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LEGISLATIVE ACTION

Senate	.	House
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Floor: 1/AE/2R	.	Floor: SENAT/RC
03/09/2016 07:30 PM	.	03/11/2016 10:25 AM
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Senator Gaetz moved the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Section 381.4019, Florida Statutes, is created
6 to read:
7 381.4019 Dental care access accounts.—Subject to the
8 availability of funds, the Legislature establishes a joint local
9 and state dental care access account initiative and authorizes
10 the creation of dental care access accounts to promote economic
11 development by supporting qualified dentists who practice in

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12 dental health professional shortage areas or medically
13 underserved areas or who treat a medically underserved
14 population. The Legislature recognizes that maintaining good
15 oral health is integral to overall health status and that the
16 good health of residents of this state is an important
17 contributing factor in economic development. Better health,
18 including better oral health, enables workers to be more
19 productive, reduces the burden of health care costs, and enables
20 children to improve in cognitive development.
21 (1) As used in this section, the term:
22 (a) "Dental health professional shortage area" means a
23 geographic area so designated by the Health Resources and
24 Services Administration of the United States Department of
25 Health and Human Services.
26 (b) "Department" means the Department of Health.
27 (c) "Medically underserved area" means a geographic area so
28 designated by the Health Resources and Services Administration
29 of the United States Department of Health and Human Services.
30 (d) "Public health program" means a county health
31 department, the Children's Medical Services Network, a federally
32 qualified community health center, a federally funded migrant
33 health center, or other publicly funded or nonprofit health care
34 program as designated by the department.
35 (2) The department shall develop and implement a dental
36 care access account initiative to benefit dentists licensed to
37 practice in this state who demonstrate, as required by the
38 department by rule:
39 (a) Active employment by a public health program located in
40 a dental health professional shortage area or a medically

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41 underserved area; or
42 (b) A commitment to opening a private practice in a dental
43 health professional shortage area or a medically underserved
44 area, as demonstrated by the dentist residing in the designated
45 area, maintaining an active Medicaid provider agreement,
46 enrolling in one or more Medicaid managed care plans, expending
47 sufficient capital to make substantial progress in opening a
48 dental practice that is capable of serving at least 1,200
49 patients, and obtaining financial support from the local
50 community in which the dentist is practicing or intending to
51 open a practice.
52 (3) The department shall establish dental care access
53 accounts as individual benefit accounts for each dentist who
54 satisfies the requirements of subsection (2) and is selected by
55 the department for participation. The department shall implement
56 an electronic benefit transfer system that enables each dentist
57 to spend funds from his or her account for the purposes
58 described in subsection (4).
59 (4) Funds contributed from state and local sources to a
60 dental care access account may be used for one or more of the
61 following purposes:
62 (a) Repayment of dental school student loans.
63 (b) Investment in property, facilities, or equipment
64 necessary to establish and operate a dental office consisting of
65 no fewer than two operatories.
66 (c) Payment of transitional expenses related to the
67 relocation or opening of a dental practice which are
68 specifically approved by the department.
69 (5) Subject to legislative appropriation, the department

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70 shall distribute state funds as an award to each dental care
71 access account. An individual award must be in an amount not
72 more than $100,000 and not less than $10,000, except that a
73 state award may not exceed 3 times the amount contributed to an
74 account in the same year from local sources. If a dentist
75 qualifies for a dental care access account under paragraph
76 (2)(a), the dentist's salary and associated employer
77 expenditures constitute a local match and qualify the account
78 for a state award if the salary and associated expenditures do
79 not come from state funds. State funds may not be included in a
80 determination of the amount contributed to an account from local
81 sources.
82 (6) The department may accept contributions of funds from a
83 local source for deposit in the account of a dentist designated
84 by the donor.
85 (7) The department shall close an account no later than 5
86 years after the first deposit of state or local funds into that
87 account or immediately upon the occurrence of any of the
88 following:
89 (a) Termination of the dentist's employment with a public
90 health program, unless, within 30 days after such termination,
91 the dentist opens a private practice in a dental health
92 professional shortage area or medically underserved area.
93 (b) Termination of the dentist's practice in a designated
94 dental health professional shortage area or medically
95 underserved area.
96 (c) Termination of the dentist's participation in the
97 Florida Medicaid program.
98 (d) Participation by the dentist in any fraudulent

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99 activity.
100 (8) Any state funds remaining in a closed account may be
101 awarded and transferred to another account concurrent with the
102 distribution of funds under the next legislative appropriation
103 for the initiative. The department shall return to the donor on
104 a pro rata basis unspent funds from local sources which remain
105 in a closed account.
106 (9) If the department determines that a dentist has
107 withdrawn account funds after the occurrence of an event
108 specified in subsection (7), has used funds for purposes not
109 authorized in subsection (4), or has not remained eligible for a
110 dental care access account for a minimum of 2 years, the dentist
111 shall repay the funds to his or her account. The department may
112 recover the withdrawn funds through disciplinary enforcement
113 actions and other methods authorized by law.
114 (10) The department shall establish by rule:
115 (a) Application procedures for dentists who wish to apply
116 for a dental care access account. An applicant may demonstrate
117 that he or she has expended sufficient capital to make
118 substantial progress in opening a dental practice that is
119 capable of serving at least 1,200 patients by documenting
120 contracts for the purchase or lease of a practice location and
121 providing executed obligations for the purchase or other
122 acquisition of at least 30 percent of the value of equipment or
123 supplies necessary to operate a dental practice. The department
124 may limit the number of applicants selected and shall give
125 priority to those applicants practicing in the areas receiving
126 higher rankings pursuant to subsection (11). The department may
127 establish additional criteria for selection which recognize an

