

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 85 Recovery Care Services  
**SPONSOR(S):** Fitzenhagen  
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 212

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Affordable Healthcare Access	10 Y, 4 N	Guzzo	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

### SUMMARY ANALYSIS

Pursuant to s. 395.002, 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, 2016.

# 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.<sup>1</sup>

In Florida, outpatient surgery is performed in two settings, hospital outpatient surgery departments (HOPDs) and ASCs. Currently, there are 429 ASCs in Florida and 204 HOPDs.<sup>2</sup>

In 2014, there were 2,933,087 visits to ASCs and HOPDs in Florida.<sup>3</sup> HOPDs accounted for 46 percent and ASCs accounted for 54 percent of the total number of visits. Of the \$33.8 billion in total combined charges in HOPDs and ASCs in 2014, HOPDs accounted for 77 percent of the charges, while ASCs accounted for 23 percent.<sup>4</sup> The average charge at the HOPDs (\$19,140) was larger than the average charge at the ASCs (\$5,018).<sup>5</sup> Two procedures, colonoscopy and gastrointestinal endoscopy, are consistently in the top 10 procedures performed by both facility types.<sup>6</sup> In 2014, the average charge for a colonoscopy by site was \$6,694 for HOPDs and \$2,391 for ASCs.<sup>7</sup> The average charge for gastrointestinal endoscopy by site was \$9,537 for HOPDs and \$2,269 for ASCs.<sup>8</sup> This data was not adjusted for acuity, so it may reflect higher acuity levels in hospital patients.

In 2014, the charges for visits to ASCs and HOPDs were paid mainly by commercial Insurance and Medicare. Commercial insurance paid for 40 percent of charges (\$13.6 billion), while Medicare paid for 30 percent of charges (\$10.1 billion).<sup>9</sup> The next three top payer groups (Medicare Managed Care, Medicaid, and Medicaid Managed Care) accounted for a combined 21.6 percent (\$7.3 billion) of charges.<sup>10</sup>

##### ASC Licensure

ASCs are licensed and regulated by the Agency for Health Care Administration (AHCA) under the same regulatory framework as hospitals.<sup>11</sup> 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.<sup>12</sup>

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<sup>1</sup> S. 395.002(3), F.S.

<sup>2</sup> AHCA Agency Bill Analysis, dated September 18, 2015, pg. 3 (on file with Select Committee on Affordable Healthcare Access staff).

<sup>3</sup> Agency for Health Care Administration, *Ambulatory (Outpatient) Surgery Query Results; By Facility Type and Average Charges*, available at <http://www.floridahealthfinder.gov/QueryTool/QTResults.aspx?T=O> (last viewed on November 12, 2015).

<sup>4</sup> Id.

<sup>5</sup> Id.

<sup>6</sup> 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 November 12, 2015).

<sup>7</sup> Id.

<sup>8</sup> Id.

<sup>9</sup> Agency for Health Care Administration, *Ambulatory (Outpatient) Surgery Query Results; By Patient, Primary Payer, and Average Charges* <http://www.floridahealthfinder.gov/QueryTool/QTResults.aspx> (last viewed on November 10, 2015).

<sup>10</sup> Id.

<sup>11</sup> SS. 395.001-1065, F.S., and Part II, Chapter 408, F.S.

<sup>12</sup> Rule 59A-5.003(4), F.A.C.

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;
- A roster of registered nurses and licensed practical nurses with current license numbers;
- A fire plan; and
- The comprehensive Emergency Management Plan.<sup>13</sup>

AHCA is authorized to adopt rules for hospitals and ASCs.<sup>14</sup> Separate standards may be provided for general and specialty hospitals, ASCs, mobile surgical facilities, and statutory rural hospitals,<sup>15</sup> 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
- 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.<sup>16</sup> In providing these services, ACSs are required to have certain professional staff available, including:

- A registered nurse to serve as operating room circulating nurse;<sup>17</sup>
- 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;<sup>18</sup> and
- A Registered professional nurse in the recovery area during the patient's recovery period.<sup>19</sup>

#### *Infection Control Rules*

ASCs are required to establish an infection control program, which must include written policies and procedures reflecting the scope of the program.<sup>20</sup> The written policies and procedures must be reviewed at least every two years by the infection control program members.<sup>21</sup> The infection control program must include:

- Surveillance, prevention, and control of infection among patients and personnel;<sup>22</sup>
- A system for identifying, reporting, evaluating and maintaining records of infections;<sup>23</sup>

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<sup>13</sup> Rule 59A-5.003(5), F.A.C.

<sup>14</sup> S. 395.1055, F.S.

<sup>15</sup> S. 395.1055(2), F.S.

<sup>16</sup> Rule 59A-5.0085, F.A.C.

<sup>17</sup> Rule 59A-5.0085(3)(c), F.A.C.

<sup>18</sup> Rule 59A-5.0085(2)(b), F.A.C.

<sup>19</sup> Rule 59A-5.0085(3)(d), F.A.C.

<sup>20</sup> Rule 59A-5.011(1), F.A.C.

<sup>21</sup> Rule 59A-5.011(2), F.A.C.

<sup>22</sup> Rule 59A-5.011(1)(a), F.A.C.

<sup>23</sup> Rule 59A-5.011(1)(b), F.A.C.

- Ongoing review and evaluation of aseptic, isolation and sanitation techniques employed by the ASC;<sup>24</sup> and
- Development and coordination of training programs in infection control for all personnel.<sup>25</sup>

### *Emergency Management Plan Rules*

ASCs are required to develop and adopt a written comprehensive emergency management plan for emergency care during an internal or external disaster or emergency.<sup>26</sup> The ASC must review the plan and update it annually.<sup>27</sup>

### *Accreditation*

ASCs may seek voluntary accreditation by the Joint Commission for Health Care Organizations, the Accreditation Association for Ambulatory Health Care, and the American Osteopathic Association Healthcare Facilities Accreditation Program.<sup>28</sup> AHCA is required to conduct an annual licensure inspection survey for non-accredited ASCs.<sup>29</sup> AHCA must accept survey reports of accredited ASCs from accrediting organizations if the standards included in the survey report are determined to document that the ASC is in substantial compliance with state licensure requirements.<sup>30</sup> AHCA is required to conduct annual validation inspections on a minimum of 5 percent of the ASCs which were inspected by an accreditation organization.<sup>31</sup>

AHCA is required to conduct annual life safety inspections of all ASCs to ensure compliance with life safety codes and disaster preparedness requirements.<sup>32</sup> 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.<sup>33</sup>

In 2014, 373 licensed ASCs in Florida were accredited by a national accrediting organization.<sup>34</sup>

## 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 "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<sup>35</sup> following an admission.<sup>36</sup>

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

<sup>24</sup> Rule 59A-5.011(1)(c), F.A.C.

<sup>25</sup> Rule 59A-5.011(1)(d), F.A.C.

<sup>26</sup> Rule 59A-5.018(1), F.A.C.

<sup>27</sup> Id.

<sup>28</sup> Rule 59A-5.004(3), F.A.C., and AHCA Ambulatory Surgical Center; *Accrediting Organizations for Ambulatory Surgical Centers*, available at [http://ahca.myflorida.com/MCHQ/Health\\_Facility\\_Regulation/Hospital\\_Outpatient/ambulatory.shtml](http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/ambulatory.shtml) (last viewed November 13, 2015).

<sup>29</sup> Rule 59A-5.004(1) and (2), F.A.C.

<sup>30</sup> Rule 59A-5.004(3), F.A.C.

<sup>31</sup> Rule 59A-5.004(5), F.A.C.

<sup>32</sup> Rule 59A-5.004(1), F.S., and s. 395.0161, F.S.

<sup>33</sup> S. 395.0161(2), F.S.

<sup>34</sup> Agency for Health Care Administration, *Ambulatory Surgical Center Regulatory Overview*, March 2015 (on file with Select Committee on Affordable Healthcare Access staff).

