HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 145 Recovery Care Services
SPONSOR(S): Renner; Fitzenhagen
TIED BILLS: **IDEN./SIM. BILLS:** SB 222

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	15 Y, 0 N	Poche	Poche
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Pursuant to s. 395.002(3), F.S., an ambulatory surgical center (ASC) is a facility that is not part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within the same working day and is not permitted to stay overnight.

Federal Medicare reimbursement is generally limited to stays of no more than 24 hours. The bill changes the allowable length of stay in an ASC from less than one working day to no more than 24 hours, which is the federal Medicare length of stay standard.

The bill creates a new license 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 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, but likely insignificant, fiscal impact on state government.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Ambulatory Surgical Centers (ASCs)

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

Currently, there are 432 licensed ASCs in Florida.[2] Of the 306 licensed hospitals in the state, 218 report providing outpatient surgical services.[3]

In 2015, there were 3,029,199 visits to ASCs in Florida.[4] Visits occur at hospital-based outpatient facilities or freestanding ASCs. Hospital-based outpatient facilities accounted for 47 percent and freestanding ASCs accounted for 53 percent of the total number of visits.[5] Of the $37.9 billion in total charges for ambulatory procedures in 2015, hospital-based outpatient facilities accounted for 76 percent of the charges, while freestanding ASCs accounted for 24 percent.[6] The average charge at the hospital-based facilities, $20,444, was more than three times larger than the average charge at the freestanding ASCs, $5,561.[7]

In Florida, for 2015, the top five medical procedures, by total charges, at a freestanding ASC and hospital-based outpatient facility were:

- Esophagogastroduodenoscopy with biopsy;
- Cataract surgery with IOL implant;
- Colonoscopy and biopsy;
- Diagnostic colonoscopy; and
- Colonoscopy with lesion removal.[8]

The following chart shows the total number of visits for each of the top five medical procedures and the average charge for each procedure[9]:

[1] S. 395.002(3), F.S.
[2] Agency for Health Care Administration, *All Florida Ambulatory (Outpatient) Surgery Centers Results*, available at http://www.floridahealthfinder.gov/CompareCare/ListFacilities.aspx (last viewed February 5, 2017).
[3] Agency for Health Care Administration, *2017 Agency Legislative Bill Analysis-HB 145*, page 2, January 4, 2017 (on file with Health Innovation Subcommittee staff).
[4] Agency for Health Care Administration, *Presentation on Ambulatory Surgical Centers- Health Innovation Subcommittee*, slide 10, January 25, 2017 (on staff with Health Innovation Subcommittee staff).
[5] Office of Program Policy and Government Accountability, *Presentation on Ambulatory Surgical Centers and Recovery Care Centers-Health Innovation Subcommittee*, slide 4, January 25, 2017 (on staff with Health Innovation Subcommittee staff).
[6] Id. at slide 5.
[7] Id.
[8] Agency for Health Care Administration, *Ambulatory (Outpatient) Surgery Query Results; By Current Procedural Terminology Code and Facility Type,* available at http://www.floridahealthfinder.gov/QueryTool/QTResults.aspx?T=O (last viewed on February 5, 2017).
[9] Id.

Procedure	Total Visits	Average Charge
Esophagogastroduodenoscopy with biopsy	241,006	$4,930
Cataract surgery with IOL implant	229,289	$4,535
Colonoscopy and biopsy	185,707	$4,345
Diagnostic colonoscopy	202,687	$3,411
Colonoscopy with lesion removal	153,917	$4,404

In 2015, payment for visits to freestanding ASCs and hospital-based outpatient facilities was made mainly by commercial insurance and regular Medicare. Commercial insurance paid $15.5 billion or 41 percent of charges, while Medicare paid $10.8 billion or 31 percent of charges.[10] The next three top payer groups, Medicare managed care, Medicaid managed care, and self-pay, accounted for a combined $8.6 billion or 22.9 percent of charges.[11]