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128 applicant's active engagement with and commitment to the
129 community providing a local match.
130 (b) A process to verify that funds withdrawn from a dental
131 care access account have been used solely for the purposes
132 described in subsection (4).
133 (11) The Department of Economic Opportunity shall rank the
134 dental health professional shortage areas and medically
135 underserved areas of the state based on the extent to which
136 limited access to dental care is impeding the areas' economic
137 development, with a higher ranking indicating a greater
138 impediment to development.
139 (12) The department shall develop a marketing plan for the
140 dental care access account initiative in cooperation with the
141 University of Florida College of Dentistry, the Nova
142 Southeastern University College of Dental Medicine, the Lake
143 Erie College of Osteopathic Medicine School of Dental Medicine,
144 and the Florida Dental Association.
145 (13)(a) By January 1 of each year, beginning in 2018, the
146 department shall issue a report to the Governor, the President
147 of the Senate, and the Speaker of the House of Representatives
148 which must include:
149 1. The number of patients served by dentists receiving
150 funding under this section.
151 2. The number of Medicaid recipients served by dentists
152 receiving funding under this section.
153 3. The average number of hours worked and patients served
154 in a week by dentists receiving funding under this section.
155 4. The number of dentists in each dental health
156 professional shortage area or medically underserved area

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157 receiving funding under this section.
158 5. The amount and source of local matching funds received
159 by the department.
160 6. The amount of state funds awarded to dentists under this
161 section.
162 7. A complete accounting of the use of funds by categories
163 identified by the department, including, but not limited to,
164 loans, supplies, equipment, rental property payments, real
165 property purchases, and salary and wages.
166 (b) The department shall adopt rules to require dentists to
167 report information to the department which is necessary for the
168 department to fulfill its reporting requirement under this
169 subsection.
170 Section 2. Subsection (3) of section 395.002, Florida
171 Statutes, is amended to read:
172 395.002 Definitions.—As used in this chapter:
173 (3) "Ambulatory surgical center" or "mobile surgical
174 facility" means a facility the primary purpose of which is to
175 provide elective surgical care, in which the patient is admitted
176 to and discharged from such facility within 24 hours ~~the same~~
177 ~~working day and is not permitted to stay overnight~~, and which is
178 not part of a hospital. However, a facility existing for the
179 primary purpose of performing terminations of pregnancy, an
180 office maintained by a physician for the practice of medicine,
181 or an office maintained for the practice of dentistry shall not
182 be construed to be an ambulatory surgical center, provided that
183 any facility or office which is certified or seeks certification
184 as a Medicare ambulatory surgical center shall be licensed as an
185 ambulatory surgical center pursuant to s. 395.003. Any structure

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or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.

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

395.003 Licensure; denial, suspension, and revocation.—

(6) An ambulatory surgical center, as a condition of initial licensure and license renewal, must provide services to Medicare patients, Medicaid patients, and patients who qualify for charity care in an amount equal to or greater than the applicable district average among licensed providers of similar services. Ambulatory surgical centers shall report the same financial, patient, postoperative surgical infection, and other data pursuant to s. 408.061 as reported by hospitals to the Agency for Health Care Administration or otherwise published by the agency. For the purposes of this subsection, “charity care” means uncompensated care delivered to uninsured patients with incomes at or below 200 percent of the federal poverty level when such services are preauthorized by the licensee and not subject to collection procedures. An ambulatory surgical center that keeps patients later than midnight on the day of the procedure must comply with the same building codes and lifesafety codes as a hospital.

(10) ~~(9)~~ A hospital licensed as of June 1, 2004, shall be

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215 exempt from subsection (9) ~~subsection (8)~~ as long as the
216 hospital maintains the same ownership, facility street address,
217 and range of services that were in existence on June 1, 2004.
218 Any transfer of beds, or other agreements that result in the
219 establishment of a hospital or hospital services within the
220 intent of this section, shall be subject to subsection (9)
221 ~~subsection (8)~~. Unless the hospital is otherwise exempt under
222 subsection (9) ~~subsection (8)~~, the agency shall deny or revoke
223 the license of a hospital that violates any of the criteria set
224 forth in that subsection.
225 (11)~~(10)~~ The agency may adopt rules implementing the
226 licensure requirements set forth in subsection (9) ~~subsection~~
227 ~~(8)~~. Within 14 days after rendering its decision on a license
228 application or revocation, the agency shall publish its proposed
229 decision in the Florida Administrative Register. Within 21 days
230 after publication of the agency's decision, any authorized
231 person may file a request for an administrative hearing. In
232 administrative proceedings challenging the approval, denial, or
233 revocation of a license pursuant to subsection (9) ~~subsection~~
234 ~~(8)~~, the hearing must be based on the facts and law existing at
235 the time of the agency's proposed agency action. Existing
236 hospitals may initiate or intervene in an administrative hearing
237 to approve, deny, or revoke licensure under subsection (9)
238 ~~subsection (8)~~ based upon a showing that an established program
239 will be substantially affected by the issuance or renewal of a
240 license to a hospital within the same district or service area.
241 Section 4. Present subsections (1) through (10) of section
242 395.0191, Florida Statutes, are redesignated as subsections (2)
243 through (11), respectively, a new subsection (1) and subsection

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244 (12) are added to that section, and present subsection (6) of
245 that section is amended, to read:
246 395.0191 Staff membership and clinical privileges.—
247 (1) As used in this section, the term:
248 (a) "Certified surgical assistant" means a surgical
249 assistant who maintains a valid and active certification under
250 one of the following designations: certified surgical first
251 assistant, from the National Board of Surgical Technology and
252 Surgical Assisting; certified surgical assistant, from the
253 National Surgical Assistant Association; or surgical assistant-
254 certified, from the American Board of Surgical Assistants.
255 (b) "Certified surgical technologist" means a surgical
256 technologist who maintains a valid and active certification as a
257 certified surgical technologist from the National Board of
258 Surgical Technology and Surgical Assisting.
259 (c) "Surgeon" means a health care practitioner as defined
260 in s. 456.001 whose scope of practice includes performing
261 surgery and who is listed as the primary surgeon in the
262 operative record.
263 (d) "Surgical assistant" means a person who provides aid in
264 exposure, hemostasis, closures, and other intraoperative
265 technical functions and who assists the surgeon in performing a
266 safe operation with optimal results for the patient.
267 (e) "Surgical technologist" means a person whose duties
268 include, but are not limited to, maintaining sterility during a
269 surgical procedure, handling and ensuring the availability of
270 necessary equipment and supplies, and maintaining visibility of
271 the operative site to ensure that the operating room environment
272 is safe, that proper equipment is available, and that the

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273 operative procedure is conducted efficiently.
274 (7) ~~(6)~~ Upon the written request of the applicant, any
275 licensed facility that has denied staff membership or clinical
276 privileges to any applicant specified in ~~subsection (1) or~~
277 subsection (2) or subsection (3) shall, within 30 days of such
278 request, provide the applicant with the reasons for such denial
279 in writing. A denial of staff membership or clinical privileges
280 to any applicant shall be submitted, in writing, to the
281 applicant's respective licensing board.
282 (12) At least 50 percent of the surgical assistants and 50
283 percent of the surgical technologists that a licensed facility
284 employs or with whom it contracts must be certified surgical
285 assistants and certified surgical technologists, respectively.
286 The requirements of this subsection do not apply to the
287 following:
288 (a) A person who has completed an appropriate training
289 program for surgical technology in any branch of the Armed
290 Forces or reserve component of the Armed Forces.
291 (b) A person who was employed or contracted to perform the
292 duties of a surgical technologist or surgical assistant at any
293 time before July 1, 2016.
294 (c) A health care practitioner as defined in s. 456.001 or
295 a student if the duties performed by the practitioner or the
296 student are within the scope of the practitioner's or the
297 student's training and practice.
298 (d) A person enrolled in a surgical technology or surgical
299 assisting training program accredited by the Commission on
300 Accreditation of Allied Health Education Programs, the
301 Accrediting Bureau of Health Education Schools, or another

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302 accrediting body recognized by the United States Department of
303 Education on July 1, 2016. A person may practice as a surgical
304 technologist or a surgical assistant for 2 years after
305 completion of such a training program before he or she is
306 required to obtain a certification under this subsection.
307 Section 5. Section 624.27, Florida Statutes, is created to
308 read:
309 624.27 Application of code as to direct primary care
310 agreements.—
311 (1) As used in this section, the term:
312 (a) "Direct primary care agreement" means a contract
313 between a primary care provider and a patient, the patient's
314 legal representative, or an employer which meets the
315 requirements specified under subsection (4) and does not
316 indemnify for services provided by a third party.
317 (b) "Primary care provider" means a health care
318 practitioner licensed under chapter 458, chapter 459, chapter
319 460, or chapter 464, or a primary care group practice that
320 provides medical services to patients which are commonly
321 provided without referral from another health care provider.
322 (c) "Primary care service" means the screening, assessment,
323 diagnosis, and treatment of a patient for the purpose of
324 promoting health or detecting and managing disease or injury
325 within the competency and training of the primary care provider.
326 (2) A direct primary care agreement does not constitute
327 insurance and is not subject to chapter 636 or any other chapter
328 of the Florida Insurance Code. The act of entering into a direct
329 primary care agreement does not constitute the business of
330 insurance and is not subject to chapter 636 or any other chapter

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331 of the Florida Insurance Code.
332 (3) A primary care provider or an agent of a primary care
333 provider is not required to obtain a certificate of authority or
334 license under chapter 636 or any other chapter of the Florida
335 Insurance Code to market, sell, or offer to sell a direct
336 primary care agreement.
337 (4) For purposes of this section, a direct primary care
338 agreement must:
339 (a) Be in writing.
340 (b) Be signed by the primary care provider or an agent of
341 the primary care provider and the patient, the patient's legal
342 representative, or an employer.
343 (c) Allow a party to terminate the agreement by giving the
344 other party at least 30 days' advance written notice. The
345 agreement may provide for immediate termination due to a
346 violation of the physician-patient relationship or a breach of
347 the terms of the agreement.
348 (d) Describe the scope of primary care services that are
349 covered by the monthly fee.
350 (e) Specify the monthly fee and any fees for primary care
351 services not covered by the monthly fee.
352 (f) Specify the duration of the agreement and any automatic
353 renewal provisions.
354 (g) Offer a refund to the patient of monthly fees paid in
355 advance if the primary care provider ceases to offer primary
356 care services for any reason.
357 (h) Contain in contrasting color and in not less than 12-
358 point type the following statements on the same page as the
359 applicant's signature:

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360 1. The agreement is not health insurance and the primary
361 care provider will not file any claims against the patient's
362 health insurance policy or plan for reimbursement of any primary
363 care services covered by the agreement.
364 2. The agreement does not qualify as minimum essential
365 coverage to satisfy the individual shared responsibility
366 provision of the Patient Protection and Affordable Care Act, 26
367 U.S.C. s. 5000A.
368 Section 6. The sections created and amendments made by this
369 act to ss. 409.967, 627.42392, 641.31, and 641.394, Florida
370 Statutes, may be known as the "Right Medicine Right Time Act."
371 Section 7. Effective January 1, 2017, paragraph (c) of
372 subsection (2) of section 409.967, Florida Statutes, is amended
373 to read:
374 409.967 Managed care plan accountability.—
375 (2) The agency shall establish such contract requirements
376 as are necessary for the operation of the statewide managed care
377 program. In addition to any other provisions the agency may deem
378 necessary, the contract must require:
379 (c) *Access.*—
380 1. The agency shall establish specific standards for the
381 number, type, and regional distribution of providers in managed
382 care plan networks to ensure access to care for both adults and
383 children. Each plan must maintain a regionwide network of
384 providers in sufficient numbers to meet the access standards for
385 specific medical services for all recipients enrolled in the
386 plan. The exclusive use of mail-order pharmacies may not be
387 sufficient to meet network access standards. Consistent with the
388 standards established by the agency, provider networks may

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389 include providers located outside the region. A plan may
390 contract with a new hospital facility before the date the
391 hospital becomes operational if the hospital has commenced
392 construction, will be licensed and operational by January 1,
393 2013, and a final order has issued in any civil or
394 administrative challenge. Each plan shall establish and maintain
395 an accurate and complete electronic database of contracted
396 providers, including information about licensure or
397 registration, locations and hours of operation, specialty
398 credentials and other certifications, specific performance
399 indicators, and such other information as the agency deems
400 necessary. The database must be available online to both the
401 agency and the public and have the capability to compare the
402 availability of providers to network adequacy standards and to
403 accept and display feedback from each provider's patients. Each
404 plan shall submit quarterly reports to the agency identifying
405 the number of enrollees assigned to each primary care provider.
406 2.a. Each managed care plan must publish any prescribed
407 drug formulary or preferred drug list on the plan's website in a
408 manner that is accessible to and searchable by enrollees and
409 providers. The plan must update the list within 24 hours after
410 making a change. Each plan must ensure that the prior
411 authorization process for prescribed drugs is readily accessible
412 to health care providers, including posting appropriate contact
413 information on its website and providing timely responses to
414 providers. For Medicaid recipients diagnosed with hemophilia who
415 have been prescribed anti-hemophilic-factor replacement
416 products, the agency shall provide for those products and
417 hemophilia overlay services through the agency's hemophilia

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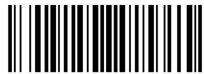
418 disease management program.
419 b. If a managed care plan restricts the use of prescribed
420 drugs through a fail-first protocol, it must establish a clear
421 and convenient process that a prescribing physician may use to
422 request an override of the restriction from the managed care
423 plan. The managed care plan shall grant an override of the
424 protocol within 24 hours if:
425 (I) Based on sound clinical evidence, the prescribing
426 provider concludes that the preferred treatment required under
427 the fail-first protocol has been ineffective in the treatment of
428 the enrollee’s disease or medical condition; or
429 (II) Based on sound clinical evidence or medical and
430 scientific evidence, the prescribing provider believes that the
431 preferred treatment required under the fail-first protocol:
432 (A) Is likely to be ineffective given the known relevant
433 physical or mental characteristics and medical history of the
434 enrollee and the known characteristics of the drug regimen; or
435 (B) Will cause or is likely to cause an adverse reaction or
436 other physical harm to the enrollee.
437
438 If the prescribing provider follows the fail-first protocol
439 recommended by the managed care plan for an enrollee, the
440 duration of treatment under the fail-first protocol may not
441 exceed a period deemed appropriate by the prescribing provider.
442 Following such period, if the prescribing provider deems the
443 treatment provided under the protocol clinically ineffective,
444 the enrollee is entitled to receive the course of therapy that
445 the prescribing provider recommends, and the provider is not
446 required to seek approval of an override of the fail-first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447 protocol. As used in this subparagraph, the term “fail-first
448 protocol” means a prescription practice that begins medication
449 for a medical condition with the most cost-effective drug
450 therapy and progresses to other more costly or risky therapies
451 only if necessary.
452 3. Managed care plans, and their fiscal agents or
453 intermediaries, must accept prior authorization requests for any
454 service electronically.
455 4. Managed care plans serving children in the care and
456 custody of the Department of Children and Families shall ~~must~~
457 maintain complete medical, dental, and behavioral health
458 encounter information and participate in making such information
459 available to the department or the applicable contracted
460 community-based care lead agency for use in providing
461 comprehensive and coordinated case management. The agency and
462 the department shall establish an interagency agreement to
463 provide guidance for the format, confidentiality, recipient,
464 scope, and method of information to be made available and the
465 deadlines for submission of the data. The scope of information
466 available to the department are ~~shall be~~ the data that managed
467 care plans are required to submit to the agency. The agency
468 shall determine the plan’s compliance with standards for access
469 to medical, dental, and behavioral health services; the use of
470 medications; and followup on all medically necessary services
471 recommended as a result of early and periodic screening,
472 diagnosis, and treatment.
473 Section 8. Effective January 1, 2017, section 627.42392,
474 Florida Statutes, is created to read:
475 627.42392 Fail-first protocols.—If an insurer restricts the

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476 use of prescribed drugs through a fail-first protocol, it must
477 establish a clear and convenient process that a prescribing
478 physician may use to request an override of the restriction from
479 the insurer. The insurer shall grant an override of the protocol
480 within 24 hours if:
481 (1) Based on sound clinical evidence, the prescribing
482 provider concludes that the preferred treatment required under
483 the fail-first protocol has been ineffective in the treatment of
484 the insured's disease or medical condition; or
485 (2) Based on sound clinical evidence or medical and
486 scientific evidence, the prescribing provider believes that the
487 preferred treatment required under the fail-first protocol:
488 (a) Is likely to be ineffective given the known relevant
489 physical or mental characteristics and medical history of the
490 insured and the known characteristics of the drug regimen; or
491 (b) Will cause or is likely to cause an adverse reaction or
492 other physical harm to the insured.
493
494 If the prescribing provider follows the fail-first protocol
495 recommended by the insurer for an insured, the duration of
496 treatment under the fail-first protocol may not exceed a period
497 deemed appropriate by the prescribing provider. Following such
498 period, if the prescribing provider deems the treatment provided
499 under the protocol clinically ineffective, the insured is
500 entitled to receive the course of therapy that the prescribing
501 provider recommends, and the provider is not required to seek
502 approval of an override of the fail-first protocol. As used in
503 this section, the term "fail-first protocol" means a
504 prescription practice that begins medication for a medical

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505 condition with the most cost-effective drug therapy and
506 progresses to other more costly or risky therapies only if
507 necessary.
508 Section 9. Effective January 1, 2017, subsection (44) is
509 added to section 641.31, Florida Statutes, to read:
510 641.31 Health maintenance contracts.—
511 (44) A health maintenance organization may not require a
512 health care provider, by contract with another health care
513 provider, a patient, or another individual or entity, to use a
514 clinical decision support system or a laboratory benefits
515 management program before the provider may order clinical
516 laboratory services or in an attempt to direct or limit the
517 provider's medical decisionmaking relating to the use of such
518 services. This subsection may not be construed to prohibit any
519 prior authorization requirements that the health maintenance
520 organization may have regarding the provision of clinical
521 laboratory services. As used in this subsection, the term:
522 (a) "Clinical decision support system" means software
523 designed to direct or assist clinical decisionmaking by matching
524 the characteristics of an individual patient to a computerized
525 clinical knowledge base and providing patient-specific
526 assessments or recommendations based on the match.
527 (b) "Clinical laboratory services" means the examination of
528 fluids or other materials taken from the human body, which
529 examination is ordered by a health care provider for use in the
530 diagnosis, prevention, or treatment of a disease or in the
531 identification or assessment of a medical or physical condition.
532 (c) "Laboratory benefits management program" means a health
533 maintenance organization protocol that dictates or limits health

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534 care provider decisionmaking relating to the use of clinical
535 laboratory services.
536 Section 10. Effective January 1, 2017, section 641.394,
537 Florida Statutes, is created to read:
538 641.394 Fail-first protocols.—If a health maintenance
539 organization restricts the use of prescribed drugs through a
540 fail-first protocol, it must establish a clear and convenient
541 process that a prescribing physician may use to request an
542 override of the restriction from the health maintenance
543 organization. The health maintenance organization shall grant an
544 override of the protocol within 24 hours if:
545 (1) Based on sound clinical evidence, the prescribing
546 provider concludes that the preferred treatment required under
547 the fail-first protocol has been ineffective in the treatment of
548 the subscriber's disease or medical condition; or
549 (2) Based on sound clinical evidence or medical and
550 scientific evidence, the prescribing provider believes that the
551 preferred treatment required under the fail-first protocol:
552 (a) Is likely to be ineffective given the known relevant
553 physical or mental characteristics and medical history of the
554 subscriber and the known characteristics of the drug regimen; or
555 (b) Will cause or is likely to cause an adverse reaction or
556 other physical harm to the subscriber.
557
558 If the prescribing provider follows the fail-first protocol
559 recommended by the health maintenance organization for a
560 subscriber, the duration of treatment under the fail-first
561 protocol may not exceed a period deemed appropriate by the
562 prescribing provider. Following such period, if the prescribing

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563 provider deems the treatment provided under the protocol
564 clinically ineffective, the subscriber is entitled to receive
565 the course of therapy that the prescribing provider recommends,
566 and the provider is not required to seek approval of an override
567 of the fail-first protocol. As used in this section, the term
568 “fail-first protocol” means a prescription practice that begins
569 medication for a medical condition with the most cost-effective
570 drug therapy and progresses to other more costly or risky
571 therapies only if necessary.
572 Section 11. Paragraphs (a) and (d) of subsection (3) and
573 subsections (4) and (5) of section 766.1115, Florida Statutes,
574 are amended to read:
575 766.1115 Health care providers; creation of agency
576 relationship with governmental contractors.—
577 (3) DEFINITIONS.—As used in this section, the term:
578 (a) “Contract” means an agreement executed in compliance
579 with this section between a health care provider and a
580 governmental contractor for volunteer, uncompensated services
581 which allows the health care provider to deliver health care
582 services to low-income recipients as an agent of the
583 governmental contractor. ~~The contract must be for volunteer,~~
584 ~~uncompensated services, except as provided in paragraph (4)(g).~~
585 For services to qualify as volunteer, uncompensated services
586 under this section, the health care provider, or any employee or
587 agent of the health care provider, must receive no compensation
588 from the governmental contractor for any services provided under
589 the contract and must not bill or accept compensation from the
590 recipient, or a public or private third-party payor, for the
591 specific services provided to the low-income recipients covered

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592 by the contract, except as provided in paragraph (4)(g). A free
593 clinic as described in subparagraph (d)14. may receive a
594 legislative appropriation, a grant through a legislative
595 appropriation, or a grant from a governmental entity or
596 nonprofit corporation to support the delivery of contracted
597 services by volunteer health care providers, including the
598 employment of health care providers to supplement, coordinate,
599 or support the delivery of such services. The appropriation or
600 grant for the free clinic does not constitute compensation under
601 this paragraph from the governmental contractor for services
602 provided under the contract, nor does receipt or use of the
603 appropriation or grant constitute the acceptance of compensation
604 under this paragraph for the specific services provided to the
605 low-income recipients covered by the contract.
606 (d) "Health care provider" or "provider" means:
607 1. A birth center licensed under chapter 383.
608 2. An ambulatory surgical center licensed under chapter
609 395.
610 3. A hospital licensed under chapter 395.
611 4. A physician or physician assistant licensed under
612 chapter 458.
613 5. An osteopathic physician or osteopathic physician
614 assistant licensed under chapter 459.
615 6. A chiropractic physician licensed under chapter 460.
616 7. A podiatric physician licensed under chapter 461.
617 8. A registered nurse, nurse midwife, licensed practical
618 nurse, or advanced registered nurse practitioner licensed or
619 registered under part I of chapter 464 or any facility which
620 employs nurses licensed or registered under part I of chapter

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621 464 to supply all or part of the care delivered under this
622 section.
623 9. A midwife licensed under chapter 467.
624 10. A health maintenance organization certificated under
625 part I of chapter 641.
626 11. A health care professional association ~~and its~~
627 ~~employees~~ or a corporate medical group ~~and its employees~~.
628 12. Any other medical facility the primary purpose of which
629 is to deliver human medical diagnostic services or which
630 delivers nonsurgical human medical treatment, and which includes
631 an office maintained by a provider.
632 13. A dentist or dental hygienist licensed under chapter
633 466.
634 14. A free clinic that delivers only medical diagnostic
635 services or nonsurgical medical treatment free of charge to all
636 low-income recipients.
637 15. Any other health care professional, practitioner,
638 provider, or facility under contract with a governmental
639 contractor, including a student enrolled in an accredited
640 program that prepares the student for licensure as any one of
641 the professionals listed in subparagraphs 4.-9.
642
643 The term includes any nonprofit corporation qualified as exempt
644 from federal income taxation under s. 501(a) of the Internal
645 Revenue Code, and described in s. 501(c) of the Internal Revenue
646 Code, which delivers health care services provided by licensed
647 professionals listed in this paragraph, any federally funded
648 community health center, and any volunteer corporation or
649 volunteer health care provider that delivers health care

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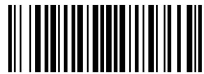
650 services.
651 (4) CONTRACT REQUIREMENTS.—A health care provider that
652 executes a contract with a governmental contractor to deliver
653 health care services ~~on or after April 17, 1992,~~ as an agent of
654 the governmental contractor, or any employee or agent of such
655 health care provider, is an agent for purposes of s. 768.28(9),
656 while acting within the scope of duties under the contract, if
657 the contract complies with the requirements of this section and
658 regardless of whether the individual treated is later found to
659 be ineligible. A health care provider, or any employee or agent
660 of such health care provider, shall continue to be an agent for
661 purposes of s. 768.28(9) for 30 days after a determination of
662 ineligibility to allow for treatment until the individual
663 transitions to treatment by another health care provider. A
664 health care provider, or any employee or agent of such health
665 care provider, under contract with the state may not be named as
666 a defendant in any action arising out of medical care or
667 treatment ~~provided on or after April 17, 1992,~~ under contracts
668 entered into under this section. The contract must provide that:
669 (a) The right of dismissal or termination of any health
670 care provider delivering services under the contract is retained
671 by the governmental contractor.
672 (b) The governmental contractor has access to the patient
673 records of any health care provider delivering services under
674 the contract.
675 (c) Adverse incidents and information on treatment outcomes
676 must be reported by any health care provider to the governmental
677 contractor if the incidents and information pertain to a patient
678 treated under the contract. The health care provider shall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679 submit the reports required by s. 395.0197. If an incident
680 involves a professional licensed by the Department of Health or
681 a facility licensed by the Agency for Health Care
682 Administration, the governmental contractor shall submit such
683 incident reports to the appropriate department or agency, which
684 shall review each incident and determine whether it involves
685 conduct by the licensee that is subject to disciplinary action.
686 All patient medical records and any identifying information
687 contained in adverse incident reports and treatment outcomes
688 which are obtained by governmental entities under this paragraph
689 are confidential and exempt from the provisions of s. 119.07(1)
690 and s. 24(a), Art. I of the State Constitution.
691 (d) Patient selection and initial referral must be made by
692 the governmental contractor or the provider. Patients may not be
693 transferred to the provider based on a violation of the
694 antidumping provisions of the Omnibus Budget Reconciliation Act
695 of 1989, the Omnibus Budget Reconciliation Act of 1990, or
696 chapter 395.
697 (e) If emergency care is required, the patient need not be
698 referred before receiving treatment, but must be referred within
699 48 hours after treatment is commenced or within 48 hours after
700 the patient has the mental capacity to consent to treatment,
701 whichever occurs later.
702 (f) The provider is subject to supervision and regular
703 inspection by the governmental contractor.
704 (g) ~~As an agent of the governmental contractor for purposes~~
705 ~~of s. 768.28(9), while acting within the scope of duties under~~
706 ~~the contract,~~ A health care provider licensed under chapter 466,
707 as an agent of the governmental contractor for purposes of s.

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708 768.28(9), may allow a patient, or a parent or guardian of the
709 patient, to voluntarily contribute a monetary amount to cover
710 costs of dental laboratory work related to the services provided
711 to the patient within the scope of duties under the contract.
712 This contribution may not exceed the actual cost of the dental
713 laboratory charges.
714
715 A governmental contractor that is also a health care provider is
716 not required to enter into a contract under this section with
717 respect to the health care services delivered by its employees.
718 (5) NOTICE OF AGENCY RELATIONSHIP.—The governmental
719 contractor must provide written notice to each patient, or the
720 patient's legal representative, receipt of which must be
721 acknowledged in writing at the initial visit, that the provider
722 is an agent of the governmental contractor and that the
723 exclusive remedy for injury or damage suffered as the result of
724 any act or omission of the provider or of any employee or agent
725 thereof acting within the scope of duties pursuant to the
726 contract is by commencement of an action pursuant to ~~the~~
727 ~~provisions of~~ s. 768.28. Thereafter, or with respect to any
728 federally funded community health center, the notice
729 requirements may be met by posting in a place conspicuous to all
730 persons a notice that the health care provider, or federally
731 funded community health center, is an agent of the governmental
732 contractor and that the exclusive remedy for injury or damage
733 suffered as the result of any act or omission of the provider or
734 of any employee or agent thereof acting within the scope of
735 duties pursuant to the contract is by commencement of an action
736 pursuant to ~~the provisions of~~ s. 768.28.

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737 Section 12. Paragraphs (a) and (b) of subsection (9) of
738 section 768.28, Florida Statutes, are amended to read:
739 768.28 Waiver of sovereign immunity in tort actions;
740 recovery limits; limitation on attorney fees; statute of
741 limitations; exclusions; indemnification; risk management
742 programs.—
743 (9)(a) An ~~No~~ officer, employee, or agent of the state or of
744 any of its subdivisions may not ~~shall~~ be held personally liable
745 in tort or named as a party defendant in any action for any
746 injury or damage suffered as a result of any act, event, or
747 omission of action in the scope of her or his employment or
748 function, unless such officer, employee, or agent acted in bad
749 faith or with malicious purpose or in a manner exhibiting wanton
750 and willful disregard of human rights, safety, or property.
751 However, such officer, employee, or agent shall be considered an
752 adverse witness in a tort action for any injury or damage
753 suffered as a result of any act, event, or omission of action in
754 the scope of her or his employment or function. The exclusive
755 remedy for injury or damage suffered as a result of an act,
756 event, or omission of an officer, employee, or agent of the
757 state or any of its subdivisions or constitutional officers is
758 ~~shall be~~ by action against the governmental entity, or the head
759 of such entity in her or his official capacity, or the
760 constitutional officer of which the officer, employee, or agent
761 is an employee, unless such act or omission was committed in bad
762 faith or with malicious purpose or in a manner exhibiting wanton
763 and willful disregard of human rights, safety, or property. The
764 state or its subdivisions are ~~shall~~ not ~~be~~ liable in tort for
765 the acts or omissions of an officer, employee, or agent

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766 committed while acting outside the course and scope of her or
767 his employment or committed in bad faith or with malicious
768 purpose or in a manner exhibiting wanton and willful disregard
769 of human rights, safety, or property.
770 (b) As used in this subsection, the term:
771 1. “Employee” includes any volunteer firefighter.
772 2. “Officer, employee, or agent” includes, but is not
773 limited to, any health care provider, and its employees or
774 agents, when providing services pursuant to s. 766.1115; any
775 nonprofit independent college or university located and
776 chartered in this state which owns or operates an accredited
777 medical school, and its employees or agents, when providing
778 patient services pursuant to paragraph (10)(f); and any public
779 defender or her or his employee or agent, including~~, among~~
780 ~~others,~~ an assistant public defender or ~~and~~ an investigator.
781 Section 13. Except as otherwise expressly provided in this
782 act, this act shall take effect July 1, 2016.
783
784 ================= T I T L E A M E N D M E N T ================
785 And the title is amended as follows:
786 Delete everything before the enacting clause
787 and insert:
788 A bill to be entitled
789 An act relating to health care; creating s. 381.4019,
790 F.S.; establishing a joint local and state dental care
791 access account initiative, subject to the availability
792 of funding; authorizing the creation of dental care
793 access accounts; specifying the purpose of the
794 initiative; defining terms; providing criteria for the

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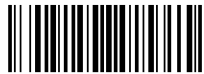
795 selection of dentists for participation in the
796 initiative; providing for the establishment of
797 accounts; requiring the Department of Health to
798 implement an electronic benefit transfer system;
799 providing for the use of funds deposited in the
800 accounts; requiring the department to distribute state
801 funds to accounts, subject to legislative
802 appropriations; authorizing the department to accept
803 contributions from a local source for deposit in a
804 designated account; limiting the number of years that
805 an account may remain open; providing for the
806 immediate closing of accounts under certain
807 circumstances; authorizing the department to transfer
808 state funds remaining in a closed account at a
809 specified time and to return unspent funds from local
810 sources; requiring a dentist to repay funds in certain
811 circumstances; authorizing the department to pursue
812 disciplinary enforcement actions and to use other
813 legal means to recover funds; requiring the department
814 to establish by rule application procedures and a
815 process to verify the use of funds withdrawn from a
816 dental care access account; requiring the department
817 to give priority to applications from dentists
818 practicing in certain areas; requiring the Department
819 of Economic Opportunity to rank dental health
820 professional shortage areas and medically underserved
821 areas; requiring the Department of Health to develop a
822 marketing plan in cooperation with certain dental
823 colleges and the Florida Dental Association; requiring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824 the Department of Health to annually submit a report
825 with certain information to the Governor and the
826 Legislature; providing rulemaking authority to require
827 the submission of information for such reporting;
828 amending s. 395.002, F.S.; revising the definition of
829 the term “ambulatory surgical center” or “mobile
830 surgical facility”; amending s. 395.003, F.S.;
831 requiring, as a condition of licensure and license
832 renewal, that ambulatory surgical centers provide
833 services to specified patients in at least a specified
834 amount; requiring ambulatory surgical centers to
835 report certain data; defining a term; requiring
836 ambulatory surgical centers to comply with certain
837 building and lifesafety codes in certain
838 circumstances; amending s. 395.0191, F.S.; defining
839 terms; conforming cross-references; requiring a
840 certain percentage of surgical assistants and surgical
841 technologists employed or contracting with a hospital
842 to be certified; providing exceptions to the
843 certification requirement; creating s. 624.27, F.S.;
844 defining terms; specifying that a direct primary care
845 agreement does not constitute insurance and is not
846 subject to ch. 636, F.S., relating to prepaid limited
847 health service organizations and discount medical plan
848 organizations, or any other chapter of the Florida
849 Insurance Code; specifying that entering into a direct
850 primary care agreement does not constitute the
851 business of insurance and is not subject to ch. 636,
852 F.S., or any other chapter of the code; providing that

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853 certain certificates of authority and licenses are not
854 required to market, sell, or offer to sell a direct
855 primary care agreement; specifying requirements for a
856 direct primary care agreement; providing a short
857 title; amending s. 409.967, F.S.; requiring a managed
858 care plan to establish a process by which a
859 prescribing physician may request an override of
860 certain restrictions in certain circumstances;
861 providing the circumstances under which an override
862 must be granted; defining the term "fail-first
863 protocol"; creating s. 627.42392, F.S.; requiring an
864 insurer to establish a process by which a prescribing
865 physician may request an override of certain
866 restrictions in certain circumstances; providing the
867 circumstances under which an override must be granted;
868 defining the term "fail-first protocol"; amending s.
869 641.31, F.S.; prohibiting a health maintenance
870 organization from requiring that a health care
871 provider use a clinical decision support system or a
872 laboratory benefits management program in certain
873 circumstances; defining terms; providing for
874 construction; creating s. 641.394, F.S.; requiring a
875 health maintenance organization to establish a process
876 by which a prescribing physician may request an
877 override of certain restrictions in certain
878 circumstances; providing the circumstances under which
879 an override must be granted; defining the term "fail-
880 first protocol"; amending s. 766.1115, F.S.; revising
881 the definitions of the terms "contract" and "health

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882 care provider”; deleting an obsolete date; extending
883 sovereign immunity to employees or agents of a health
884 care provider that executes a contract with a
885 governmental contractor; clarifying that a receipt of
886 specified notice must be acknowledged by a patient or
887 the patient’s representative at the initial visit;
888 requiring the posting of notice that a specified
889 health care provider is an agent of a governmental
890 contractor; amending s. 768.28, F.S.; revising the
891 definition of the term “officer, employee, or agent”
892 to include employees or agents of a health care
893 provider as it applies to immunity from personal
894 liability in certain actions; providing effective
895 dates.