<sup>35</sup> State Operations Manual Appendix L, *Guidance for Surveyors: Ambulatory Surgical Centers* (Rev. 99, 01-31-14) 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 §416.25. In addition, review of the cases that exceed the time frame may also reveal noncompliance with CfCs related to surgical services, patient admission and assessment, and quality assurance/performance improvement.

<sup>36</sup> 42 C.F.R. §416.2

reasonable assurance that the conditions are met.<sup>37</sup> All of the CMS conditions for coverage requirements are included in Chapter 59A-5, F.A.C., and apply to all ASCs in Florida. 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.

### 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.<sup>38</sup> 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 ASCs following surgery, which allows ASCs to perform more complex procedures.<sup>39</sup>

RCCs are not eligible for Medicare reimbursement.<sup>40</sup> However, RCCs may receive payments from Medicaid programs. One 1999 survey noted that RCCs received payment in the following breakdown: 41% from managed care plans, 29% from self-pay, 16% from indemnity plans, and 9% from workers' compensation.<sup>41</sup>

Three states, Arizona, Connecticut, and Illinois, have specific licenses for "recovery care centers."<sup>42</sup> Other states license RCCs as nursing facilities or hospitals.<sup>43</sup> One study found that eighteen states allow RCCs to have stays over 24 hours, usually with a maximum stay of 72 hours.<sup>44</sup>

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<sup>37</sup> 42 C.F.R. §416.26(1)

<sup>38</sup> Medicare Payment Advisory Comm'n, Report to the Congress: Medicare Payment for Post-Surgical Recovery Care Centers, (2000).

<sup>39</sup> Id. at 4.

<sup>40</sup> See Medicare Payment Advisory Comm'n, Supra FN 20.

<sup>41</sup> Medicare Payment Advisory Comm'n, Supra FN 20, at 6 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

<sup>42</sup> Ariz. Rev. Stat. Ann. §§ 36-448.51-36-448.55; Conn. Conn. Agencies Regs § 19A-495-571; 210 Ill. Comp. Stat. Ann. 3/35.

<sup>43</sup> Sandra Lee Breisch, *Profits in Short Stays*, Am. Acad. of Orthopaedic Surgeons Bulletin (June, 1999), available at <http://www2.aaos.org/bulletin/jun99/asc.htm>

<sup>44</sup> Medicare Payment Advisory Comm'n, supra FN 20, at 4 (citing Federated Ambulatory Surgery Association, Post-Surgical Recovery Care, (2000)).

## Comparison of RCC Regulations in Arizona, Connecticut, and Illinois

Regulation	Arizona <sup>45</sup>	Connecticut <sup>46</sup>	Illinois <sup>47</sup>
<b>Licensure Required</b>	X	X	X
<b>Written Policies</b>	X	X	X
<b>Maintain Medical Records</b>	X	X	X
<b>Patient's Bill of Rights</b>	X	X	X
<b>Allows Freestanding Facility or Attached</b>	Not Addressed.	X	X
<b>Length of Stay</b>	Not Addressed.	Expected 3 days Maximum 21 days	Expected 48 hours Maximum 72 hours
<b>Emergency Care Transfer Agreement</b>	For care not provided by the recovery care center.	With a hospital and an ambulance service.	With a hospital within 15 minutes travel time.
<b>Prohibited Patients</b>	Patients needing: <ul style="list-style-type: none"> <li>• Intensive care</li> <li>• Coronary care</li> <li>• Critical care</li> </ul>	Patients needing: <ul style="list-style-type: none"> <li>• Intensive care</li> <li>• Coronary care</li> <li>• Critical care</li> </ul>	<ul style="list-style-type: none"> <li>• Patients with chronic infectious conditions</li> <li>• Children under age 3</li> </ul>
<b>Prohibited Services</b>	<ul style="list-style-type: none"> <li>• Surgical</li> <li>• Radiological</li> <li>• Pediatric</li> <li>• Obstetrical</li> </ul>	<ul style="list-style-type: none"> <li>• Surgical</li> <li>• Radiological</li> <li>• Pre-adolescent pediatric</li> <li>• Hospice</li> <li>• Obstetrical services over 24 week gestation</li> <li>• Intravenous therapy for non-hospital based RCC</li> </ul>	<ul style="list-style-type: none"> <li>• Blood administration (only blood products allowed)</li> </ul>
<b>Required Services</b>	<ul style="list-style-type: none"> <li>• Laboratory</li> <li>• Pharmaceutical</li> <li>• Food</li> </ul>	<ul style="list-style-type: none"> <li>• Pharmaceutical</li> <li>• Dietary</li> <li>• Personal care</li> <li>• Rehabilitation</li> <li>• Therapeutic</li> <li>• Social work</li> </ul>	<ul style="list-style-type: none"> <li>• Laboratory</li> <li>• Pharmaceutical</li> <li>• Food</li> <li>• Radiological</li> </ul>
<b>Bed Limitation</b>	Not Addressed.	Not Addressed.	20
<b>Required Staff</b>	<ul style="list-style-type: none"> <li>• Governing authority</li> <li>• Administrator</li> </ul>	<ul style="list-style-type: none"> <li>• Governing body</li> <li>• Administrator</li> </ul>	<ul style="list-style-type: none"> <li>• Consulting committee</li> </ul>
<b>Required Medical Personnel</b>	<ul style="list-style-type: none"> <li>• At least two physicians</li> <li>• Director of nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Medical advisory board</li> <li>• Medical director</li> <li>• Director of nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Medical director</li> <li>• Nursing supervisor</li> </ul>
<b>Required Personnel When Patients Are Present</b>	<ul style="list-style-type: none"> <li>• Director of nursing 40 hours per week</li> <li>• One registered nurse</li> <li>• One other nurse</li> </ul>	<ul style="list-style-type: none"> <li>• Two persons for patient care</li> </ul>	<ul style="list-style-type: none"> <li>• One registered nurse</li> <li>• One other nurse</li> </ul>

### Effect of Proposed Changes

<sup>45</sup> 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).

<sup>46</sup> Conn. Agencies Regs. § 19A-495-571.

<sup>47</sup> 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. Federal 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. The bill adds RCCs to the list of facilities subject to the provisions of Chapter 395, Part I. An applicant for RCC licensure must follow the general licensing procedures in Chapter 408, Part II. Additionally, the applicant will be subject to the license, inspection, safety, facility and other requirements of Chapter 395, Part I.

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

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

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

The bill requires all patients to be certified as medically stable and not in need of acute hospitalization by their attending or referring physician prior to admission to an RCC. A patient may receive recovery care services in an 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. The bill directs AHCA to adopt rules for RCCs that address all the same regulatory areas currently addressed in rules for hospitals and ASCs, 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.

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.<sup>48</sup>

The bill provides an effective date of July 1, 2016.

**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. 395.301, F.S., related to itemized patient bill; form and content prescribed by the agency.

**Section 8:** Amends s. 408.802, F.S., related to applicability.

**Section 9:** Amends s. 408.820, F.S., related to exemptions.

**Section 10:** Amends s. 394.4787, F.S., related to definitions.

**Section 11:** Amends s. 409.975, F.S., related to managed care plan accountability.

**Section 12:** Provides an effective date of July 1, 2016.

## **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. AHCA estimates that five entities may apply for licensure. Applicants for licensure as a RCC will be subject to a 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.<sup>49</sup>

**2. Expenditures:**

The creation of the RCC license will require AHCA to regulate these facilities in accordance with Chapters 395 and 408, F.S., and any rules adopted by AHCA. The fees associated with the new license are anticipated to cover the expenses incurred by AHCA in enforcement and regulation of the new license. No additional staff will be required as existing regulatory staff is sufficient to absorb the workload associated with up to 10 licenses.<sup>50</sup>

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS:**

**1. Revenues:**

None.

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<sup>48</sup> Section 395.004, F.S.

<sup>49</sup> AHCA Agency Bill Analysis, dated September 18, 2015, pg. 3 (on file with Select Committee on Affordable Healthcare Access staff).

<sup>50</sup> Id.



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 merely because the recovery time will be longer than the ASC limit would allow.

Being able to keep patients longer in an ASC 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