A bill to be entitled

An act relating to long-term care services; providing that certain prior offenses shall be considered in conducting employment screening, notwithstanding the provisions of section 64 of ch. 95-228, Laws of Florida; amending s. 400.071, F.S.; requiring applicants for licensure as a nursing home to provide proof of a legal right to occupy the property; amending s. 400.414, F.S.; delineating the types and number of deficiencies justifying denial, revocation, or suspension of a license as an assisted living facility; amending s. 400.417, F.S.; providing an alternative method of providing notice to an assisted living facility that a license must be renewed; amending s. 400.419, F.S.; providing that administrative fines for assisted living facilities or its personnel shall be imposed by the Agency for Health Care Administration in the manner provided in ch. 120, F.S.; amending s. 400.441, F.S.; prohibiting the use of certain restraints for discipline or convenience; providing exceptions; amending s. 400.557, F.S.; providing an alternative method of providing notice to an adult day care center that a license must be renewed; amending s. 400.619, F.S.; requiring that the Agency for Health Care Administration provide advance notice to an adult family-care home that a license must be renewed; reenacting and amending s. 400.980, F.S.; providing that the provisions governing background screening of persons involved with health care services pools shall not stand repealed; amending s. 408.061, F.S.; exempting nursing homes and continuing care facilities from certain financial reporting requirements;

amending s. 408.062, F.S.; providing that the Agency for Health Care Administration is not required to evaluate financial reports of nursing homes; amending s. 408.831, F.S.; requiring that licensees of the Agency for Health Care Administration pay or arrange for payment of amounts owed to the agency by the licensee prior to transfer of the license or issuance of a license to a transferee; amending s. 409.9116, F.S.; correcting a cross reference; providing an effective date.

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

Section 1. Notwithstanding the provisions of section 64 of chapter 95-228, Laws of Florida, the provisions of chapter 435, Florida Statutes, as created therein and as subsequently amended, and any reference thereto, shall apply to all offenses regardless of the date on which offenses referenced in chapter 435, Florida Statutes, were committed, unless specifically provided otherwise in a provision other than section 64 of chapter 95-228, Laws of Florida.

Section 2. Subsection (12) is added to section 400.071, Florida Statutes, to read:

400.071 Application for license.--

(12) The applicant must provide the agency with proof of a legal right to occupy the property before a license may be issued. Proof may include, but is not limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, or quitclaim deeds.

Section 3. Subsection (1) of section 400.414, Florida Statutes, is amended to read:

400.414 Denial, revocation, or suspension of license; imposition of administrative fine; grounds.--

(1) The agency may deny, revoke, or suspend any license issued under this part, or impose an administrative fine in the manner provided in chapter 120, for any of the following actions by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 400.4174, or for the actions of any facility employee:

(a) An intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(b) The determination by the agency that the owner lacks the financial ability to provide continuing adequate care to residents.

(c) Misappropriation or conversion of the property of a resident of the facility.

(d) Failure to follow the criteria and procedures provided under part I of chapter 394 relating to the transportation, voluntary admission, and involuntary examination of a facility resident.

(e) A citation of any of the following deficiencies as defined in s. 400.419:

1. One or more cited class I deficiencies.

2. Three or more cited class II deficiencies.

3. Five or more cited class III deficiencies that have been cited on a single survey and have not been corrected within the times specified ~~One or more class I, three or more class II, or five or more repeated or recurring identical or similar class III violations that are similar or identical to violations which were identified by the agency within the last 2 years~~.

(f) A determination that a person subject to level 2 background screening under s. 400.4174(1) does not meet the screening standards of s. 435.04 or that the facility is retaining an employee subject to level 1 background screening standards under s. 400.4174(2) who does not meet the screening standards of s. 435.03 and for whom exemptions from disqualification have not been provided by the agency.

(g) A determination that an employee, volunteer, administrator, or owner, or person who otherwise has access to the residents of a facility does not meet the criteria specified in s. 435.03(2), and the owner or administrator has not taken action to remove the person. Exemptions from disqualification may be granted as set forth in s. 435.07. No administrative action may be taken against the facility if the person is granted an exemption.

(h) Violation of a moratorium.

(i) Failure of the license applicant, the licensee during relicensure, or a licensee that holds a provisional license to meet the minimum license requirements of this part, or related rules, at the time of license application or renewal.

(j) A fraudulent statement or omission of any material fact on an application for a license or any other document required by the agency, including the submission of a license application that conceals the fact that any board member, officer, or person owning 5 percent or more of the facility may not meet the background screening requirements of s. 400.4174, or that the applicant has been excluded, permanently suspended, or terminated from the Medicaid or Medicare programs.

(k) An intentional or negligent life-threatening act in violation of the uniform firesafety standards for assisted

living facilities or other firesafety standards that threatens the health, safety, or welfare of a resident of a facility, as communicated to the agency by the local authority having jurisdiction or the State Fire Marshal.

(l) Exclusion, permanent suspension, or termination from the Medicare or Medicaid programs.

(m) Knowingly operating any unlicensed facility or providing without a license any service that must be licensed under this chapter.

(n) Any act constituting a ground upon which application for a license may be denied.

Administrative proceedings challenging agency action under this subsection shall be reviewed on the basis of the facts and conditions that resulted in the agency action.

Section 4. Subsection (1) of section 400.417, Florida Statutes, is amended to read:

400.417 Expiration of license; renewal; conditional license.--

(1) Biennial licenses, unless sooner suspended or revoked, shall expire 2 years from the date of issuance. Limited nursing, extended congregate care, and limited mental health licenses shall expire at the same time as the facility's standard license, regardless of when issued. The agency shall notify the facility ~~by certified mail~~ at least 120 days prior to expiration that a renewal license is necessary to continue operation. The notification must be provided electronically or by mail delivery. Ninety days prior to the expiration date, an application for renewal shall be submitted to the agency. Fees must be prorated. The failure to file a timely renewal

application shall result in a late fee charged to the facility in an amount equal to 50 percent of the current fee.

Section 5. Section 400.419, Florida Statutes, is amended to read:

400.419 Violations; imposition of administrative fines; grounds.--

(1) The agency shall impose an administrative fine in the manner provided in chapter 120 for any of the actions or violations as set forth within this section by an assisted living facility, for the actions of any person subject to level 2 background screening under s. 400.4174, for the actions of any facility employee, or for an intentional or negligent act seriously affecting the health, safety, or welfare of a resident of the facility.

(2)~~(1)~~ Each violation of this part and adopted rules shall be classified according to the nature of the violation and the gravity of its probable effect on facility residents. The agency shall indicate the classification on the written notice of the violation as follows:

(a) Class "I" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines present an imminent danger to the residents or guests of the facility or a substantial probability that death or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction. The agency shall impose an administrative fine for a cited class I violation ~~is subject to an administrative fine~~ in an amount not

less than $5,000 and not exceeding $10,000 for each violation. A fine may be levied notwithstanding the correction of the violation.

(b) Class "II" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines directly threaten the physical or emotional health, safety, or security of the facility residents, other than class I violations. The agency shall impose an administrative fine for a cited class II violation ~~is subject to an administrative fine~~ in an amount not less than $1,000 and not exceeding $5,000 for each violation. A fine shall be levied notwithstanding the correction of the violation ~~A citation for a class II violation must specify the time within which the violation is required to be corrected~~.

(c) Class "III" violations are those conditions or occurrences related to the operation and maintenance of a facility or to the personal care of residents which the agency determines indirectly or potentially threaten the physical or emotional health, safety, or security of facility residents, other than class I or class II violations. The agency shall impose an administrative fine for a cited class III violation in an amount ~~is subject to an administrative fine of~~ not less than $500 and not exceeding $1,000 for each violation. A citation for a class III violation must specify the time within which the violation is required to be corrected. If a class III violation is corrected within the time specified, no fine may be imposed, unless it is a repeated offense.

(d) Class "IV" violations are those conditions or occurrences related to the operation and maintenance of a

building or to required reports, forms, or documents that do not have the potential of negatively affecting residents. These violations are of a type that the agency determines do not threaten the health, safety, or security of residents of the facility. The agency shall impose an administrative fine for a cited class IV violation in an amount ~~A facility that does not correct a class IV violation within the time specified in the agency-approved corrective action plan is subject to an administrative fine of~~ not less than $100 and not exceeding ~~nor more than~~ $200 for each violation. A citation for a class IV violation must specify the time within which the violation is required to be corrected. If a class IV violation is corrected within the time specified, no fine shall be imposed. Any class IV violation that is corrected during the time an agency survey is being conducted will be identified as an agency finding and not as a violation.

(3)~~(2)~~ In determining if a penalty is to be imposed and in fixing the amount of the fine, the agency shall consider the following factors:

(a) The gravity of the violation, including the probability that death or serious physical or emotional harm to a resident will result or has resulted, the severity of the action or potential harm, and the extent to which the provisions of the applicable laws or rules were violated.

(b) Actions taken by the owner or administrator to correct violations.

(c) Any previous violations.

(d) The financial benefit to the facility of committing or continuing the violation.

(e) The licensed capacity of the facility.

(4)~~(3)~~ Each day of continuing violation after the date fixed for termination of the violation, as ordered by the agency, constitutes an additional, separate, and distinct violation.

(5)~~(4)~~ Any action taken to correct a violation shall be documented in writing by the owner or administrator of the facility and verified through followup visits by agency personnel. The agency may impose a fine and, in the case of an owner-operated facility, revoke or deny a facility's license when a facility administrator fraudulently misrepresents action taken to correct a violation.

(6)~~(5)~~ For fines that are upheld following administrative or judicial review, the violator shall pay the fine, plus interest at the rate as specified in s. 55.03, for each day beyond the date set by the agency for payment of the fine.

(7)~~(6)~~ Any unlicensed facility that continues to operate after agency notification is subject to a $1,000 fine per day.

(8)~~(7)~~ Any licensed facility whose owner or administrator concurrently operates an unlicensed facility shall be subject to an administrative fine of $5,000 per day.

(9)~~(8)~~ Any facility whose owner fails to apply for a change-of-ownership license in accordance with s. 400.412 and operates the facility under the new ownership is subject to a fine of $5,000.

(10)~~(9)~~ In addition to any administrative fines imposed, the agency may assess a survey fee, equal to the lesser of one half of the facility's biennial license and bed fee or $500, to cover the cost of conducting initial complaint investigations that result in the finding of a violation that was the subject

of the complaint or monitoring visits conducted under s. 400.428(3)(c) to verify the correction of the violations.

(11)~~(10)~~ The agency, as an alternative to or in conjunction with an administrative action against a facility for violations of this part and adopted rules, shall make a reasonable attempt to discuss each violation and recommended corrective action with the owner or administrator of the facility, prior to written notification. The agency, instead of fixing a period within which the facility shall enter into compliance with standards, may request a plan of corrective action from the facility which demonstrates a good faith effort to remedy each violation by a specific date, subject to the approval of the agency.

(12)~~(11)~~ Administrative fines paid by any facility under this section shall be deposited into the Health Care Trust Fund and expended as provided in s. 400.418.

(13)~~(12)~~ The agency shall develop and disseminate an annual list of all facilities sanctioned or fined $5,000 or more for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of Elderly Affairs, the Department of Health, the Department of Children and Family Services, the area agencies on aging, the Florida Statewide Advocacy Council, and the state and local ombudsman councils. The Department of Children and Family Services shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of

printing and postage to other interested parties requesting a copy of this list.

Section 6. Paragraph (k) of subsection (1) of section 400.441, Florida Statutes, is amended to read:

400.441 Rules establishing standards.--

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of Children and Family Services, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which must include reasonable and fair minimum standards in relation to:

(k) The use of physical or chemical restraints. Restraints shall not be used for discipline or convenience. Assistive devices that are ~~The use of physical restraints is limited to half-bed rails as~~ prescribed or approved and documented by the resident's physician with the consent of the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact are not restraints for purposes of this section. The use of chemical restraints is limited to prescribed dosages of medications

authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

Section 7. Subsection (1) of section 400.557, Florida Statutes, is amended to read:

400.557 Expiration of license; renewal; conditional license or permit.--

(1) A license issued for the operation of an adult day care center, unless sooner suspended or revoked, expires 2 years after the date of issuance. The agency shall notify a licensee ~~by certified mail, return receipt requested,~~ at least 120 days before the expiration date that license renewal is required to continue operation. The notification must be provided electronically or by mail delivery. At least 90 days prior to the expiration date, an application for renewal must be submitted to the agency. A license shall be renewed, upon the filing of an application on forms furnished by the agency, if the applicant has first met the requirements of this part and of the rules adopted under this part. The applicant must file with the application satisfactory proof of financial ability to operate the center in accordance with the requirements of this part and in accordance with the needs of the participants to be served and an affidavit of compliance with the background screening requirements of s. 400.5572.

Section 8. Subsection (3) of section 400.619, Florida Statutes, is amended to read:

400.619 Licensure application and renewal.--

(3) The agency shall notify a licensee at least 120 days before the expiration date that license renewal is required to continue operation. The notification must be provided electronically or by mail delivery. Application for a license or annual license renewal must be made on a form provided by the agency, signed under oath, and must be accompanied by a licensing fee of $100 per year.

Section 9. Subsection (4) of section 400.980, Florida Statutes, is reenacted and amended to read:

400.980 Health care services pools.--

(4) Each applicant for registration must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 1 standards for screening set forth in chapter 435, of every individual who will have contact with patients. The agency shall require background screening of the managing employee or other similarly titled individual who is responsible for the operation of the entity, and of the financial officer or other similarly titled individual who is responsible for the financial operation of the entity, including billings for services in accordance with the level 2 standards for background screening as set forth in chapter 435.

(b) The agency may require background screening of any other individual who is affiliated with the applicant if the agency has a reasonable basis for believing that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care or assisted living licensure requirements of this state is acceptable in fulfillment of paragraph (a).

(d) A provisional registration may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check but the agency has not yet received background screening results from the Federal Bureau of Investigation. A standard registration may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and if a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and controlling

interests under the Medicaid or Medicare programs may be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 which was committed by a member of the board of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization who serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation's or organization's board of directors, and has no financial interest and no family members having a financial interest in the corporation or organization, if the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A registration may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

~~(h) The provisions of this section which require an applicant for registration to undergo background screening shall stand repealed on June 30, 2001, unless reviewed and saved from repeal through reenactment by the Legislature.~~

(h)~~(i)~~ Failure to provide all required documentation within 30 days after a written request from the agency will result in denial of the application for registration.

(i)~~(j)~~ The agency must take final action on an application for registration within 60 days after receipt of all required documentation.

(j)~~(k)~~ The agency may deny, revoke, or suspend the registration of any applicant or registrant who:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or

2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

3. Fails to comply with this section or applicable rules.

4. Commits an intentional, reckless, or negligent act that materially affects the health or safety of a person receiving services.

Section 10. Section 408.061, Florida Statutes, is amended to read:

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

(1) The agency may require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties. Specifications for data to be collected under this section shall be developed by the agency with the assistance of technical advisory panels including representatives of affected entities, consumers,

purchasers, and such other interested parties as may be determined by the agency.

(a) Data to be submitted by health care facilities may include, but are not limited to: case-mix data, patient admission or discharge data with patient and provider-specific identifiers included, actual charge data by diagnostic groups, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information.

(b) Data to be submitted by health care providers may include, but are not limited to: Medicare and Medicaid participation, types of services offered to patients, amount of revenue and expenses of the health care provider, and such other data which are reasonably necessary to study utilization patterns.

(c) Data to be submitted by health insurers may include, but are not limited to: claims, premium, administration, and financial information.

(d) Data required to be submitted by health care facilities, health care providers, or health insurers shall not include specific provider contract reimbursement information. However, such specific provider reimbursement data shall be reasonably available for onsite inspection by the agency as is necessary to carry out the agency's regulatory duties. Any such data obtained by the agency as a result of onsite inspections

may not be used by the state for purposes of direct provider contracting and are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(e) A requirement to submit data shall be adopted by rule if the submission of data is being required of all members of any type of health care facility, health care provider, or health insurer. Rules are not required, however, for the submission of data for a special study mandated by the Legislature or when information is being requested for a single health care facility, health care provider, or health insurer.

(2) The agency shall, by rule, after consulting with appropriate professional and governmental advisory bodies and holding public hearings and considering existing and proposed systems of accounting and reporting utilized by health care facilities, specify a uniform system of financial reporting for each type of facility based on a uniform chart of accounts developed after considering any chart of accounts developed by the national association for such facilities and generally accepted accounting principles. Such systems shall, to the extent feasible, use existing accounting systems and shall minimize the paperwork required of facilities. This provision shall not be construed to authorize the agency to require health care facilities to adopt a uniform accounting system. As a part of such uniform system of financial reporting, the agency may require the filing of any information relating to the cost to the provider and the charge to the consumer of any service provided in such facility, except the cost of a physician's services which is billed independently of the facility.

(3) When more than one licensed facility is operated by the reporting organization, the information required by this section shall be reported for each facility separately.

(4)~~(a)~~ Within 120 days after the end of its fiscal year, each health care facility, excluding continuing care facilities and nursing homes as defined in s. 408.07(14) and (36), shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. ~~Nursing homes that do not participate in the Medicare or Medicaid programs shall also submit audited actual experience.~~ Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

~~(b) Each nursing home shall also submit a schedule of the charges in effect at the beginning of the fiscal year and any changes that were made during the fiscal year. A nursing home which is certified under Title XIX of the Social Security Act and files annual Medicaid cost reports may substitute copies of such reports and any Medicaid audits to the agency in lieu of a report and audit required under this subsection. For such~~

~~facilities, the agency may require only information in compliance with this chapter that is not contained in the Medicaid cost report. Facilities that are certified under Title XVIII, but not Title XIX, of the Social Security Act must submit a report as developed by the agency. This report shall be substantially the same as the Medicaid cost report and shall not require any more information than is contained in the Medicare cost report unless that information is required of all nursing homes. The audit under Title XVIII shall satisfy the audit requirement under this subsection.~~

(5) In addition to information submitted in accordance with subsection (4), each nursing home shall track and file with the agency, on a form adopted by the agency, data related to each resident's admission, discharge, or conversion to Medicaid; health and functional status; plan of care; and other information pertinent to the resident's placement in a nursing home.

~~(6) Any nursing home which assesses residents a separate charge for personal laundry services shall submit to the agency data on the monthly charge for such services, excluding drycleaning. For facilities that charge based on the amount of laundry, the most recent schedule of charges and the average monthly charge shall be submitted to the agency.~~

(6)~~(7)~~ The agency may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of this chapter.

(7)~~(8)~~ Portions of patient records obtained or generated by the agency containing the name, residence or business address, telephone number, social security or other identifying number, or photograph of any person or the spouse, relative, or

guardian of such person, or any other identifying information which is patient-specific or otherwise identifies the patient, either directly or indirectly, are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(8)~~(9)~~ The identity of any health care provider, health care facility, or health insurer who submits any data which is proprietary business information to the agency pursuant to the provisions of this section shall remain confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. As used in this section, "proprietary business information" shall include, but not be limited to, information relating to specific provider contract reimbursement information; information relating to security measures, systems, or procedures; and information concerning bids or other contractual data, the disclosure of which would impair efforts to contract for goods or services on favorable terms or would injure the affected entity's ability to compete in the marketplace. Notwithstanding the provisions of this subsection, any information obtained or generated pursuant to the provisions of former s. 407.61, either by the former Health Care Cost Containment Board or by the Agency for Health Care Administration upon transfer to that agency of the duties and functions of the former Health Care Cost Containment Board, is not confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Such proprietary business information may be used in published analyses and reports or otherwise made available for public disclosure in such manner as to preserve the confidentiality of the identity of the provider. This exemption shall not limit the use of any

information used in conjunction with investigation or enforcement purposes under the provisions of s. 456.073.

(9)~~(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 or for the release of such data by the agency as authorized by this chapter.

(10)~~(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 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.

(11)~~(12)~~ The agency shall cooperate with local health councils and the state health planning agency with regard to

health care data collection and dissemination and shall cooperate with state agencies in any efforts to establish an integrated health care database.

(12)~~(13)~~ It is the policy of this state that philanthropic support for health care should be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system.

(13)~~(14)~~ For purposes of determining reasonable costs of services furnished by health care facilities, unrestricted grants, gifts, and income from endowments shall not be deducted from any operating costs of such health care facilities, and, in addition, the following items shall not be deducted from any operating costs of such health care facilities:

(a) An unrestricted grant or gift, or income from such a grant or gift, which is not available for use as operating funds because of its designation by the health care facility's governing board.

(b) A grant or similar payment which is made by a governmental entity and which is not available, under the terms of the grant or payment, for use as operating funds.

(c) The sale or mortgage of any real estate or other capital assets of the health care facility which the health care facility acquired through a gift or grant and which is not available for use as operating funds under the terms of the gift or grant or because of its designation by the health care facility's governing board, except for recovery of the appropriate share of gains and losses realized from the disposal of depreciable assets.

Section 11. Section 408.062, Florida Statutes, is amended to read:

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

(1) The agency shall have the authority to conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to, research and analysis relating to:

(a) The financial status of any health care facility or facilities subject to the provisions of this chapter.

(b) The impact of uncompensated charity care on health care facilities and health care providers.

(c) The state's role in assisting to fund indigent care.

(d) The availability and affordability of health insurance for small businesses.

(e) Total health care expenditures in the state according to the sources of payment and the type of expenditure.

(f) The quality of health services, using techniques such as small area analysis, severity adjustments, and risk-adjusted mortality rates.

(g) The development of physician payment systems which are capable of taking into account the amount of resources consumed and the outcomes produced in the delivery of care.

(h) The impact of subacute admissions on hospital revenues and expenses for purposes of calculating adjusted admissions as defined in s. 408.07.

~~(2) The agency 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 shall be included in an annual report to the Governor and Legislature by January 1 each year.~~

(2)~~(3)~~ The agency may assess annually the caesarean section rate in Florida hospitals using the analysis methodology that the agency determines most appropriate. To assist the agency in determining the impact of this chapter on Florida hospitals' caesarean section rates, each provider hospital, as defined in s. 383.336, shall notify the agency of the date of implementation of the practice parameters and the date of the first meeting of the hospital peer review board created pursuant to this chapter. The agency shall use these dates in monitoring any change in provider hospital caesarean section rates. An annual report based on this monitoring and assessment shall be submitted to the Governor, the Speaker of the House of Representatives, and the President of the Senate by the agency, with the first annual report due January 1, 1993.

(3)~~(4)~~ The agency may also prepare such summaries and compilations or other supplementary reports based on the information analyzed by the agency under this section, as will advance the purposes of this chapter.

(4)~~(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.

Section 12. Subsection (2) of section 408.831, Florida Statutes, is renumbered as subsection (3) and a new subsection (2) is added to said section to read:

408.831 Denial, suspension, or revocation of a license, registration, certificate, or application.--

(2) In reviewing any application requesting a change of ownership or change of the licensee, registrant, or certificate holder, the transferor shall, prior to agency approval of the

change, repay or make arrangements to repay any amounts owed to the agency. Should the transferor fail to repay or make arrangements to repay the amounts owed to the agency, the issuance of a license, registration, or certificate to the transferee shall be delayed until repayment or until arrangements for repayment are made.

Section 13. Subsection (1) of section 409.9116, Florida Statutes, is amended to read:

409.9116 Disproportionate share/financial assistance program for rural hospitals.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall administer a federally matched disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency shall make disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance payments to statutory rural hospitals that do not qualify for disproportionate share payments. The disproportionate share program payments shall be limited by and conform with federal requirements. Funds shall be distributed quarterly in each fiscal year for which an appropriation is made. 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) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program or the financial assistance program:

TAERH = (CCD + MDD)/TPD

Where:

CCD = total charity care-other, plus charity care-Hill-Burton, minus 50 percent of unrestricted tax revenue from local governments, and restricted funds for indigent care, divided by gross revenue per adjusted patient day; however, if CCD is less than zero, then zero shall be used for CCD.

MDD = Medicaid inpatient days plus Medicaid HMO inpatient days.

TPD = total inpatient days.

TAERH = total amount earned by each rural hospital.

In computing the total amount earned by each rural hospital, the agency must use the most recent actual data reported in accordance with s. 408.061(4)~~(a)~~.

Section 14. This act shall take effect upon becoming a law.