ASC Licensure

ASCs are licensed and regulated by the Agency for Health Care Administration (AHCA) under the same regulatory framework as hospitals.[12] Applicants for ASC licensure must submit certain information to AHCA prior to accepting patients for care or treatment, including:

- An affidavit of compliance with fictitious name;
- Proof of registration of articles of incorporation; and
- A zoning certificate or proof of compliance with zoning requirements.[13]

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

- Governing body bylaws, rules, and regulations;
- Medical staff bylaws, rules, and regulations;
- A roster of medical staff members;
- A nursing procedure manual;
- A roster of registered nurses and licensed practical nurses with current license numbers;
- A fire plan; and
- The comprehensive Emergency Management Plan.[14]

AHCA is authorized to adopt rules for hospitals and ASCs.[15] Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals,[16] but the rules for all hospitals and ASCs must include minimum standards for ensuring that:

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

[10] Agency for Health Care Administration, *Ambulatory (Outpatient) Surgery Query Results; By Patient, Primary Payer, and Average Charges* http://www.floridahealthfinder/gov/QueryTool/QTResults.aspx?T=O (last viewed February 5, 2017).
[11] Id.
[12] SS. 395.001-.1065, F.S., and Part II, Chapter 408, F.S.
[13] Rule 59A-5.003(4), F.A.C.
[14] Rule 59A-5.003(5), F.A.C.
[15] S. 395.1055, F.S.
[16] S. 395.1055(2), F.S.

- Licensed facility beds conform to minimum space, equipment, and furnishing standards

The minimum standards for ASCs are contained in Chapter 59A-5, F.A.C.

Staff and Personnel Rules

ASCs are required to have written policies and procedures for surgical services, anesthesia services, nursing services, pharmaceutical services, and laboratory and radiologic services.[17] In providing these services, ACSs are required to have certain professional staff available, including:

- A registered nurse to serve as an operating room circulating nurse;[18]
- An anesthesiologist or other physician, or a certified registered nurse anesthetist under the on-site medical direction of a licensed physician in the ASC during the anesthesia and post-anesthesia recovery period until all patients are alert or discharged;[19] and
- A registered professional nurse in the recovery area during the patient's recovery period.[20]

Infection Control Rules

ASCs are required to establish infection control programs, which must include written policies and procedures reflecting the scope of the program.[21] The written policies and procedures must be reviewed at least every two years by the infection control program members.[22] The infection control program must include:

- Surveillance, prevention, and control of infection among patients and personnel;[23]
- A system for identifying, reporting, evaluating and maintaining records of infections;[24]
- Ongoing review and evaluation of aseptic, isolation and sanitation techniques employed by the ASC;[25] and
- Development and coordination of training programs in infection control for all personnel.[26]

Emergency Management Plan Rules

ASCs are required to develop and adopt written comprehensive emergency management plans for emergency care during an internal or external disaster or emergency.[27] Some of the elements that must be in the plan include:

- Provisions for internal and external disasters, and emergencies;
- A description of the center's role in a community wide comprehensive emergency management plan;
- Information about how the center plans to implement specific procedures outlined in its plan;
- Precautionary measures, including voluntary cessation of center operations, to be taken by the center in preparation and response to warnings of inclement weather, including hurricanes and tornadoes, or other potential emergency conditions;
- Provisions for coordinating with hospitals that would receive patients to be transferred;
- Provisions for the management of staff, including the distribution and assignment of responsibilities and functions, and the assignment of staff to accompany patients to a hospital or subacute care facility;

[17] Rule 59A-5.0085, F.A.C.
[18] Rule 59A-5.0085(3)(c), F.A.C.
[19] Rule 59A-5.0085(2)(b), F.A.C.
[20] Rule 59A-5.0085(3)(d), F.A.C.
[21] Rule 59A-5.011(1), F.A.C.
[22] Rule 59A-5.011(2), F.A.C.
[23] Rule 59A-5.011(1)(a), F.A.C.
[24] Rule 59A-5.011(1)(b), F.A.C.
[25] Rule 59A-5.011(1)(c), F.A.C.
[26] Rule 59A-5.011(1)(d), F.A.C.
[27] Rule 59A-5.018(1), F.A.C.

- Provisions for the management of patients who may be treated at the center during an internal or external disaster or emergencies, including control of patient information and medical records, individual identification of patients, transfer of patients to hospital(s) and treatment of mass casualties;
- Provisions for contacting relatives and necessary persons advising them of patient location changes; and
- A provision for educating and training personnel in carrying out their responsibilities in accordance with the adopted plan.

The ASC must review the plan and update it annually.[28]

Accreditation

ASCs may seek voluntary accreditation by the Joint Commission for Health Care Organizations, the Accreditation Association for Ambulatory Health Care, or the American Osteopathic Association Healthcare Facilities Accreditation Program.[29] AHCA is required to conduct an annual licensure inspection survey for non-accredited ASCs.[30] AHCA must accept survey reports of accredited ASCs from accrediting organizations if the standards included in the survey report document that the ASC is in substantial compliance with state licensure requirements.[31] AHCA is required to conduct annual validation inspections on a minimum of 5 percent of the ASCs which were inspected by an accreditation organization.[32]

AHCA is also required to conduct annual life safety inspections of all ASCs to ensure compliance with life safety codes and disaster preparedness requirements.[33] However, the life-safety inspection may be waived if an accreditation inspection was conducted on an ASC by a certified life safety inspector and the ASC was found to be in compliance with the life safety requirements.[34]

Of the 432 licensed ASCs in Florida, as of December 2016, 304 were accredited by the Accreditation Association for Ambulatory Health Care and 83 by the Joint Commission.[35]

Federal Requirements

Medicare

ASCs are required to have an agreement with the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare. ASCs are also required to comply with specific conditions for coverage. CMS defines an "ASC" as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours[36] following an admission.[37]

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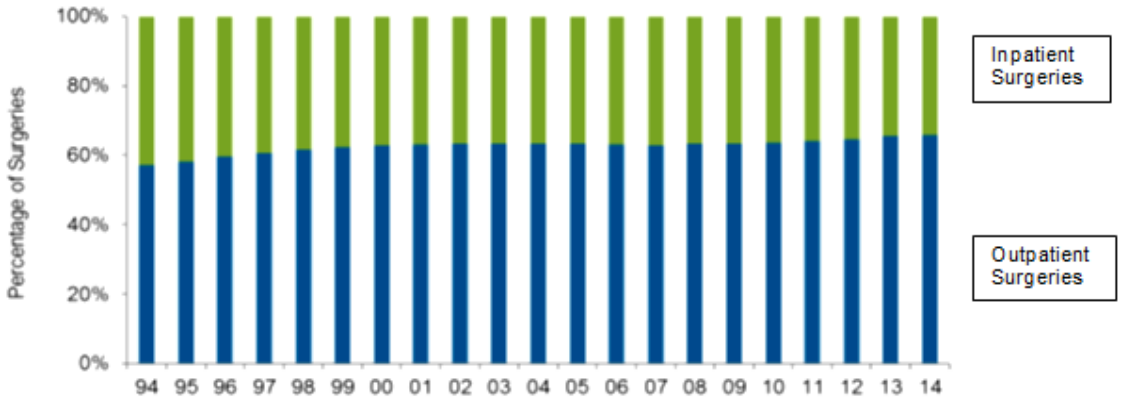
[28] Rule 59A-5.018(2)(a), F.A.C.
[29] Rule 59A-5.004(3), F.A.C.; Agency for Health Care Administration, Ambulatory Surgical Center, *Accrediting Organizations for Ambulatory Surgical Centers,* available at http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/ambulatory.shtml (last viewed February 5, 2017).
[30] Rule 59A-5.004(1) and (2), F.A.C.
[31] Rule 59A-5.004(3), F.A.C.
[32] Rule 59A-5.004(5), F.A.C.
[33] Rule 59A-5.004(1), F.S., and s. 395.0161, F.S.
[34] S. 395.0161(2), F.S.
[35] Supra, FN 3.
[36] State Operations Manual Appendix L, *Guidance for Surveyors: Ambulatory Surgical Centers* (Rev. 137, 04-01-15), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_l_ambulatory.pdf (last viewed February 5, 2017); Exceeding the 24-hour time frame is expected to be a rare occurrence and each rare occurrence is expected to be demonstrated to have been something which ordinarily could not have been foreseen. Not meeting this requirement constitutes condition-level noncompliance with regulations. In addition, review of the cases that exceed the time frame may also reveal noncompliance with conditions for coverage related to surgical services, patient admission and assessment, and quality assurance/performance improvement.
[37] 42 C.F.R. §416.2

CMS may deem an ASC to be in compliance with all of the conditions for coverage if the ASC is accredited by a national accrediting body or licensed by a state agency that CMS determines provides reasonable assurance that the conditions are met.[38] All of the CMS conditions for coverage requirements are included in Chapter 59A-5, F.A.C., and apply to all ASCs. The conditions for coverage require:

- A governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation;
- A quality assessment and performance improvement program;
- A transfer agreement with one or more acute care general hospitals, which will admit any patient referred who requires continuing care;
- A disaster preparedness plan;
- An organized medical staff;
- A fire control plan;
- A sanitary environment;
- An infection control program; and
- A procedure for patient admission, assessment and discharge.

ASC Cost of Care and Quality Outcomes

There has been tremendous growth in the outpatient surgery segment of health care in the U.S., facilitated by advances in technology. From 1981 through 2005, the number of outpatient surgeries increased ten-fold.[39] Outpatient surgeries now account for more than 80 percent of all surgeries completed in the U.S.[40] Research shows that procedures in ASCs are 25 percent faster on average than hospital-based outpatient facilities, driven mainly by technological, system and process efficiencies in ASCs.[41]



The increased use of outpatient surgery may help lower health care costs and meet increased patient demand for outpatient surgery, which is frequently more convenient for patients and their families and allows for less stressful recovery.

ASC Cost of Care

[38] 42 C.F.R. §416.26(a)(1)
[39] Munnich E. and Parente S., *Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up*, Health Affairs 33;5: 764-69, 764 (2014).
[40] Munnich E. and Parente S., *Returns to Specialization: Evidence from the Outpatient Surgery Market*, pg. 1 (April 2014); Chart data is from an analysis of the American Hospital Association Annual Survey data from 2014 for community hospitals.
[41] Professor Elizabeth L. Munnich, University of Louisville, Louisville, Kentucky, *Presentation on Measuring Cost and Quality in Ambulatory Surgical Centers-Health Innovation Subcommittee*, slide 5, January 25, 2017 (on file with Health Innovation Subcommittee staff); Trentman T., et al, *Outpatient surgery performed in an ambulatory surgery center versus a hospital: comparison of perioperative time intervals*, Amer. J. Surgery 100;1: 64-67 (July 2010).

Despite the volume of outpatient surgeries today, there is little research on cost savings associated with ASCs.[42] The study that found procedures in ASCs were completed 25 percent faster than the same procedures in hospital-based outpatient facilities also found that ASC efficiency generated a savings of $363-$1,000 per outpatient case.[43]

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.[44] 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.[45] The OIG also found that Medicare beneficiaries realized savings of $2 billion in the form of reduced co-payment obligations in the ASC setting.[46] 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.[47] Beneficiaries, in turn, would save $3 billion.[48]

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.[49] More than $5 billion of the cost reduction accrued to the patient through lower deductible and coinsurance payments.[50] 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.[51]

An analysis by the Ambulatory Surgery Center Association of 2014 data from the Center for Medicaid and Medicare Services focused on the impact of Florida ASCs to Medicare. Specifically, the analysis found:

- Medicare saved more than $84 million on cataract procedures because beneficiaries elected to have those procedures performed in an ASC.
- Florida patients saved more than $23.4 million by having upper GI procedures in an ASC.
- Medicare saved an additional $42.6 million on colonoscopies performed in ASCs.[52]

ASC Quality Outcomes

The body of evidence shows that patients undergoing outpatient surgery in an ASC have the same or better outcomes as patients undergoing surgery at a hospital-based outpatient department.[53] Another

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[42] Supra, FN 41 at slide 2.
[43] Supra, FN 39 at pg. 767; The savings calculation is based on the estimated charges for operating room time, set at $29 to $80 per minute, not including surgeon and anesthesia provider fees. Macario A. *What does one minute of operating room time cost?* J Clin Anesth. 2010;22(4):233–6.
[44] 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).
[45] Id. at pg. i.
[46] Id. at pg. ii.
[47] Id.
[48] Id.
[49] 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 February 7, 2017).
[50] Id.
[51] Id.
[52] Dr. David Shapiro, Florida Society of Ambulatory Surgery Centers, *Issues and Trends in Ambulatory Surgery-A Presentation to the Florida House of Representatives Health Innovation Subcommittee*, slide 8, January 25, 2017 (on file with Health Innovation Subcommittee staff).
[53] Office of Program Policy and Government Accountability, Research Memorandum, *Ambulatory Surgical Centers and Recovery Care Centers*, January 19, 2016 (on file with Health Innovation Subcommittee staff). The OPPAGA research literature review found nine studies supporting the conclusion that ASCs provide more timely service to patients and have low rates of unexpected safety events. The review also found five studies concluding that the increase in patient volume to ASCs was not associated with an increase in hospital admissions or patient mortality. *Outpatient Surgery Performed in an Ambulatory Surgery Center Versus a Hospital: Comparison of Perioperative Time Intervals* (Trentman et al., 2010*); A Comparative Study of Quality Outcomes in Freestanding*

study showed that patients who underwent a high volume procedure in an ASC were less likely than those treated in a hospital-based outpatient department to visit an ER or be admitted to the hospital following surgery.[54] The finding held true across timeframe since surgery and for low and high risk patients. Researchers concluded that ASCs provide high volume services more efficiently that hospital-based outpatient departments, but not at the expense of quality of care.[55]

One study found patient satisfaction with care received at ASCs across the country measured at 92 percent.[56]

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.[57] RCC patients are typically healthy persons that have had elective surgery. RCCs can be either freestanding or attached to an 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.[58]

RCCs are not eligible for Medicare reimbursement.[59] However, RCCs may receive payments from Medicaid programs.

Three states, Arizona, Connecticut, and Illinois, have specific licenses for RCCs.[60] Other states license RCCs as nursing facilities or hospitals.[61] One study found that eighteen states allow RCCs to have stays over 24 hours, usually with a maximum stay of 72 hours.[62]

Ambulatory Surgery Centers and Hospital-Based Outpatient Departments: 1997-2004 (Chukmaitov et al., 2008); *Comparing Quality at an Ambulatory Surgery Center and a Hospital-Based Facility: Preliminary Findings* (Grisel and Arjmand, 2009); *Ambulatory Surgery Centers and Their Intended Effects on Outpatient Surgery* (Hollenbeck et al., 2015); *Changing Access to Emergency Care for Patients Undergoing Outpatient Procedures at Ambulatory Surgery Centers: Evidence From Florida* (Neuman et al., 2011); and *Hospital-Based, Acute Care After Ambulatory Surgery Center Discharge* (Fox et al., 2014).

[54] Supra, FN 41 at pgs. 26-29; Fleisher LA, Pasternak LR, Herbert R, Anderson GF. *Inpatient hospital admission and death after outpatient surgery in elderly patients: importance of patient and system characteristics and location of care*. Arch Surg. 2004 Jan;139(1):67-72.

[55] Supra, FN 41 at slide 8.

