cost reduction accrued to the patient through lower deductible and coinsurance payments.[11] This cost reduction is driven by the fact that, in general, ASC prices are significantly lower than hospital outpatient department prices for the same procedure in all markets, regardless of payer. The study also looks at the potential savings that could be achieved if additional procedures were redirected to ASCs. As much as $55 billion could be saved annually depending on the percentage of procedures that migrate to ASCs and the mix of ASCs selected instead of HOPDs.[12] As a result, patients, employers,

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[1] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment for Post-Surgical Recovery Care Centers*, (2000), available at https://permanent.access.gpo.gov/lps20907/nov2000medpay.pdf (last viewed January 1, 2020).
[2] Id.
[3] Id. at pg. 4.
[4] Dyrda, L.(2017, February 10). 16 things to know about outpatient total joint replacement and ASCs. *Becker's ASC Review.*
[5] U.S. Department of Health and Human Services, Office of Inspector General, *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates*, Audit A-05-12-00020 (April 16, 2014).
[6] Id. at pg. i.
[7] Id. at pg. ii.
[8] Id.
[9] Id.
[10] Healthcare Bluebook and HealthSmart, *Commercial Insurance Cost Savings in Ambulatory Surgery Centers*, page 7 (June 2016), available at http://www.ascassociation.org/asca/communities/community-home/librarydocuments/viewdocument?DocumentKey=61197e80-d852-4004-860a-2424968b005b (last viewed January 1, 2020).
[11] Id.
[12] Id.

and insurers are interested in ways to safely migrate procedures to ASCs. Conversely, hospitals remain in solitary opposition of the idea.

Three states have specific licenses for RCCs.[13] Other states license RCCs as nursing facilities or hospitals.[14] One study found that eighteen states allow RCCs to have stays over 24 hours, usually with a maximum stay of 72 hours.[15]

Comparison of RCC Regulations in Arizona, Connecticut, and Illinois

Regulation	Arizona[16]	Connecticut[17]	Illinois[18]
Licensure Required	X	X	X
Written Policies	X	X	X
Maintain Medical Records	X	X	X
Patient's Bill of Rights	X	X	X
Freestanding and Attached	Not Addressed.	X	X
Length of Stay	Not Addressed.	Expected 3 days; maximum 21 days	Expected 48 hours; maximum 72 hrs
Emergency Care Transfer	For care not provided by the RCC.	With a hospital and an ambulance service.	With a hospital within 15 minutes travel time.
Prohibited Patients	• Intensive care • Coronary care • Critical care	• Intensive care • Coronary care • Critical care	• Patients with chronic infectious conditions • Children under age 3
Prohibited Services	• Surgical • Radiological • Pediatric • Obstetrical	• Surgical • Hospice • Pre-adolescent pediatric • OB (over 24 weeks) • IV-therapy (non-hospital RCC) • Radiological	Blood administration (only blood products allowed)
Required Services	• Laboratory • Pharmaceutical • Food	• Pharmacy • Dietary • Personal care • Rehabilitation • Therapeutic • Social work	• Laboratory • Pharmaceutical • Food • Radiological
Bed Limit	Not Addressed.	Not Addressed.	20
Required Staff	• Governing authority • Administrator	• Governing body • Administrator	Consulting committee
Required Medical Personnel	• At least two physicians • Director of nursing	• Medical advisory board • Medical director • Director of nursing	• Medical director • Nursing supervisor
Required Personnel When Patients Present	• Director of nursing 40 hrs/wk • One RN • One other nurse	• Two persons for patient care	• One RN • One other nurse

Effect of Proposed Changes

[13] Ariz. Rev. Stat. Ann.§§ 36-448.51-36-448.55; Conn. Conn. Agencies Regs § 19A-495-571; 210 Ill. Comp. Stat. Ann. 3/35. In 2009, Illinois limited the total number of RCCs to those centers holding a certificate of need for beds as of January 1, 2008. The five existing RCCs were grandfathered in and continue to be regulated under 77 Ill. Admin. Code 210.

[14] Sandra Lee Breisch, *Profits in Short Stays*, Am. Acad. of Orthopedic Surgeons Bulletin (June, 1999), available at http://www2.aaos.org/bulletin/jun99/asc.htm (last viewed January 1, 2020).

[15] Supra FN 1, at pg. 4 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

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

[17] Conn. Agencies Regs. § 19A-495-571.

[18] 210 Ill. Comp. Stat. Ann. 3/35; Ill. Admin. Code tit. 77, §§ 210.2500 & 210.2800.

The bill creates a new license for a Recovery Care Center (RCC). The new RCC license is modeled after the current licensure program for hospitals and ASCs in Chapters 395 and 408, F.S. An applicant for RCC licensure must follow the general licensing procedures in Chapter 408, Part II. Additionally, the applicant will be subject to the license, inspection, safety, facility, and other requirements of Chapter 395, Part I.

The bill defines a RCC as a facility whose primary purpose is to provide recovery care services, to which the patient is admitted and discharged within 72 hours, and is not part of a hospital. The bill defines recovery care services as:

- Postsurgical and post-diagnostic medical and general nursing care to patients for whom acute hospitalization is not required and an uncomplicated recovery is reasonably expected; and
- Postsurgical rehabilitation services.

Recovery care services do not include intensive care services, coronary care services, or critical care services.

The bill requires all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission to a RCC. A patient may receive recovery care services in a RCC upon:

- Discharge from an ASC after surgery;
- Discharge from a hospital after surgery or other treatment; or
- Receiving an out-patient medical treatment, such as chemotherapy.

A RCC must have emergency care and transfer protocols, including transportation arrangements, and a referral or admission agreement with at least one hospital. Further, AHCA is authorized to adopt rules regarding RCC admission and discharge procedures.

The bill authorizes AHCA to adopt, by rule, appropriate standards for RCCs pursuant to s. 395.1055, F.S. in the same categories for hospitals and ASCs:

- Staffing;
- Infection control;
- Housekeeping;
- Medical records;
- Emergency management;
- Inspections;
- Accreditation;
- Organization, including a governing body and organized medical staff;
- Departments and services;
- Quality assessment and improvement;
- Minimum space; and
- Equipment and furnishings.

In addition, the bill requires AHCA to adopt rules to set standards for dietetic departments, proper use of medications, and pharmacies in RCCs.

The bill provides an effective date of July 1, 2019.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.001, F.S., related to legislative intent.
Section 2: Amends s. 395.002, F.S., related to definitions.
Section 3: Amends s. 395.003, F.S., related to licensure; denial, suspension, and revocation.

Section 4: Creates s. 395.0171, F.S., related to recovery care center admissions; emergency and transfer protocols; discharge planning and protocols.
Section 5: Amends s. 395.1055, F.S., related to rules and enforcement.
Section 6: Amends s. 395.10973, F.S., related to powers and duties of the agency.
Section 7: Amends s. 408.802, F.S., related to applicability.
Section 8: Amends s. 408.820, F.S., related to exemptions.
Section 9: Amends 385.211, F.S., related to refractory and intractable epilepsy treatment and research at recognized medical centers.
Section 10: Amends s. 394.4787, F.S., related to definitions.
Section 11: Amends s. 409.975, F.S., related to managed care plan accountability.
Section 12: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Section 408.805, F.S., requires AHCA to set license fees that are reasonably calculated to cover the cost of regulation. PCB HMR 20-01, which is linked to this bill, authorizes AHCA to set license fees for RCCs. Applicants for licensure as a RCC will be subject to the current Plans and Construction project review fee of $2,000 plus $100 per hour for building plan reviews, an application fee of at least $1,500, and a licensure inspection fee of $400.[19]

2. Expenditures:

   The bill requires AHCA to regulate RCCs in accordance with Chapters 395 and 408, F.S., and any rules adopted by the agency. PCB HMR 20-01, which is linked to this bill, authorizes AHCA to set license fees for RCCs. The fees associated with the license are anticipated to cover the expense incurred by AHCA in enforcing and regulating the new license.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Individuals needing surgery may save money by being able to stay in a RCC rather than having the original procedure in a hospital and remaining in the hospital to recover.

Hospitals may experience a negative fiscal impact if patients receive care in an ASC followed by RCC care.

D. FISCAL COMMENTS:

None.

[19] Agency for Health Care Administration, 2019 Agency Legislative Bill Analysis-HB 25, March 11, 2019 (on file with Health Market Reform Subcommittee staff).

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

There is sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES