The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Appropriations

BILL:	CS/SB 1690
INTRODUCER:	Health Policy Committee and Senator Bean
SUBJECT:	Volunteer Health Services
DATE:	April 15, 2013
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.	Brown	Hansen	AP	**Pre-meeting**
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

CS/SB 1690 amends the Access to Health Care Act (the Act) to:

- Revise contractual requirements between health care providers and governmental contractors relating to patient referrals;
- Delete a provision that patient care delivered under the Act, including any follow-up or hospital care, is subject to approval by governmental contractors;
- Require the Department of Health (DOH) to post specified information online concerning volunteer providers; and
- Allow volunteer providers to earn continuing education credits for participating in the program.

The bill has no fiscal impact.

The bill has an effective date of July 1, 2013.

The bill substantially amends section 766.1115, Florida Statutes.

II. Present Situation:

The Access to Health Care Act

Section 766.1115, F.S., is entitled "The Access to Health Care Act." The Act was enacted in 1992 to encourage health care providers to provide care to low-income persons.[1] This section extends sovereign immunity to health care providers who execute a contract with a governmental contractor and who provide volunteer, uncompensated health care services to low-income individuals as agents of the state. These health care providers are considered agents of the state under s. 768.28(9), F.S., for purposes of extending sovereign immunity while acting within the scope of duties required under the Act.

Health care providers under the Act include:[2]

- A birth center licensed under ch. 383, F.S.;
- An ambulatory surgical center licensed under ch. 395, F.S.;
- A hospital licensed under ch. 395, F.S.;
- A physician or physician assistant licensed under ch. 458, F.S.;
- An osteopathic physician or osteopathic physician assistant licensed under ch. 459, F.S.;
- A chiropractic physician licensed under ch. 460, F.S.;
- A podiatric physician licensed under ch. 461, F.S.;
- A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of ch. 464, F.S., or any facility that employs nurses licensed or registered under part I of ch. 464, F.S., to supply all or part of the care delivered under the Act;
- A dentist or dental hygienist licensed under ch. 466, F.S.;
- A midwife licensed under ch. 467, F.S.;
- A health maintenance organization certificated under part I of ch. 641, F.S.;
- A health care professional association and its employees or a corporate medical group and its employees;
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider;
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients;
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as a physician, physician assistant, osteopath, chiropractor, podiatrist, registered nurse, nurse midwife, licensed practical nurse, advanced registered nurse practitioner, or midwife; and
- Any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code,

[1] Low-income persons are defined in the Act as a person who is Medicaid-eligible, a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, or any eligible client of the Department of Health who voluntarily chooses to participate in a program offered or approved by the department.
[2] s. 766.1115(3)(d), F.S.

which delivers health care services provided by the listed licensed professionals, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

A governmental contractor is defined in the Act as the DOH, a county health department, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.[3]

The definition of contract under the Act provides that the contract must be for volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services, the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or any public or private third-party payer, for the specific services provided to the low-income recipients covered by the contract.[4]

The Act further specifies contract requirements. The contract must provide that:

- The governmental contractor retains the right of dismissal or termination of any health care provider delivering services under the contract;
- The governmental contractor has access to the patient records of any health care provider delivering services under the contract;
- The health care provider must report adverse incidents and information on treatment outcomes;
- The governmental contractor must make patient selection and initial referrals;
- The health care provider must accept all referred patients; however, the contract may specify limits on the number of patients to be referred and patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or ch. 395, F.S.;
- Patient care, including any follow-up or hospital care, is subject to approval by the governmental contractor; and
- The health care provider is subject to supervision and regular inspection by the governmental contractor.

The governmental contractor must provide written notice to each patient or the patient's legal representative – receipt of which must be acknowledged in writing – that the provider is covered under s. 768.28, F.S., for purposes of actions related to medical negligence.

The individual accepting services through a contracted provider must not have medical or dental care coverage for the illness, injury, or condition for which medical or dental care is sought.[5] The services not covered under this program include experimental procedures and clinically unproven procedures. The governmental contractor shall determine whether or not a procedure is covered.

[3] s. 766.1115(3)(c), F.S.
[4] s. 766.1115(3)(a), F.S.
[5] Rule 64I-2.001, F.A.C.

Annually, the DOH reports a summary to the Legislature containing the efficacy of access and treatment outcomes while providing health care for low-income persons.

Sovereign Immunity

The term "sovereign immunity" originally referred to the English common law concept that the government may not be sued because "the King can do no wrong." Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, s. 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the right to waive such immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state.

Under this statue, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event or omission of action in the scope of his or her employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Instead, the state steps in as the party litigant and defends against the claim. Damages awarded to any one person are limited to $200,000 for one incidence, and total damages awarded to all persons related to one incidence are limited to $300,000. The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps but the plaintiff cannot recover the excess damages without action by the Legislature.[6]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[7] In *Stoll v. Noel,* the Florida Supreme Court explained that independent contractor physicians may be agents of the state for purposes of sovereign immunity:

> One who contracts on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also independent contractor.[8]

The court examined the employment contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship and held that it did.[9] The court explained:

> Whether the CMS physician consultants are agents of the state turns on the degree of control retained or exercised by CMS. This Court has held that the right to control depends upon the terms of the employment contract. *National Sur. Corp. v. Windham*, 74 So. 2d 549, 550 (Fla. 1954) ("The [principal's] right to control depends upon the terms of the contract of

[6] *See* s. 768.28(5), F.S.
[7] Stoll v. Noel, 694 So. 2d 701, 703(Fla. 1997)
[8] Stoll v. Noel, 694 So. 2d 701, 703(Fla. 1997) (quoting The Restatement of Agency)
[9] Stoll v. Noel, 694 So. 2d 701, 703(Fla. 1997)

employment…") The CMS requires each consultant, as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS[10] Manual and CMS Consultants Guide which contain CMS policies and rules governing its relationship with the consultants. The Consultant's Guide states that all services provided to CMS patients must be authorized in advance by the clinic medical director. The language of the HRS Manual ascribes to CMS responsibility to supervise and direct the medical care of all CMS patients and supervisory authority over all personnel. The manual also grants to the CMS medical director absolute authority over payment for treatments proposed by consultants. The HRS Manual and the Consultant's Guide demonstrate that CMS has final authority over all care and treatment provided to CMS patients, and it can refuse to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.

Our conclusion is buttressed by HRS's acknowledgement that the manual creates an agency relationship between CMS and its physician consultants, and despite its potential liability in this case, HRS has acknowledged full financial responsibility for the physicians' actions. HRS's interpretation of its manual is entitled to judicial deference and great weight.[11]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 766.1115, F.S., to revise contractual requirements for patient referrals and care under the "Access to Health Care Act." The contract between the governmental contractor and the provider may authorize the provider to determine patient selection and initial referral. Current law authorizes the DOH to specify by rule the contractual conditions under which the provider may perform the patient eligibility and referral process. The bill requires the DOH to retain review and oversight authority of this process. The bill eliminates a requirement that patient care, including follow up or hospital care, is subject to approval by a governmental contractor. The bill requires the DOH to post specified information online concerning volunteer providers' hours and number of patient visits. The bill also allows a volunteer provider to earn continuing education credits for participating in the program for up to eight credits per licensure period.

Section 2 of the bill provides an effective date of July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[10] Florida's former Department of Health and Rehabilitative Services
[11] Stoll v. Noel, 694 So. 2d 701, 703(Fla. 1997)

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Additional health care providers may be incented to volunteer under the Act due to the continuing education credits authorized in the bill.

C. Government Sector Impact:

The bill requires the DOH to post specified information online concerning volunteer providers. The DOH advises that this may require an indeterminate amount of additional staffing.

The bill allows each hour of volunteer services to count as a continuing education hour for up to eight hours. To monitor and record each hour will require current continuing education procedures to be updated within the DOH.

The DOH advises that there may be additional costs associated with the collecting and online reporting of volunteer hours and patient visits that cannot be determined. As of June 30, 2012, there were 12,867 licensed providers volunteering under the Act.[12]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Whether sovereign immunity is extended to a contracted health care provider depends on the degree of control retained or exercised by the governmental entity. The bill removes the specific requirement that patient care is subject to approval by the governmental contractor. Although the DOH retains responsibility to adopt rules to administer the Act, the extent to which oversight and control of the provider is diminished, if any, might affect a court's determination of whether sovereign immunity applies.

[12] DOH Bill Analysis for SB 1690 dated March 6, 2013, on file with the Senate Health Policy Committee

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 20, 2013:
The CS reinstates and adds language concerning DOH rulemaking related to methods for determination and approval of patient eligibility and referral by governmental contractors and providers. The DOH will review and oversee authority of the patient eligibility and referral determination. The CS also reinstates language pertaining to antidumping prohibitions.

B. Amendments:

None.