[56] *Press Ganey Outpatient Pulse Report 2008*. Represents the experiences of 1,039,289 patients treated at 1,218 facilities nationwide between January 1 and December 31, 2007.

[57] 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 February 5, 2017).

[58] Id. at pg. 4.

[59] Supra, FN 57.

[60] 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.

[61] 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 February 5, 2017).

[62] Supra FN 57, at pg. 4 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

Comparison of RCC Regulations in Arizona, Connecticut, and Illinois

Regulation	Arizona[63]	Connecticut[64]	Illinois[65]
Licensure Required	X	X	X
Written Policies	X	X	X
Maintain Medical Records	X	X	X
Patient's Bill of Rights	X	X	X
Allows Freestanding Facility or Attached	Not Addressed.	X	X
Length of Stay	Not Addressed.	Expected 3 days Maximum 21 days	Expected 48 hours Maximum 72 hours
Emergency Care Transfer Agreement	For care not provided by the RCC.	With a hospital and an ambulance service.	With a hospital within 15 minutes travel time.
Prohibited Patients	Patients needing: • Intensive care • Coronary care • Critical care	Patients needing: • Intensive care • Coronary care • Critical care	• Patients with chronic infectious conditions • Children under age 3
Prohibited Services	• Surgical • Radiological • Pediatric • Obstetrical	• Surgical • Radiological • Pre-adolescent pediatric • Hospice • Obstetrical services over 24 week gestation • Intravenous therapy for non-hospital based RCC	• Blood administration (only blood products allowed)
Required Services	• Laboratory • Pharmaceutical • Food	• Pharmaceutical • Dietary • Personal care • Rehabilitation • Therapeutic • Social work	• Laboratory • Pharmaceutical • Food • Radiological
Bed Limitation	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 Are Present	• Director of nursing 40 hours per week • One registered nurse • One other nurse	• Two persons for patient care	• One registered nurse • One other nurse

Effect of Proposed Changes

[63] 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).
[64] Conn. Agencies Regs. § 19A-495-571.
[65] 210 Ill. Comp. Stat. Ann. 3/35; Ill. Admin. Code tit. 77, §§ 210.2500 & 210.2800.

Pursuant to s. 395.002(3), F.S., patients receiving services in an ASC must be discharged on the same working day that they were admitted and cannot stay overnight. Medicare reimbursement policy limits the length of stay in an ASC to 24 hours following admission. The bill amends s. 395.002(3), F.S., to permit a patient to stay at an ASC for no longer than 24 hours. The change conforms to the Medicare length of stay requirement.

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 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.

Section 395.1055, F.S., directs AHCA to adopt rules for hospitals and ASCs that set standards to ensure patient safety, including requirements for:

- 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.

The bill authorizes AHCA to adopt, by rule, appropriate standards for RCCs pursuant to s. 395.1055, F.S. In addition, the bill requires AHCA to adopt rules to set standards for dietetic departments, proper use of medications, and pharmacies in RCCs.

The license fee for a RCC will be set by rule by AHCA and must be at least $1,500.[66]

The bill provides an effective date of July 1, 2017.

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: Amends s. 627.64194, F.S., related to coverage requirements for services provided by nonparticipating providers; payment collection limitations.
Section 13: Provides an effective date of July 1, 2017.

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. Applicants for licensure as a RCC will be subject to the 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.[67]

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. The fees associated with the new license are anticipated to cover the expenses incurred by AHCA in enforcing and regulating the new license. No additional staff will be required as existing regulatory staff is sufficient to absorb the workload associated with up to 10 licensees.

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 longer in an ASC or stay in a RCC rather than having the original procedure in a hospital and remaining in the hospital to recover merely because the recovery time will be longer than the ASC limit would allow.

[66] S. 395.004, F.S.
[67] Supra, FN 3 at page 6.

Being able to keep patients longer may have a positive fiscal impact on the ASC by being able to perform more complex procedures.

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

D. FISCAL COMMENTS:

None.

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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES