By the Committee on Health Care and Senator Brown-Waite

317-822A-98

A bill to be entitled

An act relating to the regulation of health care facilities; amending s. 20.42, F.S.; deleting the responsibility of the Division of Health Policy and Cost Control within the Agency for Health Care Administration for reviewing hospital budgets; abolishing the Health Care Board; amending s. 154.304, F.S., relating to health care for indigent persons; revising definitions; amending s. 394.4788, F.S., relating to mental health services; updating provisions relating to duties of the agency formerly performed by the Health Care Cost Containment Board; amending s. 240.4076, F.S.; conforming a cross-reference to changes made by the act; amending s. 395.0163, F.S.; providing exemptions from construction inspections and investigations by the Agency for Health Care Administration for certain outpatient facilities; providing exceptions; amending s. 395.1055, F.S.; requiring the Agency for Health Care Administration to adopt rules to assure that, following a disaster, licensed facilities are capable of serving as shelters only for patients, staff, and the families of staff and patients; providing for applicability; providing for a report by the agency to the Governor and Legislature; amending s. 395.401, F.S.; providing for certain reports formerly made to the Health Care Board to be made to the agency; amending

s. 395.701, F.S., relating to the Public Medical Assistance Trust Fund; revising definitions; amending ss. 408.05, 408.061, 408.062, 408.063, F.S., relating to the State Center for Health Statistics and the collection and dissemination of health care information; updating provisions to reflect the assumption by the Agency for Health Care Administration of duties formerly performed by the Health Care Board and the former Department of Health and Rehabilitative Services; authorizing the agency to conduct data-based studies and make recommendations; deleting obsolete provisions; amending s. 408.07, F.S.; deleting definitions made obsolete by the repeal of requirements with respect to hospital budget reviews; amending s. 408.08, F.S.; deleting provisions requiring the Health Care Board to review the budgets of certain hospitals; deleting requirements that a hospital file budget letters; deleting certain administrative penalties; amending s. 408.40, F.S.; removing a reference to the duties of the Public Counsel with respect to hospital budget review proceedings; amending ss. 409.2673, 409.9113, F.S., relating to health care programs for low-income persons and the disproportionate share program for teaching hospitals; updating provisions to reflect the abolishment of the Health Care Cost Containment Board and the assumption of its duties by the agency;

repealing ss. 395.403(9), 395.806(3), 407.61, 408.003, 408.072, 408.085, F.S., relating to reimbursement of state-sponsored trauma centers, studies by the Health Care Board, appointment of members to the Health Care Board, review of hospital budgets, and budget reviews of comprehensive inpatient rehabilitation hospitals; providing for retroactive application of provisions of the act relating to repeal of review of hospital budgets; amending ss. 381.026, 381.0261, F.S.; requiring distribution of the Florida Patient's Bill of Rights and Responsibilities; providing penalties; repealing s. 395.002(2) and (15), F.S.; deleting definitions of "adverse or untoward incident" and "injury"; amending s. 395.0193, F.S.; revising provisions relating to facility peer review disciplinary actions against practitioners; requiring a report to the Agency for Health Care Administration; providing penalties; amending s. 395.0197, F.S.; revising provisions relating to internal risk management; defining the term "adverse incident"; requiring certain reports to the agency; including minors in provisions relating to notification of sexual misconduct or abuse; requiring facility corrective action plans; providing penalties; renumbering s. 626.941, F.S., relating to the purpose of the health care risk manager licensure program; renumbering and amending s. 626.942, F.S.,

relating to the Health Care Risk Manager Advisory Council; renumbering and amending s. 626.943, F.S.; providing powers and duties of the agency; renumbering and amending s. 626.944, F.S., relating to qualifications for health care risk managers; providing for fees; providing for issuance, cancellation, and renewal of licenses; renumbering and amending s. 626.945, F.S., relating to grounds for denial, suspension, or revocation of licenses; amending s. 766.101, F.S., relating to medical review committees; adding "physician-hospital organization," "provider-sponsored organization," and "integrated delivery system" to the definition of "medical review committee" or "committee"; amending ss. 394.4787, 395.602, 400.051, 409.905, 440.13, 458.331, 459.015, 468.505, 641.55, 766.1115, F.S.; conforming references and correcting cross-references; transferring the internal risk manager licensure program from the Department of Insurance to the Agency for Health Care Administration; providing an appropriation; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraphs (b), (d), and (e) of subsection (2) and subsections (6) and (7) of section 20.42, Florida Statutes, are amended to read:

20.42 Agency for Health Care Administration.--There is created the Agency for Health Care Administration within the Department of Business and Professional Regulation. The agency shall be a separate budget entity, and the director of the agency shall be the agency head for all purposes. The agency shall not be subject to control, supervision, or direction by the Department of Business and Professional Regulation in any manner, including, but not limited to, personnel, purchasing, transactions involving real or personal property, and budgetary matters.

(2) ORGANIZATION OF THE AGENCY.--The agency shall be organized as follows:

(b) The Division of Health Policy and Cost Control, which shall be responsible for health policy, the State Center for Health Statistics, the development of The Florida Health Plan, certificate of need, ~~hospital budget review,~~state and local health planning under s. 408.033, and research and analysis.

~~(d) The Health Care Board, which shall be responsible for hospital budget review, nursing home financial analysis, and special studies as assigned by the secretary or the Legislature.~~

(d)~~(e)~~ The Division of Administrative Services, which shall be responsible for revenue management, budget, personnel, and general services.

~~(6) HEALTH CARE BOARD.--The Health Care Board shall be composed of 11 members appointed by the Governor, subject to confirmation by the Senate. The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall be responsible for hospital budget review, nursing home financial review and analysis, and~~

~~special studies requested by the Governor, the Legislature, or the director.~~

(6)~~(7)~~ DEPUTY DIRECTOR OF ADMINISTRATIVE SERVICES.--The director shall appoint a Deputy Director of Administrative Services who shall serve at the pleasure of, and be directly responsible to, the director. The deputy director shall be responsible for the Division of Administrative Services.

Section 2. Subsections (1) and (8) of section 154.304, Florida Statutes, are amended to read:

154.304 Definitions.--For the purpose of this act:

(1) "Agency" means the Agency for Health Care Administration.~~"Board" means the Health Care Board as established in chapter 408.~~

(8) "Participating hospital" means a hospital which is eligible to receive reimbursement under the provisions of this act because it has been certified by the agency ~~board~~ as having met its charity care obligation and has either:

(a) A formal signed agreement with a county or counties to treat such county's indigent patients; or

(b) Demonstrated to the agency ~~board~~ that at least 2.5 percent of its uncompensated charity care, as reported to the board, is generated by out-of-county residents.

Section 3. Subsections (2) and (3) of section 394.4788, Florida Statutes, are amended to read:

394.4788 Use of certain PMATF funds for the purchase of acute care mental health services.--

(2) ~~By October 1, 1989, and annually thereafter,~~The agency shall annually calculate a per diem reimbursement rate for each specialty psychiatric hospital to be paid to the specialty psychiatric hospitals for the provision of acute

mental health services provided to indigent mentally ill patients who meet the criteria in subsection (1). After the first rate period, providers shall be notified of new reimbursement rates for each new state fiscal year by June 1. The new reimbursement rates shall commence July 1.

(3) Reimbursement rates shall be calculated using the most recent audited actual costs received by the agency. Cost data received ~~as of August 15, 1989, and~~ each April 15 ~~thereafter~~ shall be used in the calculation of the rates. Historic costs shall be inflated from the midpoint of a hospital's fiscal year to the midpoint of the state fiscal year. The inflation adjustment shall be made utilizing the latest available projections as of March 31 for the Data Resources Incorporated National and Regional Hospital Input Price Indices as calculated by the Medicaid program office.

Section 4. Paragraph (a) of subsection (4) of section 240.4076, Florida Statutes, is amended to read:

240.4076 Nursing scholarship loan program.--

(4) Credit for repayment of a scholarship loan shall be on a year-for-year basis as follows:

(a) For each year of scholarship loan assistance, the recipient agrees to work for 12 months at a health care facility in a medically underserved area as approved by the Department of Health and Rehabilitative Services. Eligible health care facilities include state-operated medical or health care facilities, county public health units, federally sponsored community health centers, or teaching hospitals as defined in s. 408.07 ~~s. 408.07(49)~~.

Section 5. Subsection (1) of section 395.0163, Florida Statutes, is amended to read:

395.0163 Construction inspections; plan submission and approval; fees.--

(1)(a) The agency shall make, or cause to be made, such construction inspections and investigations as it deems necessary. The agency may prescribe by rule that any licensee or applicant desiring to make specified types of alterations or additions to its facilities or to construct new facilities shall, before commencing such alteration, addition, or new construction, submit plans and specifications therefor to the agency for preliminary inspection and approval or recommendation with respect to compliance with agency rules and standards. The agency shall approve or disapprove the plans and specifications within 60 days after receipt of the fee for review of plans as required in subsection (2). The agency may be granted one 15-day extension for the review period if the director of the agency approves the extension. If the agency fails to act within the specified time, it shall be deemed to have approved the plans and specifications. When the agency disapproves plans and specifications, it shall set forth in writing the reasons for its disapproval. Conferences and consultations may be provided as necessary.

(b) All outpatient facilities that provide surgical treatments requiring general anesthesia or IV conscious sedation, that provide cardiac catheterization services, or that are to be licensed as ambulatory surgical centers shall submit plans and specifications to the agency for review under this section. All other outpatient facilities must be reviewed under this section, except that those that are physically detached from, and have no utility connections with, the hospital and that do not block emergency egress from or create a fire hazard to the hospital are exempt from review under

this section. This paragraph applies to applications for which review is pending on or after July 1, 1998.

Section 6. Paragraph (d) of subsection (1) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.--

(1) The agency shall adopt, amend, promulgate, and enforce rules to implement the provisions of this part, which shall include reasonable and fair minimum standards for ensuring that:

(d) New facilities and a new wing or floor added to an existing facility after July 1, 1999, are structurally capable of serving as shelters only for patients, staff, and families of staff and patients, and equipped to be self-supporting during and immediately following disasters.

Section 7. The Agency for Health Care Administration shall work with persons affected by section 6 and report to the Governor and Legislature by April 1, 1998, its recommendations for cost-effective renovation standards to be applied to existing facilities.

Section 8. Paragraphs (a) and (b) of subsection (1) of section 395.401, Florida Statutes, are amended to read:

395.401 Trauma services system plans; verification of trauma centers and pediatric trauma referral centers; procedures; renewal.--

(1) As used in this part, the term:

(a) "Agency" means the Agency for Health Care Administration. ~~"Board" means the Health Care Board.~~

(b) "Charity care" or "uncompensated charity care" means that portion of hospital charges reported to the agency ~~board~~ for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the

determination is less than or equal to 150 percent of the federal poverty level, unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds 4 times the federal poverty level for a family of four be considered charity.

Section 9. Subsections (1), (2), (3), and (4) of section 395.701, Florida Statutes, are amended to read:

395.701 Annual assessments on net operating revenues to fund public medical assistance; administrative fines for failure to pay assessments when due.--

(1) For the purposes of this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b)~~(a)~~ "Gross operating revenue" or "gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue.

~~(b) "Health Care Board" or "board" means the Health Care Board created by s. 20.42.~~

(c) "Hospital" means a health care institution as defined in s. 395.002(11)~~s. 395.002(12)~~, but does not include any hospital operated by the agency or the Department of Corrections.

(d) "Net operating revenue" or "net revenue" means gross revenue less deductions from revenue.

(e) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy

discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

(2) There is ~~hereby~~ imposed upon each hospital an assessment in an amount equal to 1.5 percent of the annual net operating revenue for each hospital, such revenue to be determined by the agency ~~department~~, based on the actual experience of the hospital as reported to the agency ~~department~~. Within 6 months after the end of each hospital fiscal year, the agency ~~department~~ shall certify the amount of the assessment for each hospital. The assessment shall be payable to and collected by the agency ~~department~~ in equal quarterly amounts, on or before the first day of each calendar quarter, beginning with the first full calendar quarter that occurs after the agency ~~department~~ certifies the amount of the assessment for each hospital. All moneys collected pursuant to this subsection shall be deposited into the Public Medical Assistance Trust Fund.

(3) The agency ~~department~~ shall impose an administrative fine, not to exceed $500 per day, for failure of any hospital to pay its assessment by the first day of the calendar quarter on which it is due. The failure of a hospital to pay its assessment within 30 days after the assessment is due is ground for the agency ~~department~~ to impose an administrative fine not to exceed $5,000 per day.

(4) The purchaser, successor, or assignee of a facility subject to the agency's ~~board's~~ jurisdiction shall assume full liability for any assessments, fines, or penalties of the facility or its employees, regardless of when identified. Such assessments, fines, or penalties shall be paid by the employee, owner, or licensee who incurred them,

within 15 days of the sale, transfer, or assignment. However, the purchaser, successor, or assignee of the facility may withhold such assessments, fines, or penalties from purchase moneys or payment due to the seller, transferor, or employee, and shall make such payment on behalf of the seller, transferor, or employee. Any employer, purchaser, successor, or assignee who fails to withhold sufficient funds to pay assessments, fines, or penalties arising under the provisions of chapter 408 shall make such payments within 15 days of the date of the transfer, purchase, or assignment. Failure by the transferee to make payments as provided in this subsection shall subject such transferee to the penalties and assessments provided in chapter 408. Further, in the event of sale, transfer, or assignment of any facility under the agency's ~~board's~~ jurisdiction, future assessments shall be based upon the most recently available prior year report or audited actual experience for the facility. It shall be the responsibility of the new owner or licensee to require the production of the audited financial data for the period of operation of the prior owner. If the transferee fails to obtain current audited financial data from the previous owner or licensee, the new owner shall be assessed based upon the most recent year of operation for which 12 months of audited actual experience are available or upon a reasonable estimate of 12 months of full operation as calculated by the agency ~~board~~.

Section 10. Subsection (1), paragraphs (e) and (f) of subsection (3), subsection (6), and paragraphs (c) and (d) of subsection (7) of section 408.05, Florida Statutes, are amended to read:

408.05 State Center for Health Statistics.--

(1) ESTABLISHMENT.--The agency ~~department~~ shall establish a State Center for Health Statistics. The center shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics. The center shall be staffed with public health experts, biostatisticians, information system analysts, health policy experts, economists, and other staff necessary to carry out its functions.

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to produce comparable and uniform health information and statistics, the agency shall perform the following functions:

(e) The agency ~~department~~ shall establish by rule the types of data collected, compiled, processed, used, or shared. Decisions regarding center data sets should be made based on consultation with the Comprehensive Health Information System Advisory Council and other public and private users regarding the types of data which should be collected and their uses.

(f) The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the agency ~~department~~.

(6) PROVIDER DATA REPORTING.--This section does not confer on the agency ~~department~~ the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law.

(7) BUDGET; FEES; TRUST FUND.--

(c) The center may charge such reasonable fees for services as the agency ~~department~~ prescribes by rule. The

established fees may ~~shall~~ not exceed the reasonable cost for such services. Fees collected may not be used to offset annual appropriations from the General Revenue Fund.

(d) The agency ~~department~~ shall establish a Comprehensive Health Information System Trust Fund as the repository of all funds appropriated to, and fees and grants collected for, services of the State Center for Health Statistics. Any funds, other than funds appropriated to the center from the General Revenue Fund, which are raised or collected by the agency ~~department~~ for the operation of the center and which are not needed to meet the expenses of the center for its current fiscal year shall be available to the agency ~~board~~ in succeeding years.

Section 11. Subsections (10) and (11) of section 408.061, Florida Statutes, are amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidentiality of patient records; immunity.--

(10) No health care facility, health care provider, health insurer, or other reporting entity or its employees or agents shall be held liable for civil damages or subject to criminal penalties either for the reporting of patient data to the agency ~~board~~ or for the release of such data by the agency ~~board~~ as authorized by this chapter.

(11) The agency shall be the primary source for collection and dissemination of health care data. No other agency of state government may gather data from a health care provider licensed or regulated under this chapter without first determining if the data is currently being collected by the agency and affirmatively demonstrating that it would be more cost-effective for an agency of state government other

than the agency to gather the health care data. The director ~~secretary~~ shall ensure that health care data collected by the divisions within the agency is coordinated. It is the express intent of the Legislature that all health care data be collected by a single source within the agency and that other divisions within the agency, and all other agencies of state government, obtain data for analysis, regulation, and public dissemination purposes from that single source. Confidential information may be released to other governmental entities or to parties contracting with the agency to perform agency duties or functions as needed in connection with the performance of the duties of the receiving entity. The receiving entity or party shall retain the confidentiality of such information as provided for herein.

Section 12. Subsections (2) and (5) of section 408.062, Florida Statutes, are amended to read:

408.062 Research, analyses, studies, and reports.--

(2) The agency ~~board~~ shall evaluate data from nursing home financial reports and shall document and monitor:

(a) Total revenues, annual change in revenues, and revenues by source and classification, including contributions for a resident's care from the resident's resources and from the family and contributions not directed toward any specific resident's care.

(b) Average resident charges by geographic region, payor, and type of facility ownership.

(c) Profit margins by geographic region and type of facility ownership.

(d) Amount of charity care provided by geographic region and type of facility ownership.

(e) Resident days by payor category.

(f) Experience related to Medicaid conversion as reported under s. 408.061.

(g) Other information pertaining to nursing home revenues and expenditures.

The findings of the agency ~~board~~ shall be included in an annual report to the Governor and Legislature by January 1 each year.

(5)(a) The agency may conduct data-based studies and evaluations and make recommendations to the Legislature and the Governor concerning exemptions, the effectiveness of limitations of referrals, restrictions on investment interests and compensation arrangements, and the effectiveness of public disclosure. Such analysis may include, but need not be limited to, utilization of services, cost of care, quality of care, and access to care. The agency may require the submission of data necessary to carry out this duty, which may include, but need not be limited to, data concerning ownership, Medicare and Medicaid, charity care, types of services offered to patients, revenues and expenses, patient-encounter data, and other data reasonably necessary to study utilization patterns and the impact of health care provider ownership interests in health-care-related entities on the cost, quality, and accessibility of health care.

(b) The agency may collect such data from any health facility as a special study.~~The board is directed to research hospital financial and nonfinancial data in order to determine the need for establishing a category of inpatient hospital patients defined as medically indigent. For purposes of this section, a medically indigent patient is an individual who is admitted as an inpatient to a hospital, who is not classified~~

~~as a Medicare beneficiary, a Medicaid recipient, or a charity care patient, but who has insufficient financial resources to pay for needed medical care. In its determination of the need for establishing a category of medically indigent patients, the board shall consider the creation of income and asset levels that would establish a person as medically indigent. The board shall submit a report and recommendations to the Governor and the Legislature on the establishment of a category of medically indigent inpatient hospital patients on or before January 1, 1994. If the board recommends the establishment of a category of medically indigent patients, it shall provide a specific recommendation for the eligibility determination process to be used in classifying a patient as medically indigent.~~

Section 13. Subsection (1) of section 408.063, Florida Statutes, is amended to read:

408.063 Dissemination of health care information.--

(1) The agency, relying on data collected pursuant to this chapter, shall establish a reliable, timely, and consistent information system <u>that</u> ~~which~~ distributes information and serves as the basis for the <u>agency's</u> ~~board's~~ public education programs. The agency shall seek advice from consumers, health care purchasers, health care providers, health care facilities, health insurers, and local health councils in the development and implementation of its information system. Whenever appropriate, the agency shall use the local health councils for the dissemination of information and education of the public.

Section 14. Section 408.07, Florida Statutes, is amended to read:

408.07 Definitions.--As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(1) "Accepted" means that the agency ~~board~~ has found that a report or data submitted by a health care facility or a health care provider contains all schedules and data required by the agency ~~board~~ and has been prepared in the format specified by the agency ~~board~~, and otherwise conforms to applicable rule or Florida Hospital Uniform Reporting System manual requirements regarding reports in effect at the time such report was submitted, and the data are mathematically reasonable and accurate.

(2) "Adjusted admission" means the sum of acute and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues. If a hospital reports only subacute admissions, then "adjusted admission" means the sum of subacute admissions divided by the ratio of total inpatient revenues to gross revenues.

(3) "Agency" means the Agency for Health Care Administration.

(4) "Alcohol or chemical dependency treatment center" means an organization licensed under chapter 397.

(5) "Ambulatory care center" means an organization which employs or contracts with licensed health care professionals to provide diagnosis or treatment services predominantly on a walk-in basis and the organization holds itself out as providing care on a walk-in basis. Such an organization is not an ambulatory care center if it is wholly owned and operated by five or fewer health care providers.

(6) "Ambulatory surgical center" means a facility licensed as an ambulatory surgical center under chapter 395.

~~(7) "Applicable rate of increase" means the maximum allowable rate of increase (MARI) when applied to gross revenue per adjusted admission, unless the board has approved a different rate of increase, in which case the board-approved rate of increase shall apply.~~

(7)~~(8)~~ "Audited actual data" means information contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards, but does not include data within a financial statement about which the certified public accountant does not express an opinion or issues a disclaimer.

~~(9) "Banked points" means the percentage points earned by a hospital when the actual rate of increase in gross revenue per adjusted admission (GRAA) is less than the maximum allowable rate of increase (MARI) or the actual rate of increase in the net revenue per adjusted admission (NRAA) is less than the market basket index.~~

(8)~~(10)~~ "Birth center" means an organization licensed under s. 383.305.

~~(11) "Board" means the Health Care Board established under s. 408.003.~~

~~(12) "Budget" means the projections by the hospital, for a specified future time period, of expenditures and revenues, with supporting statistical indicators, or a budget letter verified by the board pursuant to s. 408.072(3)(a).~~

(9)~~(13)~~ "Cardiac catheterization laboratory" means a freestanding facility that ~~which~~ employs or contracts with licensed health care professionals to provide diagnostic or therapeutic services for cardiac conditions such as cardiac catheterization or balloon angioplasty.

(10)~~(14)~~ "Case mix" means a calculated index for each health care facility or health care provider, based on patient data, reflecting the relative costliness of the mix of cases to that facility or provider compared to a state or national mix of cases.

(11)~~(15)~~ "Clinical laboratory" means a facility licensed under s. 483.091, excluding: any hospital laboratory defined under s. 483.041(5); any clinical laboratory operated by the state or a political subdivision of the state; any blood or tissue bank where the majority of revenues are received from the sale of blood or tissue and where blood, plasma, or tissue is procured from volunteer donors and donated, processed, stored, or distributed on a nonprofit basis; and any clinical laboratory which is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice, and at which no clinical laboratory work is performed for patients referred by any health care provider who is not a member of that same group practice.

(12)~~(16)~~ "Comprehensive rehabilitative hospital" or "rehabilitative hospital" means a hospital licensed by the agency ~~for Health Care Administration~~ as a specialty hospital as defined in s. 395.002; provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the hospital are classified as "comprehensive rehabilitative beds" pursuant to s. 395.003(4), and are not classified as "general beds."

(13)~~(17)~~ "Consumer" means any person other than a person who administers health activities, is a member of the

governing body of a health care facility, provides health services, has a fiduciary interest in a health facility or other health agency or its affiliated entities, or has a material financial interest in the rendering of health services.

(14)~~(18)~~ "Continuing care facility" means a facility licensed under chapter 651.

(15)~~(19)~~ "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing such service as to offset some of the costs of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.

(16)~~(20)~~ "Deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. For hospitals, such reductions include contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

(17)~~(21)~~ "Diagnostic-imaging center" means a freestanding outpatient facility that provides specialized services for the diagnosis of a disease by examination and also provides radiological services. Such a facility is not a diagnostic-imaging center if it is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice and no diagnostic-imaging work is performed at such facility for

patients referred by any health care provider who is not a member of that same group practice.

(18)~~(22)~~ "FHURS" means the Florida Hospital Uniform Reporting System developed by the agency ~~board~~.

(19)~~(23)~~ "Freestanding" means that a health facility bills and receives revenue which is not directly subject to the hospital assessment for the Public Medical Assistance Trust Fund as described in s. 395.701.

(20)~~(24)~~ "Freestanding radiation therapy center" means a facility where treatment is provided through the use of radiation therapy machines that are registered under s. 404.22 and the provisions of the Florida Administrative Code implementing s. 404.22. Such a facility is not a freestanding radiation therapy center if it is wholly owned and operated by physicians licensed pursuant to chapter 458 or chapter 459 who practice within the specialty of diagnostic or therapeutic radiology.

(21)~~(25)~~ "GRAA" means gross revenue per adjusted admission.

(22)~~(26)~~ "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue. Gross revenues do not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors.

(23)~~(27)~~ "Health care facility" means an ambulatory surgical center, a hospice, a nursing home, a hospital, a diagnostic-imaging center, a freestanding or hospital-based therapy center, a clinical laboratory, a home health agency, a cardiac catheterization laboratory, a medical equipment supplier, an alcohol or chemical dependency treatment center, a physical rehabilitation center, a lithotripsy center, an

ambulatory care center, a birth center, or a nursing home component licensed under chapter 400 within a continuing care facility licensed under chapter 651.

(24)~~(28)~~ "Health care provider" means a health care professional licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 464, chapter 465, chapter 466, part I, part III, part IV, part V, or part X of chapter 468, chapter 483, chapter 484, chapter 486, chapter 490, or chapter 491.

(25)~~(29)~~ "Health care purchaser" means an employer in the state, other than a health care facility, health insurer, or health care provider, who provides health care coverage for her or his employees.

(26)~~(30)~~ "Health insurer" means any insurance company authorized to transact health insurance in the state, any insurance company authorized to transact health insurance or casualty insurance in the state that is offering a minimum premium plan or stop-loss coverage for any person or entity providing health care benefits, any self-insurance plan as defined in s. 624.031, any health maintenance organization authorized to transact business in the state pursuant to part I of chapter 641, any prepaid health clinic authorized to transact business in the state pursuant to part II of chapter 641, any multiple-employer welfare arrangement authorized to transact business in the state pursuant to ss. 624.436-624.45, or any fraternal benefit society providing health benefits to its members as authorized pursuant to chapter 632.

(27)~~(31)~~ "Home health agency" means an organization licensed under part IV of chapter 400.

(28)~~(32)~~ "Hospice" means an organization licensed under part VI of chapter 400.

(29)~~(33)~~ "Hospital" means a health care institution licensed by the Agency for Health Care Administration as a hospital under chapter 395.

(30)~~(34)~~ "Lithotripsy center" means a freestanding facility that ~~which~~ employs or contracts with licensed health care professionals to provide diagnosis or treatment services using electro-hydraulic shock waves.

(31)~~(35)~~ "Local health council" means the agency defined in s. 408.033.

(32)~~(36)~~ "Market basket index" means the Florida hospital input price index (FHIPI), which is a statewide market basket index used to measure inflation in hospital input prices weighted for the Florida-specific experience which uses multistate regional and state-specific price measures, when available. The index shall be constructed in the same manner as the index employed by the Secretary of the United States Department of Health and Human Services for determining the inflation in hospital input prices for purposes of Medicare reimbursement.

~~(37) "Maximum allowable rate of increase" or "MARI" means the maximum rate at which a hospital is normally expected to increase its average gross revenues per adjusted admission for a given period. The board, using the most recent audited actual data for each hospital, shall calculate the MARI for each hospital as follows: The projected rate of increase in the market basket index shall be divided by a number which is determined by subtracting the sum of one-half of the proportion of Medicare days plus one-half of the proportion of CHAMPUS days plus the proportion of Medicaid days plus 1.5 times the proportion of charity care days from~~

~~the number one. The formula to be employed by the board to calculate the MARI shall take the following form:~~

$$MARI = \frac{FHIPI}{1-[(Me \times 0.5) + (Cp \times 0.5) + Md + (Cc \times 1.5)]}$$

~~where:~~

~~MARI = maximum allowable rate of increase applied to gross revenue.~~

~~FHIPI = Florida hospital input price index, which shall be the projected rate of change in the market basket index.~~

~~Me = proportion of Medicare days, including when available and reported to the board Medicare HMO days, to total days.~~

~~Cp = proportion of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) days to total days.~~

~~Md = proportion of Medicaid days, including when available and reported to the board Medicaid HMO days, to total days.~~

~~Cc = proportion of charity care days to total days with a 50-percent offset for restricted grants for charity care and unrestricted grants from local governments.~~

(33)~~(38)~~ "Medical equipment supplier" means an organization that ~~which~~ provides medical equipment and supplies used by health care providers and health care facilities in the diagnosis or treatment of disease.

(34)~~(39)~~ "Net revenue" means gross revenue minus deductions from revenue.

(35)~~(40)~~ "New hospital" means a hospital in its initial year of operation as a licensed hospital and does not

include any facility which has been in existence as a licensed hospital, regardless of changes in ownership, for over 1 calendar year.

(36)~~(41)~~ "Nursing home" means a facility licensed under s. 400.062 or, for resident level and financial data collection purposes only, any institution licensed under chapter 395 and which has a Medicare or Medicaid certified distinct part used for skilled nursing home care, but does not include a facility licensed under chapter 651.

(37)~~(42)~~ "Operating expenses" means total expenses excluding income taxes.

(38)~~(43)~~ "Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.

(39)~~(44)~~ "Physical rehabilitation center" means an organization that ~~which~~ employs or contracts with health care professionals licensed under part I or part III of chapter 468 or chapter 486 to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis.

(40)~~(45)~~ "Prospective payment arrangement" means a financial agreement negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payor which contains, at a minimum, the elements provided for in s. 408.50.

(41)~~(46)~~ "Rate of return" means the financial indicators used to determine or demonstrate reasonableness of the financial requirements of a hospital. Such indicators shall include, but not be limited to: return on assets, return on equity, total margin, and debt service coverage.

(42)~~(47)~~ "Rural hospital" means an acute care hospital licensed under chapter 395, with 85 licensed beds or fewer,

which has an emergency room and is located in an area defined as rural by the United States Census, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county; or

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile.

(43)~~(48)~~ "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the agency ~~for Health Care Administration~~ in meeting its responsibilities pursuant to this chapter.

(44)~~(49)~~ "Teaching hospital" means any hospital formally affiliated with an accredited medical school which ~~that~~ exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

Section 15. Section 408.08, Florida Statutes, is amended to read:

408.08 Inspections and audits; violations; penalties; fines; enforcement.--

(1) The agency may inspect and audit books and records of individual or corporate ownership, including books and records of related organizations with which a health care provider or a health care facility had transactions, for

compliance with this chapter. Upon presentation of a written request for inspection to a health care provider or a health care facility by the agency or its staff, the health care provider or the health care facility shall make available to the agency or its staff for inspection, copying, and review all books and records relevant to the determination of whether the health care provider or the health care facility has complied with this chapter.

~~(2) The board shall annually compare the audited actual experience of each hospital to the audited actual experience of that hospital for the previous year.~~

~~(a) For a hospital submitting a budget letter, if the board determines that the audited actual experience of the hospital exceeded its previous year's audited actual experience by more than the maximum allowable rate of increase as certified in the budget letter plus any banked points utilized in the budget letter, the amount of such excess shall be determined by the board and a penalty shall be levied against such hospital pursuant to subsection (3).~~

~~(b) For a hospital subject to budget review, if the board determines that the audited actual experience of the hospital exceeded its previous year's audited actual experience by more than the most recent approved budget or the most recent approved budget as amended, the amount of such excess shall be determined by the board, and a penalty shall be levied against such hospital pursuant to subsection (3).~~

~~(c) For a hospital submitting a budget letter and for a hospital subject to budget review, the board shall annually compare each hospital's audited actual experience for net revenues per adjusted admission to the hospital's audited actual experience for net revenues per adjusted admission for~~

~~the previous year. If the rate of increase in net revenues per adjusted admission between the previous year and the current year was less than the market basket index, the hospital may carry forward the difference and earn up to a cumulative maximum of 3 banked net revenue percentage points. Such banked net revenue percentage points shall be available to the hospital to offset, in any future year, penalties for exceeding the approved budget or the maximum allowable rate of increase as set forth in subsection (3). Nothing in this paragraph shall be used by a hospital to justify the approval of a budget or a budget amendment by the board in excess of the maximum allowable rate of increase pursuant to s. 408.072.~~

~~(3) Penalties shall be assessed as follows:~~

~~(a) For the first occurrence within a 5-year period, the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 5 percent; and, if such excess is greater than 5 percent over the maximum allowable rate of increase, any amount in excess of 5 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund.~~

~~(b) For the second occurrence with the 5-year period following the first occurrence as set forth in paragraph (a), the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 2 percent; and, if such excess is greater than 2 percent over the maximum allowable rate of increase, any amount in excess of 2 percent shall be levied by the board as a fine against such hospital to be deposited in the Public Medical Assistance Trust Fund.~~

~~(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:~~

~~1. Levy a fine against the hospital in the total amount of the excess, to be deposited in the Public Medical Assistance Trust Fund.~~

~~2. Notify the agency of the violation, whereupon the agency shall not accept any application for a certificate of need pursuant to ss. 408.031-408.045 from or on behalf of such hospital until such time as the hospital has demonstrated to the satisfaction of the board that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected or amended budget or its applicable maximum allowable rate of increase for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.~~

~~3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the agency, whereupon the agency shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.~~

~~The determination of the amount of any such excess shall be based upon net revenues per adjusted admission, excluding funds distributed to the hospital from the Public Medical Assistance Trust Fund. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.701 minus the amount of revenues received by the hospital through the Public Medical Assistance Trust Fund. It is the responsibility of the hospital to demonstrate to the satisfaction of the board its entitlement to such~~

~~reduction. It is the intent of the Legislature that the Health Care Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital and in the hospital's intensity and severity of illness as measured by changes in the hospital's actual proportion of outlier cases to total cases and dollar increases in outlier cases' average charge per case. It is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case mix and in its intensity and severity of illness. For psychiatric hospitals and other hospitals not reimbursed under a prospective payment system by the Federal Government, until a proxy for case mix is available, the board shall also reduce the amount of excess by the change in a hospital's audited actual average length of stay without any thresholds or limitations.~~

~~(4) The following factors may be used by the board to reduce the amount of excess of the hospital as determined pursuant to this section:~~

~~(a) Unforeseen and unforeseeable events which affect the net revenue per adjusted admission and which are beyond the control of the hospital, such as prior year Medicare cost report settlements, retroactive changes in Medicare reimbursement methodology, and increases in malpractice insurance premiums, which occurred in the last 3 months of the hospital fiscal year during which the hospital generated the excess; or~~

~~(b) Imposition of the penalty would have a severe adverse effect which would jeopardize the continued existence of an otherwise economically viable hospital.~~

~~(5) The board shall reduce the amount of the excess for hospitals submitting budget letters pursuant to s. 408.072(3)(a) by the amount of any documented costs from financial assistance provided to expand or supplement the curriculum of a community college, university, or vocational training school for the purpose of training nurses or other health professionals, not including physicians. Financial assistance would include, but not be limited to, the direct costs for faculty salaries and expenses, books, equipment, recruiting efforts, tuition assistance, and hospital internships. The reduction would be based on actual documented expenses increased by the gross revenues necessary to generate net revenues sufficient to cover the expenses.~~

~~(6) If the board finds that any hospital chief executive officer or any person who is in charge of hospital administration or operations has knowingly and willfully allowed or authorized actual operating revenues or expenditures that are in excess of projected operating revenues or expenditures in the hospital's approved budget, the board shall order such officer or person to pay an administrative fine not to exceed $5,000.~~

~~(7) For hospitals filing budget letters, the board shall annually compare the audited actual experience of each hospital for the year under review to the audited actual experience of that hospital for the previous year. For hospitals which submitted detailed budgets or budget amendments, the board shall compare the audited actual experience of each hospital for the year under review to its approved gross revenue per adjusted admission for the year under review, for purposes of levying an administrative fine.~~

~~(a) For a hospital submitting a budget letter pursuant to s. 408.072(3)(a), if the board determines that the audited actual experience for the year under review exceeded the hospital's previous year's audited actual experience by more than the maximum allowable rate of increase as certified in the budget letter plus any banked points utilized in the budget letter, the amount of the excess shall be determined and an administrative fine shall be levied against such hospital pursuant to subsection (8).~~

~~(b) For a hospital which submitted a budget pursuant to s. 408.072(1), or a budget amendment pursuant to s. 408.072(6), if the board determines that the gross revenue per adjusted admission contained in the hospital's audited actual experience exceeded its board-approved gross revenue per adjusted admission, the amount of the excess shall be determined and an administrative fine shall be levied against such hospital pursuant to subsection (8).~~

~~(8) If the board determines that an excess exists pursuant to subsection (7), the board shall multiply the excess by the number of actual adjusted admissions contained in the year at issue to determine the amount of the base fine. The base fine shall be multiplied by the applicable occurrence factor to determine the amount of the administrative fine levied against the hospital.~~

~~(a) For the first occurrence within a 5-year period, the applicable occurrence factor shall be 0.25. For the second occurrence within a 5-year period, the applicable occurrence factor shall be 0.55. For the third occurrence within a 5-year period, the applicable occurrence factor shall be 1.0.~~

~~(b) In no event shall any administrative fine levied pursuant to this subsection exceed $365,000.~~

~~(9) In levying any administrative fine against a hospital pursuant to subsection (8), the board shall consider the effect of any changes in the hospital's case mix, and in the hospital's intensity and severity of illness as measured by changes in the hospital's actual proportion of outlier cases to total cases and dollar increases in outlier cases' average charge per case. The board shall adjust the amount of any excess by the changes in the hospital's case mix and in its intensity and severity of illness, based upon certified hospital patient discharge data provided to the board pursuant to s. 408.061. For psychiatric hospitals and other hospitals not reimbursed under a prospective payment system by the Federal Government, until a proxy for case mix is available, the board shall adjust the amount of any excess by the change in a hospital's audited actual average length of stay without any thresholds or limitation.~~

~~(10) In levying any administrative fine against a hospital pursuant to subsection (8), it is the intent of the Legislature that if a hospital can demonstrate to the satisfaction of the board that it operated within its approved gross revenue per adjusted admission for the first 8 months of its fiscal year and did not increase its prices, except for exceptions determined by the board during the last 5 months of its fiscal year, it shall not be subject to any administrative fine levied pursuant to subsection (8).~~

~~(11) It is the further intent of the Legislature that if a hospital can demonstrate to the satisfaction of the board that it did not increase its prices on average in excess of~~

~~the MARI for the prior year, it shall not be subject to any administrative fine levied pursuant to subsection (8).~~

~~(12) If the board finds that any hospital chief executive officer or any person who is in charge of hospital administration or operations has knowingly and willfully allowed or authorized gross revenue per adjusted admission, net revenue per adjusted admission, or rates of increase that are in excess of gross or net revenue per adjusted admission, or rates of increase in the hospital's approved budget, budget amendment, or budget letter, the agency shall order such officer or person to pay an administrative fine not to exceed $5,000.~~

(2)~~(13)~~ Any health care facility that refuses to file a report, fails to timely file a report, files a false report, or files an incomplete report and upon notification fails to timely file a complete report required under ~~this section and~~ s. 408.061; that violates ~~any provision of~~ this section, s. 408.061, or s. 408.20, or rule adopted thereunder; or that fails to provide documents or records requested by the agency under ~~the provisions of~~ this chapter shall be punished by a fine not exceeding $1,000 per day for each day in violation, to be imposed and collected by the agency.

(3)~~(14)~~ Any health care provider that refuses to file a report, fails to timely file a report, files a false report, or files an incomplete report and upon notification fails to timely file a complete report required under ~~this section and~~ s. 408.061; that violates ~~any provision of~~ this section, s. 408.061, or s. 408.20, or rule adopted thereunder; or that fails to provide documents or records requested by the agency under ~~the provisions of~~ this chapter shall be referred to the

appropriate licensing board which shall take appropriate action against the health care provider.

(4)~~(15)~~ If ~~In the event that~~ a health insurer does not comply with the requirements of s. 408.061, the agency shall report a health insurer's failure to comply to the Department of Insurance, which shall take into account the failure by the health insurer to comply in conjunction with its approval authority under s. 627.410. The agency shall adopt any rules necessary to carry out its responsibilities required by this subsection.

(5)~~(16)~~ Refusal to file, failure to timely file, or filing false or incomplete reports or other information required to be filed under the provisions of this chapter, failure to pay or failure to timely pay any assessment authorized to be collected by the agency, or violation of any other provision of this chapter or lawfully entered order of the agency or rule adopted under this chapter, shall be punished by a fine not exceeding $1,000 a day for each day in violation, to be fixed, imposed, and collected by the agency. Each day in violation shall be considered a separate offense.

(6)~~(17)~~ Notwithstanding any other provisions of this chapter, when a hospital alleges that a factual determination made by the agency ~~board~~ is incorrect, the burden of proof shall be on the hospital to demonstrate that such determination is, in light of the total record, not supported by a preponderance of the evidence. The burden of proof remains with the hospital in all cases involving administrative agency action.

Section 16. Section 408.40, Florida Statutes, is amended to read:

408.40 ~~Budget review proceedings; duty of~~ Public Counsel.--

(1) Notwithstanding any other provisions of this chapter, ~~it shall be the duty of~~ the Public Counsel shall ~~to~~ represent the ~~general~~ public ~~of the state~~ in any proceeding before the agency or its advisory panels in any administrative hearing conducted pursuant to ~~the provisions of~~ chapter 120 or before any other state and federal agencies and courts in any issue before the agency, any court, or any agency. With respect to any such proceeding, the Public Counsel is subject to the provisions of and may use ~~utilize~~ the powers granted to him or her by ss. 350.061-350.0614.

(2) The Public Counsel shall:

(a) Recommend to the agency, by petition, the commencement of any proceeding or action or to appear, in the name of the state or its citizens, in any proceeding or action before the agency and urge therein any position that ~~which~~ he or she deems to be in the public interest, whether consistent or inconsistent with positions previously adopted by the agency, and use ~~utilize~~ therein all forms of discovery available to attorneys in civil actions generally, subject to protective orders of the agency, which shall be reviewable by summary procedure in the circuit courts of this state.

(b) Have access to and use of all files, records, and data of the agency available to any other attorney representing parties in a proceeding before the agency.

(c) In any proceeding in which he or she has participated as a party, seek review of any determination, finding, or order of the agency, or of any administrative law judge, or any hearing officer or hearing examiner designated by the agency, in the name of the state or its citizens.

(d) Prepare and issue reports, recommendations, and proposed orders to the agency, the Governor, and the Legislature on any matter or subject within the jurisdiction of the agency, and to make such recommendations as he or she deems appropriate for legislation relative to agency procedures, rules, jurisdiction, personnel, and functions.

(e) Appear before other state agencies, federal agencies, and state and federal courts in connection with matters under the jurisdiction of the agency, in the name of the state or its citizens.

Section 17. Paragraph (e) of subsection (10) and subsection (14) of section 409.2673, Florida Statutes, are amended to read:

409.2673 Shared county and state health care program for low-income persons; trust fund.--

(10) Under the shared county and state program, reimbursement to a hospital for services for an eligible person must:

(e) Be conditioned, for tax district hospitals that deliver services as part of this program, on the delivery of charity care, as defined in the rules of the Agency for Health Care Administration ~~Health Care Cost Containment Board~~, which equals a minimum of 2.5 percent of the tax district hospital's net revenues; however, those tax district hospitals which by virtue of the population within the geographic boundaries of the tax district can not feasibly provide this level of charity care shall assure an "open door" policy to those residents of the geographic boundaries of the tax district who would otherwise be considered charity cases.

(14) Any dispute among a county, the Agency for Health Care Administration ~~Health Care Cost Containment Board~~, the

department, or a participating hospital shall be resolved by order as provided in chapter 120. Hearings held under this subsection shall be conducted in the same manner as provided in ss. 120.569 and 120.57, except that the administrative law judge's or hearing officer's order constitutes final agency action. Cases filed under chapter 120 may combine all relevant disputes between parties.

Section 18. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding ~~the provisions of~~ s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(1) On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency ~~department~~ shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds

appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals.

(b) The number of full-time equivalent trainees in the hospital, which comprises two components:

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and

clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index that ~~which~~ comprises three components:

1. The Agency for Health Care Administration ~~Health Care Cost Containment Board~~ Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration ~~Health Care Cost Containment Board~~ to services offered by the given hospital, as reported on ~~the Health Care Cost Containment Board~~ Worksheet A-2 for the last fiscal year reported to the agency ~~board~~ before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Administration ~~Health Care Cost Containment Board~~ Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration ~~Health Care Cost Containment Board~~ to the volume of each service, expressed in

terms of the standard units of measure reported on ~~the Health Care Cost Containment Board~~ Worksheet A-2 for the last fiscal year reported to the agency ~~board~~ before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all state statutory teaching hospitals.

The primary factor for the service index is computed as the sum of these three components, divided by three.

(2) By October 1 of each year, the agency shall use the following formula ~~shall be utilized by the department~~ to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

$$TAP = THAF \times A$$

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

~~(3) The Health Care Cost Containment Board shall report to the department the statutory teaching hospital allocation fraction prior to October 1 of each year.~~

Section 19. Subsection (9) of section 395.403, Florida Statutes, subsection (3) of section 395.806, Florida Statutes, and sections 407.61, 408.003, 408.072, and 408.085, Florida Statutes, are repealed.

Section 20. The repeal of laws governing the review of hospital budgets and related penalties contained in this act operates retroactively and applies to any hospital budget prepared for a fiscal year that ended during the 1996 calendar year.

Section 21. Subsection (6) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.--

(6) SUMMARY OF RIGHTS AND RESPONSIBILITIES.--Any health care provider who treats a patient in an office or any health care facility licensed under chapter 395 that provides emergency services and care or outpatient services and care to a patient, or admits and treats a patient, shall adopt and make available to the patient ~~public~~, in writing, a statement of the rights and responsibilities of patients, including:

SUMMARY OF THE FLORIDA PATIENT'S BILL
OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care

provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.

A patient has the right to a prompt and reasonable response to questions and requests.

A patient has the right to know who is providing medical services and who is responsible for his or her care.

A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.

A patient has the right to know what rules and regulations apply to his or her conduct.

A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.

A patient has the right to refuse any treatment, except as otherwise provided by law.

A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.

A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.

A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.

A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.

A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.

A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.

A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.

A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.

A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.

A patient is responsible for following the treatment plan recommended by the health care provider.

A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.

A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.

A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.

A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

Section 22. Section 381.0261, Florida Statutes, is amended to read:

381.0261 ~~Distribution of~~ Summary of patient's bill of rights; distribution; penalty.--

(1) The Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ shall have printed and made continuously available to health care facilities licensed under chapter 395, physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, and podiatrists licensed under chapter 461 a summary of the Florida Patient's Bill of Rights and Responsibilities. In adopting and making available to patients ~~public~~ the summary of the Florida Patient's Bill of Rights and Responsibilities, health care providers and health care facilities are not limited to the format in which the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~ prints and distributes the summary.

(2) Health care providers and health care facilities, if requested, shall inform patients of the address and telephone number of each state agency responsible for responding to patient complaints about a health care provider or health care facility's alleged noncompliance with state licensing requirements established pursuant to law.

(3) Health care facilities shall adopt policies and procedures to ensure that inpatients are provided the opportunity during the course of admission to receive information regarding their rights and how to file complaints with the facility and appropriate state agencies.

(4) An administrative fine may be imposed by the agency when any health care provider or health care facility fails to make available to patients a summary of their rights, pursuant to ss. 381.026 and this section. Initial nonwillful violations shall be subject to corrective action and shall not be subject to an administrative fine. The agency may levy a fine against a health care facility of up to $5,000 for nonwillful violations, and up to $25,000 for intentional and willful violations. The agency may levy a fine against a health care provider of up to $100 for nonwillful violations and up to $500 for willful violations. Each intentional and willful violation constitutes a separate violation and is subject to a separate fine.

(5) In determining the amount of fine to be levied for a violation, as provided in subsection (4), the following factors shall be considered:

(a) The scope and severity of the violation, including the number of patients found to not have received notice of patient rights, and whether the failure to provide notice to patients was willful.

(b) Actions taken by the health care provider or health care facility to correct the violations or to remedy complaints.

(c) Any previous violations of this section by the health care provider or health care facility.

Section 23. Subsections (2) and (15) of section 395.002, Florida Statutes, are repealed:

395.002 Definitions.--As used in this chapter:

~~(2) "Adverse or untoward incident," for purposes of reporting to the agency, means an event over which health care personnel could exercise control, which is probably associated in whole or in part with medical intervention rather than the condition for which such intervention occurred, and which causes injury to a patient, and which:~~

~~(a) Is not consistent with or expected to be a consequence of such medical intervention;~~

~~(b) Occurs as a result of medical intervention to which the patient has not given his or her informed consent;~~

~~(c) Occurs as the result of any other action or lack of any other action on the part of the hospital or personnel of the hospital;~~

~~(d) Results in a surgical procedure being performed on the wrong patient; or~~

~~(e) Results in a surgical procedure being performed that is unrelated to the patient's diagnosis or medical needs.~~

~~(15) "Injury," for purposes of reporting to the agency, means any of the following outcomes if caused by an adverse or untoward incident:~~

~~(a) Death;~~

~~(b) Brain damage;~~

~~(c) Spinal damage;~~

~~(d) Permanent disfigurement;~~

~~(e) Fracture or dislocation of bones or joints;~~

~~(f) Any condition requiring definitive or specialized medical attention which is not consistent with the routine management of the patient's case or patient's preexisting physical condition;~~

~~(g) Any condition requiring surgical intervention to correct or control;~~

~~(h) Any condition resulting in transfer of the patient, within or outside the facility, to a unit providing a more acute level of care;~~

~~(i) Any condition that extends the patient's length of stay; or~~

~~(j) Any condition that results in a limitation of neurological, physical, or sensory function which continues after discharge from the facility.~~

Section 24. Present subsections (3), (4), (5), and (7) of section 395.0193, Florida Statutes, are amended, present subsections (6), (7), (8), and (9) are renumbered as subsections (7), (8), (9), and (10), respectively, and a new subsection (6) is added to that section, to read:

395.0193 Licensed facilities; peer review; disciplinary powers; agency or partnership with physicians.--

(3) If reasonable belief exists that conduct by a staff member or physician who delivers health care services at the licensed facility may constitute one or more grounds for discipline as provided in this subsection, a peer review panel shall investigate and determine whether grounds for discipline exist with respect to such staff member or physician. The governing board of any licensed facility, after considering the recommendations of its peer review panel, shall suspend,

deny, revoke, or curtail the privileges, or reprimand, counsel, or require education, of any such staff member or physician after a final determination has been made that one or more of the following grounds exist:

(a) Incompetence.

(b) Being found to be a habitual user of intoxicants or drugs to the extent that he or she is deemed dangerous to himself, herself, or others.

(c) Mental or physical impairment which may adversely affect patient care.

(d) Being found liable by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct.

(e) One or more settlements exceeding $10,000 for medical negligence or malpractice involving negligent conduct by the staff member.

(f) Medical negligence other than as specified in paragraph (d) or paragraph (e).

(g) Failure to comply with the policies, procedures, or directives of the risk management program or any quality assurance committees of any licensed facility.

