By Representative Saunders

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. 112.153, F.S., relating to local governmental group insurance plans; updating provisions to reflect the assumption by the Agency for Health Care Administration of duties formerly performed by the Health Care Cost Containment Board; amending s. 154.304, F.S., relating to health care for indigent persons; revising definitions; amending ss. 212.055 and 394.4788, F.S., relating to discretionary sales surtaxes and 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. 395.0197, F.S.; exempting ambulatory surgical centers and hospitals from certain staffing requirements in surgical recovery rooms; 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; 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 s. 395.806, F.S.; providing for the agency to assume the board's duties in reviewing family practice teaching hospitals; amending s. 408.033, F.S.; revising membership on the Statewide Health Council to reflect the abolishment of the Health Care Board; amending ss. 408.05, 408.061, 408.062, and 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 and 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; amending s. 440.13, F.S., relating to reimbursements for medical services under the Workers' Compensation Law; deleting a reference to reviews of hospital budgets made obsolete by the act; repealing ss. 395.403(9), 407.61, 408.003, 408.072, and 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 the act; providing an effective date.

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, 1996 Supplement, 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. Section 112.153, Florida Statutes, is amended to read:

112.153 Local governmental group insurance plans; refunds with respect to overcharges by providers.--A participant in a group insurance plan offered by a county, municipality, school board, local governmental unit, and special taxing unit, who discovers that he or she was overcharged by a hospital, physician, clinical lab, and other health care providers, shall receive a refund of 50 percent of any amount recovered as a result of such overcharge, up to a maximum of $1,000 per admission. All such instances of overcharge shall be reported to the Agency for Health Care Administration ~~Health Care Cost Containment Board~~ for action it deems appropriate.

Section 3. Subsections (1), (4), 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~~.

(4) "Charity care obligation" means the minimum amount of uncompensated charity care as reported to the agency ~~Health Care Cost Containment Board~~, based on the hospital's most recent audited actual experience, which must be provided by a participating hospital or a regional referral hospital before the hospital is eligible to be reimbursed by a county under the provisions of this act. That amount shall be the ratio of uncompensated charity care days compared to total acute care inpatient days, which shall be equal to or greater than 2 percent.

(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 4. Paragraph (d) of subsection (4) and paragraph (c) of subsection (6) of section 212.055, Florida Statutes, 1996 Supplement, are amended to read:

212.055 Discretionary sales surtaxes; legislative intent; authorization and use of proceeds.--It is the legislative intent that any authorization for imposition of a discretionary sales surtax shall be published in the Florida Statutes as a subsection of this section, irrespective of the duration of the levy. Each enactment shall specify the types of counties authorized to levy; the rate or rates which may be imposed; the maximum length of time the surtax may be imposed, if any; the procedure which must be followed to secure voter

approval, if required; the purpose for which the proceeds may be expended; and such other requirements as the Legislature may provide. Taxable transactions and administrative procedures shall be as provided in s. 212.054.

(4) INDIGENT CARE SURTAX.--

(d) The ordinance adopted by the governing body providing for the imposition of the surtax shall set forth a plan for providing health care services to qualified residents, as defined in paragraph (e). Such plan and subsequent amendments to it shall fund a broad range of health care services for both indigent persons and the medically poor, including, but not limited to, primary care and preventive care as well as hospital care. It shall emphasize a continuity of care in the most cost-effective setting, taking into consideration both a high quality of care and geographic access. Where consistent with these objectives, it shall include, without limitation, services rendered by physicians, clinics, community hospitals, mental health centers, and alternative delivery sites, as well as at least one regional referral hospital where appropriate. It shall provide that agreements negotiated between the county and providers will include reimbursement methodologies that take into account the cost of services rendered to eligible patients, recognize hospitals that render a disproportionate share of indigent care, provide other incentives to promote the delivery of charity care, and require cost containment including, but not limited to, case management. It must also provide that any hospitals that are owned and operated by government entities on May 21, 1991, must, as a condition of receiving funds under this subsection, afford public access equal to that provided under s. 286.011 as to meetings of the

governing board, the subject of which is budgeting resources for the rendition of charity care as that term is defined in the rules of the Agency for Health Care Administration ~~Health Care Cost Containment Board~~. The plan must ~~shall~~ also include innovative health care programs that provide cost-effective alternatives to traditional methods of service delivery and funding.

(6) SMALL COUNTY INDIGENT CARE SURTAX.--

(c) The ordinance adopted by the governing body providing for the imposition of the surtax shall set forth a brief plan for providing health care services to qualified residents, as defined in paragraph (d). Such plan and subsequent amendments to it shall fund a broad range of health care services for both indigent persons and the medically poor, including, but not limited to, primary care and preventive care as well as hospital care. It shall emphasize a continuity of care in the most cost-effective setting, taking into consideration both a high quality of care and geographic access. Where consistent with these objectives, it shall include, without limitation, services rendered by physicians, clinics, community hospitals, mental health centers, and alternative delivery sites, as well as at least one regional referral hospital where appropriate. It shall provide that agreements negotiated between the county and providers will include reimbursement methodologies that take into account the cost of services rendered to eligible patients, recognize hospitals that render a disproportionate share of indigent care, provide other incentives to promote the delivery of charity care, and require cost containment including, but not limited to, case management. It shall also provide that any hospitals that are owned and operated by

government entities on May 21, 1991, must, as a condition of receiving funds under this subsection, afford public access equal to that provided under s. 286.011 as to meetings of the governing board, the subject of which is budgeting resources for the rendition of charity care as that term is defined in the rules of the Agency for Health Care Administration ~~Health Care Cost Containment Board~~. The plan must ~~shall~~ also include innovative health care programs that provide cost-effective alternatives to traditional methods of service delivery and funding.

Section 5. Subsections (2) and (3) of section 394.4788, Florida Statutes, 1996 Supplement, 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 6. 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 7. Subsection (1) of section 395.0163, Florida Statutes, is amended to read:

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

(1) 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. Outpatient facilities that provide surgical treatments requiring general anesthesia or intravenous conscious sedation or that provide cardiac catheterization services shall submit plans and specifications to the agency for review under this section. All other outpatient facilities that are physically detached from the hospital with no utility connections and that do not block emergency egress from or create a fire hazard to the hospital are exempt from review under this section. Applications pending review on the effective date of this act shall be governed by the exemption provided in this subsection.

Section 8. Paragraph (b) of subsection (1) of section 395.0197, Florida Statutes, 1996 Supplement, 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:

(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.

Section 9. Paragraph (d) of subsection (1) of section 395.1055, Florida Statutes, 1996 Supplement, 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, 1997, are structurally capable of serving as shelters only for patients, staff, and families of staff, and equipped to be self-supporting during and immediately following disasters.

Section 10. The Agency for Health Care Administration shall work with persons affected by section 9 and report to the Governor and Legislature by March 1, 1998, its recommendations for cost-effective renovation standards to be applied to existing facilities.

Section 11. 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 12. 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(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 13. Subsection (3) of section 395.806, Florida Statutes, is amended to read:

395.806 Designation of family practice teaching hospitals.--

(3) The agency shall create a separate review category for family practice teaching hospitals for the purpose of review by the agency ~~Health Care Board~~.

Section 14. Subsection (2) of section 408.033, Florida Statutes, is amended to read:

408.033 Local and state health planning.--

(2) STATEWIDE HEALTH COUNCIL.--The Statewide Health Council is hereby established as a state-level comprehensive health planning and policy advisory board. For administrative purposes, the council shall be located within the agency. The Statewide Health Council shall be composed of: the State Health Officer; the Deputy Director for Health Policy and Cost Control and the Deputy Director for Health Quality Assurance of the agency ~~department~~; ~~the director of the Health Care Board;~~the Insurance Commissioner or his designee; the Vice Chancellor for Health Affairs of the Board of Regents; three

chairmen of regional planning councils, selected by the regional planning councils; five chairmen of local health councils, selected by the local health councils; four members appointed by the Governor, one of whom is a consumer over 60 years of age, one of whom is a representative of organized labor, one of whom is a physician, and one of whom represents the nursing home industry; five members appointed by the President of the Senate, one of whom is a representative of the insurance industry in this state, one of whom is the chief executive officer of a business with more than 300 employees in this state, one of whom represents the hospital industry, one of whom is a primary care physician, and one of whom is a nurse, and five members appointed by the Speaker of the House of Representatives, one of whom is a consumer who represents a minority group in this state, one of whom represents the home health care industry in this state, one of whom is an allied health care professional, one of whom is the chief executive officer of a business with fewer than 25 employees in this state, and one of whom represents a county social services program that provides health care services to the indigent. Appointed members of the council shall serve for 2-year terms commencing October 1 of each even-numbered year. The council shall elect a president from among the members who are not state employees. The Statewide Health Council shall:

(a) Advise the Governor, the Legislature, and the agency ~~department~~ on state health policy issues, state and local health planning activities, and state health regulation programs;

(b) Prepare a state health plan that specifies subgoals, quantifiable objectives, strategies, and resource requirements to implement the goals and policies of the health

element of the State Comprehensive Plan. The plan must assess the health status of residents of this state; evaluate the adequacy, accessibility, and affordability of health services and facilities; assess government-financed programs and private health care insurance coverages; and address other topical local and state health care issues. Within 2 years after the health element of the State Comprehensive Plan is amended, and by July 1 of every 3rd year, if it is not amended, the Statewide Health Council shall submit the state health plan to the Executive Office of the Governor, the director of the agency ~~secretary of the department~~, the President of the Senate, and the Speaker of the House of Representatives;

(c) Promote public awareness of state health care issues and, in conjunction with the local health councils, conduct public forums throughout the state to solicit the comments and advice of the public on the adequacy, accessibility, and affordability of health care services in this state and other health care issues;

(d) Consult with local health councils, the Department of Insurance, the Department of Health ~~and Rehabilitative Services~~, and other appropriate public and private entities, including health care industry representatives regarding the development of health policies;

(e) Serve as a forum for the discussion of local health planning issues of concern to the local health councils and regional planning councils;

(f) Review district health plans for consistency with the State Comprehensive Plan and the state health plan;

(g) Review the health components of agency functional plans for consistency with the health element of the State

Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to agency functional plans to make them consistent with the State Comprehensive Plan;

(h) Review any strategic regional plans that address health issues for consistency with the health element of the State Comprehensive Plan, advise the Executive Office of the Governor regarding inconsistencies, and recommend revisions to strategic regional policy plans to make them consistent with the State Comprehensive Plan;

(i) Assist the Department of Community Affairs in the review of local government comprehensive plans to ensure consistency with policy developed in the district health plans;

(j) With the assistance of the local health councils, conduct public forums and use other means to determine the opinions of health care consumers, providers, payors, and insurers regarding the state's health care goals and policies and develop suggested revisions to the health element of the State Comprehensive Plan. The council shall submit the proposed revisions to the health element of the State Comprehensive Plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1993, and shall widely circulate the proposed revisions to affected parties. The council shall periodically assess the progress made in achieving the goals and policies contained in the health element of the State Comprehensive Plan and report to the agency ~~department~~, the Governor, the President of the Senate, and the Speaker of the House of Representatives; and

(k) Conduct any other functions or studies and analyses falling under the duties listed above.

Section 15. 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 16. Subsections (10) and (11) of section 408.061, Florida Statutes, 1996 Supplement, 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 17. 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 is empowered to conduct data-based studies and evaluations and to 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 18. 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 which distributes information and serves as the basis for the agency's ~~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 19. 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 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 20. 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 21. Section 408.40, Florida Statutes, 1996 Supplement, 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 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 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 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 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 22. Paragraph (e) of subsection (10) and subsection (14) of section 409.2673, Florida Statutes, 1996 Supplement, 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 23. 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 x 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 24. Paragraph (c) of subsection (12) of section 440.13, Florida Statutes, 1996 Supplement, is amended to read:

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

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.--

(c) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, must not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical examinations performed by health care providers under this chapter. Until the three-member panel approves a uniform

schedule of maximum reimbursement allowances and it becomes effective, all compensable charges for treatment, care, and attendance provided by physicians, ambulatory surgical centers, work-hardening programs, or pain programs shall be reimbursed at the lowest maximum reimbursement allowance across all 1992 schedules of maximum reimbursement allowances for the services provided regardless of the place of service. In determining the uniform schedule, the panel shall first approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the uniform schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers.~~;~~

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers.~~;~~

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.401, and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers'

compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers.~~;~~ ~~and~~

~~4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.~~

Section 25. Subsection (9) of section 395.403, Florida Statutes, sections 407.61, 408.003, and 408.085, Florida Statutes, and section 408.072, Florida Statutes, as amended by chapter 96-410, Laws of Florida, are hereby repealed.

Section 26. 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 1995 calendar year.

Section 27. This act shall take effect July 1, 1997.

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HOUSE SUMMARY

Removes and repeals provisions relating to the Health Care Board and review of hospital budgets. Revises, updates, and conforms various provisions to reflect the assumption by the Agency for Health Care Administration of the duties of the Health Care Board and the former Health Care Cost Containment Board and duties of the former Department of Health and Rehabilitative Services relating to indigent medical care and the State Center for Health Statistics. Requires licensed facilities to be capable of serving as disaster shelters for only patients, staff, and families of staff, limits applicability of the requirement to new facilities and new wings or floors of existing facilities, and requires the agency to recommended to the Governor and Legislature cost-effective renovation standards for existing facilities. Authorizes the agency to conduct data-based studies and evaluations and make certain recommendations to the Governor and Legislature. Exempts outpatient facilities that meet specified criteria from agency construction inspections and investigations. Provides that surgical recovery rooms of ambulatory surgical centers, as well as hospitals, are exempt from certain staffing requirements. See bill for details.