However, the grounds specified in paragraphs (a)-(g) are not the only grounds for discipline of a practitioner.~~procedures for such actions shall comply with the standards outlined by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, the Accreditation Association for Ambulatory Health Care, Inc., and the "Medicare/Medicaid Conditions of Participation," and~~

~~rules of the agency and the department. The procedures shall be adopted pursuant to hospital bylaws.~~

(4) Pursuant to ss. 458.337 and 459.016, any disciplinary actions taken under subsection (3) shall be reported in writing to the Division of Health Quality Assurance of the agency within 30 working days after its initial occurrence, regardless of the pendency of appeals to the governing board of the hospital. The notification shall identify the disciplined practitioner, the action taken, and the reason for such action.All final disciplinary actions taken under subsection (3), if different than those which were reported to the agency within 30 days after the initial occurrence,shall be reported within 10 working days to the Division of Health Quality Assurance of the agency in writing and shall specify the disciplinary action taken and the specific grounds therefor. The division shall review each report and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case s. 455.225 shall apply. The reports are not ~~report shall not be~~ subject to inspection under s. 119.07(1) even if the division's investigation results in a finding of probable cause.

(5) There shall be no monetary liability on the part of, and no cause of action for damages against, any licensed facility, its governing board or governing board members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, or employees; a committee of a hospital; ~~,~~or any other person, for any action taken without intentional fraud in carrying out the provisions of this section.

(6) For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first seek to obtain corrective action by the facility. If correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements of this section. The administrative fine for repeated nonwillful violations shall not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. The fine for an intentional and willful violation of this section may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b).

(8)~~(7)~~ The investigations, proceedings, and records of the peer review panel, a committee of a hospital, a disciplinary board, or a governing board, or agent thereof with whom there is a specific written contract for that purpose, as described in this section shall not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such group or its agent, and a person who was in attendance at a meeting of such group or its agent may not be permitted or required to testify in any such civil or administrative action as to any evidence or other matters produced or presented during the proceedings of such group or its agent or as to any findings, recommendations, evaluations, opinions, or other actions of

such group or its agent or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil or administrative action merely because they were presented during proceedings of such group, and any person who testifies before such group or who is a member of such group may not be prevented from testifying as to matters within his or her knowledge, but such witness may not be asked about his or her testimony before such a group or opinions formed by him or her as a result of such group hearings.

Section 25. Section 395.0197, Florida Statutes, is amended to read:

395.0197 Internal risk management program.--

(1) Every licensed facility shall, as a part of its administrative functions, establish an internal risk management program that includes all of the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents ~~causing injury~~ to patients.

(b) The development of appropriate measures to minimize the risk of ~~injuries and~~ adverse incidents to patients, including, but not limited to:

1. Risk management and risk prevention education and training of all nonphysician personnel as follows:

a. Such education and training of all nonphysician personnel as part of their initial orientation; and

b. At least 1 hour of such education and training annually for all nonphysician personnel of the licensed facility working in clinical areas and providing patient care.

2. A prohibition, except when emergency circumstances require otherwise, against a staff member of the licensed facility attending a patient in the recovery room, unless the staff member is authorized to attend the patient in the recovery room and is in the company of at least one other person. However, a licensed facility ~~hospital~~ is exempt from the two-person requirement if it has:

a. Live visual observation;

b. Electronic observation; or

c. Any other reasonable measure taken to ensure patient protection and privacy.

(c) The analysis of patient grievances that relate to patient care and the quality of medical services.

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after its occurrence.

(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall hire a risk manager, licensed under part IX of chapter 626, who is responsible for implementation and oversight of such facility's internal risk management program as required by this section. A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Such additional approaches may include extending internal risk management programs to health care providers' offices and the assuming of provider liability by a licensed health care facility for acts or omissions occurring within the licensed facility.

(4) The agency shall, after consulting with the Department of Insurance, adopt rules governing the establishment of internal risk management programs to meet the needs of individual licensed facilities. Each internal risk management program shall include the use of incident reports to be filed with an individual of responsibility who is competent in risk management techniques in the employ of each licensed facility, such as an insurance coordinator, or who is retained by the licensed facility as a consultant. The individual responsible for the risk management program shall have free access to all medical records of the licensed facility. The incident reports are part of the workpapers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As a part of each internal risk management program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.

(5) For purposes of reporting to the agency pursuant to this section, the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:

(a) Results in one of the following injuries:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;

6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or

7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident;

(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;

(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the

patient and documented through the informed-consent process; or

(d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.

(6)~~(5)~~(a) Each licensed facility subject to this section shall submit an annual report to the agency summarizing the incident reports that have been filed in the facility for that year. The report shall include:

1. The total number of adverse incidents ~~causing injury to patients~~.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. A code number using the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents ~~causing injury~~ to patients, the relationship of the individual to the licensed facility, and the number of incidents in which each individual has been directly involved. Each licensed facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all malpractice claims filed against the licensed facility, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and

disposition of each claim. Each report shall update status and disposition for all prior reports.

~~6. A report of all disciplinary actions pertaining to patient care taken against any medical staff member, including the nature and cause of the action.~~

(b) The information reported to the agency pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(c) The report submitted to the agency shall also contain the name and license number of the risk manager of the licensed facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce the risk of injuries and adverse ~~or untoward~~ incidents, and the results of such measures. The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any

such records which form the basis of the determination of probable cause.

(7) The licensed facility shall notify the agency no later than 1 business day after the risk manager or his or her designee has received a report pursuant to paragraph (1)(d) and is able to determine within 1 business day that any of the following adverse incidents has occurred, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility. Notification is not required if the risk manager is unable to determine within 1 business day that any of the following incidents occurred:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient;

(d) The performance of a wrong-site surgical procedure; or

(e) The performance of a wrong surgical procedure.

The notification must be made in writing and be provided by facsimile device or overnight mail delivery. The notification must include information regarding the identity of the affected patient, the type of adverse incident, the initiation of an investigation by the facility, and whether the events causing or resulting in the adverse incident represent a potential risk to other patients.

(8)~~(6)~~ Any of the following adverse incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported by the facility to the agency within 15 calendar days after its occurrence:~~If an adverse or untoward incident, whether~~

~~occurring in the licensed facility or arising from health care prior to admission in the licensed facility, results in:~~

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient; ~~or~~

(d) The performance of a wrong-site surgical procedure;

(e) The performance of a wrong surgical procedure;

(f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;

(g) The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(h) The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

~~(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient, including the surgical repair of injuries or damage resulting from the planned surgical procedure, wrong site or wrong procedure surgeries, and procedures to remove foreign objects remaining from surgical procedures,~~

~~the licensed facility shall report this incident to the agency within 15 calendar days after its occurrence.~~The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by the facility administrator to the agency. The agency may require an additional, final report. These reports shall not be

available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(9)~~(7)~~ The internal risk manager of each licensed facility shall:

(a)~~(b)~~ Investigate every allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact, when the allegation is that the sexual misconduct occurred at the facility or on the grounds of the facility; and

(b)~~(c)~~ Report every allegation of sexual misconduct to the administrator of the licensed facility.

(c)~~(a)~~ Notify the family or guardian of the victim, if a minor, that an allegation of sexual misconduct has been made and that an investigation is being conducted;

(10)~~(8)~~ Any witness who witnessed or who possesses actual knowledge of the act that is the basis of an allegation of sexual abuse shall:

(a) Notify the local police; and

(b) Notify the hospital risk manager and the administrator.

For purposes of this subsection, "sexual abuse" means acts of a sexual nature committed for the sexual gratification of anyone upon, or in the presence of, a vulnerable adult, without the vulnerable adult's informed consent, or a minor. "Sexual abuse" includes, but is not limited to, the acts defined in s. 794.011(1)(h), fondling, exposure of a vulnerable adult's or minor's sexual organs, or the use of the vulnerable adult or minor to solicit for or engage in prostitution or sexual performance. "Sexual abuse" does not include any act intended for a valid medical purpose or any act which may reasonably be construed to be a normal caregiving action.

(11)~~(9)~~ A person who, with malice or with intent to discredit or harm a licensed facility or any person, makes a false allegation of sexual misconduct against a member of a licensed facility's personnel is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(12)~~(10)~~ In addition to any penalty imposed pursuant to this section, the agency shall require a written plan of correction from the facility. For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first seek to obtain corrective action by the facility. If the

correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements of this section. The administrative fine for repeated nonwillful violations shall not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. The fine for an intentional and willful violation of this section may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b)~~may impose an administrative fine, not to exceed $5,000, for any violation of the reporting requirements of this section~~.

(13)~~(11)~~ The agency shall have access to all licensed facility records necessary to carry out the provisions of this section. The records obtained by the agency under subsection (6), subsection (8), or subsection (9)are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 455.223 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, s. 766.101 controls.

(14)~~(12)~~ The meetings of the committees and governing board of a licensed facility held solely for the purpose of achieving the objectives of risk management as provided by this section shall not be open to the public under the provisions of chapter 286. The records of such meetings are confidential and exempt from s. 119.07(1), except as provided in subsection(13)~~(11)~~.

(15)~~(13)~~ The agency shall review, as part of its licensure inspection process, the internal risk management program at each licensed facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under subsections (5),~~and~~ (6), (7), and (8).

(16)~~(14)~~ There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager, licensed under part IX of chapter 626, for the implementation and oversight of the internal risk management program in a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed within the scope of the functions of such internal risk management program if the risk manager acts without intentional fraud.

(17)~~(15)~~ If the agency, through its receipt of the annual reports prescribed in subsection(6)~~(5)~~or through any investigation, has a reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate regulatory board, the agency shall report this fact to such regulatory board.

(18)~~(16)~~ The agency shall annually publish a report summarizing the information contained in the annual incident reports submitted by licensed facilities pursuant to subsection (6)and disciplinary actions reported to the agency pursuant to s. 395.0193 ~~any serious incident reports submitted by licensed facilities~~. The report must, at a minimum, summarize:

(a) Adverse ~~and serious~~ incidents, ~~by service district of the department as defined in s. 20.19,~~by category of reported incident, and by type of professional involved.

(b) Types of malpractice claims filed, ~~by service district of the department as defined in s. 20.19, and~~ by type of professional involved.

(c) Disciplinary actions taken against professionals, by ~~service district of the department as defined in s. 20.19, and by~~ type of professional involved.

Section 26. Effective January 1, 1999, section 626.941, Florida Statutes, is renumbered as section 395.10971, Florida Statutes.

Section 27. Effective January 1, 1999, section 626.942, Florida Statutes, is renumbered as section 395.10972, Florida Statutes, and amended to read:

395.10972 ~~626.942~~ Health Care Risk Manager Advisory Council.--The Director of Health Care Administration ~~Insurance Commissioner~~ may appoint a five-member advisory council to advise the agency ~~department~~ on matters pertaining to health care risk managers. The members of the council shall serve at the pleasure of the director ~~Insurance Commissioner~~. The council shall designate a chair. The council shall meet at the call of the director ~~Insurance Commissioner~~ or at those times as may be required by rule of the agency ~~department~~.

The members of the advisory council shall receive no compensation for their services, but shall be reimbursed for travel expenses as provided in s. 112.061. The council shall consist of individuals representing the following areas:

(1) Two shall be active health care risk managers.

(2) One shall be an active hospital administrator.

(3) One shall be an employee of an insurer or self-insurer of medical malpractice coverage.

(4) One shall be a representative of the health-care-consuming public.

Section 28. Effective January 1, 1999, section 626.943, Florida Statutes, is renumbered as section 395.10973, Florida Statutes, and amended to read:

395.10973 ~~626.943~~ Powers and duties of the agency ~~department~~.--It is the function of the agency ~~department~~ to:

(1) Adopt ~~Promulgate~~ rules necessary to carry out the duties conferred upon it under this part to protect the public health, safety, and welfare.

(2) Develop, impose, and enforce specific standards within the scope of the general qualifications established by this part which must be met by individuals in order to receive licenses as health care risk managers. These standards shall be designed to ensure that health care risk managers are individuals of good character and otherwise suitable and, by training or experience in the field of health care risk management, qualified in accordance with the provisions of this part to serve as health care risk managers, within statutory requirements.

(3) Develop a method for determining whether an individual meets the standards set forth in s. 395.10974 ~~s. 626.944~~.

(4) Issue licenses~~, beginning on June 1, 1986,~~ to qualified individuals meeting the standards set forth in s. 395.10974 ~~s. 626.944~~.

(5) Receive, investigate, and take appropriate action with respect to any charge or complaint filed with the agency ~~department~~ to the effect that a certified health care risk manager has failed to comply with the requirements or standards adopted by rule by the agency ~~department~~ or to comply with the provisions of this part.

(6) Establish procedures for providing ~~the Department of Health and Rehabilitative Services with~~ periodic reports on persons certified or disciplined by the agency ~~department~~ under this part.

(7) Develop a model risk management program for health care facilities which will satisfy the requirements of s. 395.0197.

Section 29. Effective January 1, 1999, section 626.944, Florida Statutes, is renumbered as section 395.10974, Florida Statutes, and amended to read:

395.10974 ~~626.944~~ Qualifications for health care risk managers.--

(1) Any person desiring to be licensed as a health care risk manager shall submit an application on a form provided by the agency ~~department~~. In order to qualify, the applicant shall submit evidence satisfactory to the agency ~~department~~ which demonstrates the applicant's competence, by education or experience, in the following areas:

(a) Applicable standards of health care risk management.

(b) Applicable federal, state, and local health and safety laws and rules.

(c) General risk management administration.
(d) Patient care.
(e) Medical care.
(f) Personal and social care.
(g) Accident prevention.
(h) Departmental organization and management.
(i) Community interrelationships.
(j) Medical terminology.

The agency ~~department~~ may require such additional information, from the applicant or any other person, as may be reasonably required to verify the information contained in the application.

(2) The agency ~~department~~ shall not grant or issue a license as a health care risk manager to any individual unless from the application it affirmatively appears that the applicant:

(a) Is 18 years of age or over;

(b) Is a high school graduate or equivalent; and

(c)1. Has fulfilled the requirements of a 1-year program or its equivalent in health care risk management training which may be developed or approved by the agency ~~department~~;

2. Has completed 2 years of college-level studies which would prepare the applicant for health care risk management, to be further defined by rule; or

3. Has obtained 1 year of practical experience in health care risk management.

(3) The agency ~~department~~ shall issue a license~~,~~ ~~beginning on June 1, 1986,~~ to practice health care risk management to any applicant who qualifies under this section

and submits an application fee of not more than $75, a fingerprinting fee of not more than $75, and a license fee of not more than $100. The agency shall by rule establish fees and procedures for the issuance and cancellation of licenses. ~~the license fee as set forth in s. 624.501. Licenses shall be issued and canceled in the same manner as provided in part I of this chapter.~~

(4) The agency ~~department~~ shall renew a health care risk manager license upon receipt of a biennial renewal application and fees. The agency shall by rule establish a procedure for the biennial renewal of licenses ~~in accordance with procedures prescribed in s. 626.381 for agents in general~~.

Section 30. Effective January 1, 1999, section 626.945, Florida Statutes, is renumbered as section 395.10975, Florida Statutes, and amended to read:

395.10975 ~~626.945~~ Grounds for denial, suspension, or revocation of a health care risk manager's license; administrative fine.--

(1) The agency ~~department~~ may, in its discretion, deny, suspend, revoke, or refuse to renew or continue the license of any health care risk manager or applicant, if it finds that as to such applicant or licensee any one or more of the following grounds exist:

(a) Any cause for which issuance of the license could have been refused had it then existed and been known to the agency ~~department~~.

(b) Giving false or forged evidence to the agency ~~department~~ for the purpose of obtaining a license.

(c) Having been found guilty of, or having pleaded guilty or nolo contendere to, a crime in this state or any

other state relating to the practice of risk management or the ability to practice risk management, whether or not a judgment or conviction has been entered.

(d) Having been found guilty of, or having pleaded guilty or nolo contendere to, a felony, or a crime involving moral turpitude punishable by imprisonment of 1 year or more under the law of the United States, under the law of any state, or under the law of any other country, without regard to whether a judgment of conviction has been entered by the court having jurisdiction of such cases.

(e) Making or filing a report or record which the licensee knows to be false; or intentionally failing to file a report or record required by state or federal law; or willfully impeding or obstructing, or inducing another person to impede or obstruct, the filing of a report or record required by state or federal law. Such reports or records shall include only those which are signed in the capacity of a licensed health care risk manager.

(f) Fraud or deceit, negligence, incompetence, or misconduct in the practice of health care risk management.

(g) Violation of any provision of this part or any other law applicable to the business of health care risk management.

(h) Violation of any lawful order or rule of the agency ~~department~~ or failure to comply with a lawful subpoena issued by the department.

(i) Practicing with a revoked or suspended health care risk manager license.

(j) Repeatedly acting in a manner inconsistent with the health and safety of the patients of the licensed facility in which the licensee is the health care risk manager.

(k) Being unable to practice health care risk management with reasonable skill and safety to patients by reason of illness; drunkenness; or use of drugs, narcotics, chemicals, or any other material or substance or as a result of any mental or physical condition. Any person affected under this paragraph shall have the opportunity, at reasonable intervals, to demonstrate that he or she can resume the competent practices of health care risk manager with reasonable skill and safety to patients.

(l) Willfully permitting unauthorized disclosure of information relating to a patient or a patient's records.

(m) Discriminating in respect to patients, employees, or staff on account of race, religion, color, sex, or national origin.

(2) If the agency ~~department~~ finds that one or more of the grounds set forth in subsection (1) exist, it may, in lieu of or in addition to suspension or revocation, enter an order imposing one or more of the following penalties:

(a) Imposition of an administrative fine not to exceed $2,500 for each count or separate offense.

(b) Issuance of a reprimand.

(c) Placement of the licensee on probation for a period of time and subject to such conditions as the agency ~~department~~ may specify, including requiring the licensee to attend continuing education courses or to work under the supervision of another licensee.

(3) The agency ~~department~~ may reissue the license of a disciplined licensee in accordance with the provisions of this part.

Section 31. Subsection (1) of section 766.101, Florida Statutes, is amended to read:

766.101 Medical review committee, immunity from liability.--

(1) As used in this section:

(a) The term "medical review committee" or "committee" means:

1.a. A committee of a hospital or ambulatory surgical center licensed under chapter 395 or a health maintenance organization certificated under part I of chapter 641,

b. A committee of a physician-hospital organization, a provider-sponsored organization, or an integrated delivery system,

c.~~b.~~ A committee of a state or local professional society of health care providers,

d.~~c.~~ A committee of a medical staff of a licensed hospital or nursing home, provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital or nursing home,

e.~~d.~~ A committee of the Department of Corrections or the Correctional Medical Authority as created under s. 945.602, or employees, agents, or consultants of either the department or the authority or both,

f.~~e.~~ A committee of a professional service corporation formed under chapter 621 or a corporation organized under chapter 607 or chapter 617, which is formed and operated for the practice of medicine as defined in s. 458.305(3), and which has at least 25 health care providers who routinely provide health care services directly to patients,

g.~~f.~~ A committee of a mental health treatment facility licensed under chapter 394 or a community mental health center as defined in s. 394.907, provided the quality assurance

program operates pursuant to the guidelines which have been approved by the governing board of the agency,

h.~~g.~~ A committee of a substance abuse treatment and education prevention program licensed under chapter 397 provided the quality assurance program operates pursuant to the guidelines which have been approved by the governing board of the agency,

i.~~h.~~ A peer review or utilization review committee organized under chapter 440, or

j.~~i.~~ A committee of a county health department, healthy start coalition, or certified rural health network, when reviewing quality of care, or employees of these entities when reviewing mortality records,

which committee is formed to evaluate and improve the quality of health care rendered by providers of health service or to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area; or

2. A committee of an insurer, self-insurer, or joint underwriting association of medical malpractice insurance, or other persons conducting review under s. 766.106.

(b) The term "health care providers" means physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, podiatrists licensed under chapter 461, optometrists licensed under chapter 463, dentists licensed under chapter 466, chiropractors licensed under chapter 460, pharmacists licensed under chapter 465, or hospitals or ambulatory surgical centers licensed under chapter 395.

Section 32. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions.--As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(25)~~s. 395.002(27)~~as a specialty psychiatric hospital.

Section 33. Paragraph (c) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.--

(2) DEFINITIONS.--As used in this part:

(c) "Inactive rural hospital bed" means a licensed acute care hospital bed, as defined in s. 395.002(12)~~s. 395.002(13)~~, that is inactive in that it cannot be occupied by acute care inpatients.

Section 34. Paragraph (b) of subsection (1) of section 400.051, Florida Statutes, is amended to read:

400.051 Homes or institutions exempt from the provisions of this part.--

(1) The following shall be exempt from the provisions of this part:

(b) Any hospital, as defined in s. 395.002(9)~~s. 395.002(10)~~, that is licensed under chapter 395.

Section 35. Subsection (8) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be

provided only when medically necessary and in accordance with state and federal law. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(8) NURSING FACILITY SERVICES.--The agency shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined by s. 395.002(9)~~s. 395.002(10)~~, that is licensed under part I of chapter 395, and in accordance with provisions set forth in s. 409.908(2)(a), which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the agency must pay for similar services temporarily in a hospital licensed under part I of chapter 395 provided federal funding is approved and available.

Section 36. Paragraph (g) of subsection (1) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.--

(1) DEFINITIONS.--As used in this section, the term:

(g) "Emergency services and care" means emergency services and care as defined in s. 395.002~~(9)~~.

Section 37. Subsection (9) of section 458.331, Florida Statutes, is amended to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(9) When an investigation of a physician is undertaken, the department shall promptly furnish to the physician or the physician's attorney a copy of the complaint or document which resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent portions of an annual report submitted to the department pursuant to s. 395.0197(6)~~s. 395.0197(5)(b)~~; a report of an adverse ~~or untoward~~ incident which is provided to the department pursuant to s. 395.0197(8)~~the provisions of s. 395.0197(6)~~; a report of peer review disciplinary action submitted to the department pursuant to ~~the provisions of~~ s. 395.0193(4) or s. 458.337, providing that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. 395.0193(8)~~395.0193(7)~~and 458.337(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the physician of the complaint or document. The physician's written response shall be considered by the probable cause panel.

Section 38. Subsection (9) of section 459.015, Florida Statutes, is amended to read:

459.015 Grounds for disciplinary action by the board.--

(9) When an investigation of an osteopathic physician is undertaken, the department shall promptly furnish to the osteopathic physician or his or her attorney a copy of the complaint or document which resulted in the initiation of the investigation. For purposes of this subsection, such documents include, but are not limited to: the pertinent portions of an annual report submitted to the department pursuant to s. 395.0197(6)~~s. 395.0197(5)(b)~~; a report of an adverse ~~or untoward~~ incident which is provided to the department pursuant to s. 395.0197(8)~~the provisions of s. 395.0197(6)~~; a report of peer review disciplinary action submitted to the department pursuant to ~~the provisions of~~ s. 395.0193(4) or s. 459.016, provided that the investigations, proceedings, and records relating to such peer review disciplinary action shall continue to retain their privileged status even as to the licensee who is the subject of the investigation, as provided by ss. 395.0193(8)~~395.0193(7)~~and 459.016(3); a report of a closed claim submitted pursuant to s. 627.912; a presuit notice submitted pursuant to s. 766.106(2); and a petition brought under the Florida Birth-Related Neurological Injury Compensation Plan, pursuant to s. 766.305(2). The osteopathic physician may submit a written response to the information contained in the complaint or document which resulted in the initiation of the investigation within 45 days after service to the osteopathic physician of the complaint or document. The osteopathic physician's written response shall be considered by the probable cause panel.

Section 39. Subsection (1) of section 468.505, Florida Statutes, is amended to read:

468.505 Exemptions; exceptions.--

(1) Nothing in this part may be construed as prohibiting or restricting the practice, services, or activities of:

(a) A person licensed in this state under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, chapter 480, chapter 490, or chapter 491, when engaging in the profession or occupation for which he or she is licensed, or of any person employed by and under the supervision of the licensee when rendering services within the scope of the profession or occupation of the licensee.~~;~~

(b) A person employed as a dietitian by the government of the United States, if the person engages in dietetics solely under direction or control of the organization by which the person is employed.~~;~~

(c) A person employed as a cooperative extension home economist.~~;~~

(d) A person pursuing a course of study leading to a degree in dietetics and nutrition from a program or school accredited pursuant to s. 468.509(2), if the activities and services constitute a part of a supervised course of study and if the person is designated by a title that clearly indicates the person's status as a student or trainee.~~;~~

(e) A person fulfilling the supervised experience component of s. 468.509, if the activities and services constitute a part of the experience necessary to meet the requirements of s. 468.509.~~;~~

(f) Any dietitian or nutritionist from another state practicing dietetics or nutrition incidental to a course of study when taking or giving a postgraduate course or other

course of study in this state, provided such dietitian or nutritionist is licensed in another jurisdiction or is a registered dietitian or holds an appointment on the faculty of a school accredited pursuant to s. 468.509(2).~~;~~

(g) A person who markets or distributes food, food materials, or dietary supplements, or any person who engages in the explanation of the use and benefits of those products or the preparation of those products, if that person does not engage for a fee in dietetics and nutrition practice or nutrition counseling.~~;~~

(h) A person who markets or distributes food, food materials, or dietary supplements, or any person who engages in the explanation of the use of those products or the preparation of those products, as an employee of an establishment permitted pursuant to chapter 465.~~;~~

(i) An educator who is in the employ of a nonprofit organization approved by the council; a federal, state, county, or municipal agency, or other political subdivision; an elementary or secondary school; or an accredited institution of higher education the definition of which, as provided in s. 468.509(2), applies to other sections of this part, insofar as the activities and services of the educator are part of such employment.~~;~~

(j) Any person who provides weight control services or related weight control products, provided the program has been reviewed by, consultation is available from, and no program change can be initiated without prior approval by a licensed dietitian/nutritionist, a dietitian or nutritionist licensed in another state that has licensure requirements considered by the council to be at least as stringent as the requirements for licensure under this part, or a registered dietitian.~~;~~

(k) A person employed by a hospital licensed under chapter 395, or by a nursing home or assisted living facility licensed under part II or part III of chapter 400, or by a continuing care facility certified under chapter 651, if the person is employed in compliance with the laws and rules adopted thereunder regarding the operation of its dietetic department.~~;~~

(l) A person employed by a nursing facility exempt from licensing under s. 395.002(11)~~s. 395.002(12)~~, or a person exempt from licensing under s. 464.022.~~; or~~

(m) A person employed as a dietetic technician.

Section 40. Effective January 1, 1999, subsection (2) of section 641.55, Florida Statutes, is amended to read:

641.55 Internal risk management program.--

(2) The risk management program shall be the responsibility of the governing authority or board of the organization. Every organization which has an annual premium volume of $10 million or more and which directly provides health care in a building owned or leased by the organization shall hire a risk manager, certified under ss. 395.10971-395.10975 ~~ss. 626.941-626.945~~, who shall be responsible for implementation of the organization's risk management program required by this section. A part-time risk manager shall not be responsible for risk management programs in more than four organizations or facilities. Every organization which does not directly provide health care in a building owned or leased by the organization and every organization with an annual premium volume of less than $10 million shall designate an officer or employee of the organization to serve as the risk manager.

The gross data compiled under this section or s. 395.0197 shall be furnished by the agency upon request to organizations to be utilized for risk management purposes. The agency shall adopt rules necessary to carry out the provisions of this section.

Section 41. Paragraph (c) of subsection (4) of section 766.1115, Florida Statutes, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.--

(4) CONTRACT REQUIREMENTS.--A health care provider that executes a contract with a governmental contractor to deliver health care services on or after April 17, 1992, as an agent of the governmental contractor is an agent for purposes of s. 768.28(9), while acting within the scope of duties pursuant to the contract, if the contract complies with the requirements of this section. A health care provider under contract with the state may not be named as a defendant in any action arising out of the medical care or treatment provided on or after April 17, 1992, pursuant to contracts entered into under this section. The contract must provide that:

(c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if such incidents and information pertain to a patient treated pursuant to the contract. The health care provider shall annually submit an adverse incident report that includes all information required by s. 395.0197(6)(a)~~s. 395.0197(5)(a)~~, unless the adverse incident involves a result described by s. 395.0197(8)~~s. 395.0197(6)~~, in which case it shall be reported within 15 days after ~~of~~ the occurrence of such incident. If an incident involves a professional licensed by the Department of Health ~~Business and~~

~~Professional Regulation~~ or a facility licensed by the Agency for Health Care Administration ~~Department of Health and Rehabilitative Services~~, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities pursuant to this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

Section 42. Effective January 1, 1999, all powers, duties and functions, rules, records, personnel, property, and unexpended balances of appropriations, allocations, or other funds of the Department of Insurance related to the health care risk manager licensure program, as established in part IX of chapter 626, Florida Statutes, are transferred by a type two transfer, as defined in section 20.06(2), Florida Statutes, from the Department of Insurance to the Agency for Health Care Administration.

Section 43. The sum of $100,281 is appropriated from the Health Care Trust Fund to the Agency for Health Care Administration, and one full-time position is authorized, to administer the provisions of this act.

Section 44. Except as otherwise expressly provided in this act, this act shall take effect July 1, 1998.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR SB 314

Changes the applicability of the repeal of hospital budget review from hospital budgets ending in 1995 to hospital budgets ending in 1996.

Clarifies that all outpatient facilities that provide surgical treatments requiring general anesthesia or IV conscious sedation, that provide cardiac catheterization services, or that are to be licensed as ambulatory surgical centers must submit plans and specifications to AHCA for review. All other outpatient facilities must be reviewed, except that plans and specifications relating to the construction or alteration of outpatient facilities that are physically detached from the hospital on whose campus it is located, have no utility connections with the hospital, and do not block emergency egress from or create a fire hazard to the hospital are made exempt from review.

The effective date of authority for the Agency for Health Care Administration to enforce emergency preparedness requirements applicable to new facilities and new wings and floors added to existing facilities is changed from July 1, 1998 to July 1, 1999. Restrictions on use of hospitals as emergency shelters are expanded to include families of patients. Also, the date by which the Agency for Health Care Administration must report to the Governor and Legislature its recommendations for cost-effective renovation standards for existing health care facilities is changed from March 1, 1999, to April 1, 1998.

The Florida Patients Bill of Rights and Responsibilities is further amended to require health care providers and health care facilities to inform patients of the telephone number and address of each state agency responsible for responding to patient complaints only if requested. Penalties against health care providers for failure to provide patients with a summary of the rights are reduced to up to $100 for nonwillful violations and up to $500 for willful violations. The $5,000 and $25,000 limits remain applicable to health care facilities.

Amends s. 766.101, F.S., relating to medical review committees to provide for protection from liability for medical review committees and committees of physician-hospital organizations, provider-sponsored organizations, and integrated delivery systems.

Appropriates $100,281 from the Health Care Trust Fund to the Agency for Health Care Administration and authorizes one full-time equivalent position for the agency.