SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based only on the provisions contained in the legislation as of the latest date listed below.)

Date: February 9, 1998 Revised: 2/17/98

Subject: Regulation of Health Care Facilities

	Analyst	Staff Director	Reference	Action
1.	Carter	Wilson	HC	Favorable/CS
2.	Johnson	Deffenbaugh	BI	Fav/3 amendments
3.			WM	
4.				
5.				

I. Summary:

Committee Substitute for Senate Bill 314 abolishes the Health Care Board within the Agency for Health Care Administration, revises the duties of the Division of Health Policy and Cost Control within the agency to abolish its duties relating to hospital budget review, abolishes the hospital budget review process, repeals the authority for the Health Care Board to conduct data-based studies and evaluations relating to certain business practices of health care providers, transfers certain duties delegated to the Health Care Board to the agency, authorizes the agency to conduct data-based studies and evaluations relating to certain business practices of health care providers, and retroactively applies the repeal of hospital budget review to hospital budgets for fiscal years that ended during the 1996 calendar year. Additionally, the bill:

- Deregulates certain detached outpatient facilities from state construction and plan review under the hospital and ambulatory surgical center licensure law;
- Limits rulemaking authority relating to hospital emergency preparedness guidelines for hurricanes and other disasters to facilities constructed after July 1, 1999, and to new wings or floors added to existing facilities after July 1, 1999;
- Amends the Florida Patient's Bill of Rights and Responsibilities to include a requirement that health care providers give patients information on how to file a complaint with the appropriate state agency; clarifies that the Patient's Bill of Rights and Responsibilities applies to, in addition to health care providers treating a patient in an office, hospitals and ambulatory surgical centers that offer emergency and outpatient services, as well as inpatient services; and establishes administrative fines against health care providers for failure to advise patients of their rights and responsibilities;
- Amends peer review procedures that are applicable to hospitals;

- Amends the internal risk management program requirements applicable to hospitals and ambulatory surgical centers and revises pertinent definitions;

- Provides for a type two transfer of the health care risk manager licensure program from the Department of Insurance to the Agency for Health Care Administration; and

- Amends the statutory definition of "medical review committee" or "committee" to include physician-hospital organizations, provider-sponsored organizations, and integrated delivery systems.

This bill amends the following sections of the Florida Statutes: 20.42, 154.304, 240.4076, 381.026, 381.0261, 394.4787, 394.4788, 395.0163, 395.0193, 395.0197, 395.1055, 395.401, 395.602, 395.701, 400.051, 408.05, 408.061, 408.062, 408.063, 408.07, 408.08, 408.40, 409.2673, 409.905, 409.9113, 440.13, 458.331, 459.015, 468.505, 641.55, 766.101, and 766.1115.

The bill renumbers section 626.941, and renumbers and amends sections 626.942, 626.943, 626.944, and 626.945, Florida Statutes.

The bill repeals sections 395.002(2) and (15), 395.403(9), 395.806(3), 407.61, 408.003, 408.072, and 408.085, Florida Statutes.

II. Present Situation:

HEALTH CARE BOARD

Section 20.42(2), F.S., places the Health Care Board ("HCB" or "board") under the Agency for Health Care Administration ("AHCA" or "agency"). The board is delegated responsibility for hospital budget review, nursing home financial analysis, and special studies. The Health Care Board was first established under the Department of Insurance as the Hospital Cost Containment Board in 1979 by the Health Care Cost Containment Act of 1979, ch. 79-106, L.O.F. The board, as indicated by its name, was initially focused exclusively on hospitals. It was required to develop a uniform system of financial reporting for hospitals. Hospitals were required to submit financial and accounting data to the board and the board was authorized to review hospital budgets, rates, and charges. Hospital budget review was enacted with the regulatory objective of controlling the rate of increase in health care costs related to hospitalization. By regulating the projected increases in spending, hospital budget review was expected to directly affect the charges hospitals assessed insurers and patients, thereby controlling health care costs as influenced by hospital charges.

The board was authorized to disseminate to the public information on hospital rates and charges and was authorized to hold public hearings on certain hospital budgets. Chapter 82-182, Laws of Florida, provided legislative intent for broadening the board's scope beyond just hospital costs.

For instance, the board was authorized to study the effects of third-party reimbursements on health care costs. In 1984, the Legislature expanded the scope and responsibilities of the board in ch. 84-35, L.O.F., the Health Care Access Act. That Act also transferred the Hospital Cost Containment Board from the Department of Insurance to the Office of the Governor and the board's budget review authority was expanded to create a prospective budget review and approval program for hospitals with fiscal years that began on or after February 1, 1985. In ch. 85-298, L.O.F., the Legislature expanded the board's responsibilities to include the collection and analysis of financial and resident information from nursing homes. The board was required to establish a uniform system of financial reporting for nursing homes and to publish nursing home charge information for the public. However, the board was not delegated budget review and approval authority over nursing homes.

In 1987, the Hospital Cost Containment Board was transferred from the Office of the Governor to the Department of Health and Rehabilitative Services under ch. 87-92, L.O.F. (The Department of Health and Rehabilitative Services was redesignated as the Department of Children and Family Services in 1996 by ch. 96-403, L.O.F.) In ch. 88-394, L.O.F., the board was renamed the Health Care Cost Containment Board to reflect the expansion of the board's responsibilities beyond hospital costs. The hospital budget review process was changed, the data collection activities of the board were expanded, and the consumer education and assistance programs were also expanded.

Section 409.2673, F.S., provides for shared county and state reimbursement to hospitals for health care services rendered to certain low-income persons and the Health Care Cost Containment Board establishes the definition of charity care which is used in determining which hospitals can participate in the program. Section 409.9113, F.S., provides for a Medicaid disproportionate share program for teaching hospitals. The Health Care Cost Containment Board is responsible for supplying the mathematical indexes and factors for calculating a portion of the Medicaid payments relating to reimbursement for medical trainees to the teaching hospitals.

Section 440.13, F.S., prohibits reimbursement under the workers' compensation law for fees and other charges for treatment, care, and attendance delivered by a hospital or other health care provider that exceeds the amounts authorized by the uniform schedule of maximum reimbursement allowances. A three-member panel (consisting of representatives of the Insurance Commissioner, or designee, and two members appointed by the Governor) is responsible for establishing the uniform schedule. The three-member panel is required to consider the most recent average maximum allowable rate of increase for hospitals as determined by the Health Care Board in the development of the uniform schedule of maximum reimbursement allowances. In addition to regulating hospital revenues, the board also collects data on hospital net operating revenues which were the basis for the Department of Health and Rehabilitative Services' hospital assessments for the Public Medical Assistance Trust Fund.

Chapter 91-112, Laws of Florida, extended Public Medical Assistance Trust Fund assessments to four other types of health care providers: clinical laboratories, ambulatory surgical centers, diagnostic imaging centers, and radiation therapy treatment centers. Making these providers

subject to the assessment significantly expanded the board's data collection activities to include over 800 health care facilities.

Chapter 92-33, L.O.F., abolished the Health Care Cost Containment Board and provided for joint exercise of its powers, duties, and functions by the Agency for Health Care Administration and the newly created Health Care Board, both of which were created under ch. 92-33, L.O.F. However, the Health Care Board was assigned exclusive jurisdiction over a revised hospital budget review process and some health care provider and consumer assistance cost containment programs. Subsequently, ch. 93-129, L.O.F., provided for joint jurisdiction over hospital budget review between the Division of Health Policy and Cost Control and the Health Care Board.

Under its delegated authority to conduct special studies, the Health Care Cost Containment Board contracted for a study of certain business practices of health care providers that resulted in the Patient Self-Referral Act of 1992, s. 455.654, F.S., (formerly s. 455.236, F.S.), which prohibits the referral of patients to services in which the referring health care provider has a financial interest without prior disclosure to the patient of such an interest. Furthermore, referral of patients to most of the targeted services, i.e., "designated health services"--clinical laboratory services, physical therapy services, comprehensive rehabilitative services, diagnostic imaging services, and radiation therapy services--by health care providers with a financial interest in the service is prohibited effective October 1, 1994, although certain health care providers of designated health services were allowed to continue these otherwise prohibited referrals until October 1, 1996, as provided in section 15 of ch. 93-129, L.O.F. Section 407.61, F.S., authorizes the Health Care Board to collect provider referral data.

HOSPITAL BUDGET REVIEW

When the budget review process began, most hospital reimbursement was based on what the hospital charged or claimed as its costs. Managed care was virtually nonexistent. Presently, fixed-rate reimbursement by health maintenance organizations, preferred provider organizations, and insurers (including the Medicaid and Medicare programs) is increasingly common and is both a private-sector and public-sector mechanism for controlling health care costs. Medicare and Medicaid currently make up most of the fixed-price payer reimbursement. Under the Health Care and Insurance Reform Act of 1993 the legislature adopted a policy that encourages the expansion of managed care and negotiated fixed-price payment for health care services through creation of the community health purchasing alliances (CHPAs). Also, the 1993 Reform Act: expresses legislative intent, codified as s. 409.9121, F.S., that all Medicaid recipients be enrolled in a managed care program, to the extent permitted by federal law; directs AHCA, in s. 409.9122, F.S., to “investigate the feasibility of developing managed care programs” for certain specified groups of Medicaid recipients; and requires AHCA to encourage “public and private partnerships to foster the growth of health maintenance organizations and prepaid health plans.”

The hospital budget review law was moved from chapter 407, F.S., to s. 408.072, F.S., in 1992 by chapter 92-33, Laws of Florida. As designed, hospital budget review requires a hospital, to submit a budget letter at least 90 days before the start of its next fiscal year that acknowledges its

permissive (thus, calculated in accordance with the statutory formula) maximum allowable rate of increase (MARI) in gross and net revenues per adjusted admission. However, a hospital that budgets to exceed its MARI in its next fiscal year must receive approval from the board to implement such a budget. The board is required to subject a hospital that requests permission to exceed its MARI to detailed budget review. Requests must be filed with the board on forms that it adopts and in accordance with the uniform system of financial reporting using audited financial statements.

ENTITIES SUBJECT TO REGULATION BY THE HEALTH CARE BOARD AND RELATED PROVISIONS OF LAW

Chapter 395, F.S., provides for state regulation of hospitals and ambulatory surgical centers. Trauma services, which are a certain type of specialized hospital service, are regulated under s. 395.401, F.S. Hospitals are required to report to the HCB all charity care or uncompensated charity care rendered through, among others, trauma services, as provided in paragraph 395.401(1)(b), F.S. Section 395.701, F.S., imposes an assessment of 1.5 percent of the annual net operating revenue for each hospital to fund public medical assistance to pay for health care services rendered by hospitals to persons unable to pay for it. Assessments are deposited into the Public Medical Assistance Trust Fund. The Health Care Board is authorized to fine or penalize hospitals that fail to comply with, or otherwise violate, the assessment requirement. Section 395.801, F.S., directs the HCB, in consultation with the State University System Board of Regents, to calculate an allocation fraction to be used for distributing funds from the Medical Education and Tertiary Care Trust Fund. Section 395.806, F.S., requires AHCA to create a separate hospital budget review category for family practice teaching hospitals for purposes of Health Care Board review.

CONSTRUCTION, PLAN REVIEW, AND DISASTER SHELTERS

Chapter 395, F.S., contains standards relating to architectural and construction requirements for hospitals and ambulatory surgical centers. The agency's Office of Plans and Construction utilizes architects and registered engineers to perform the reviews authorized under subsection 395.0163(1), F.S. Subsection 395.0163(1), F.S., requires AHCA, through its Office of Plans and Construction or by other arrangement, to make construction inspections and investigations of the hospital and ambulatory surgical center physical plant facilities as the agency deems necessary. Section 395.0163, F.S., provides a statutory time frame that requires AHCA to approve or disapprove plans and specifications submitted for review within 60 days after receipt of a non-refundable $2,000 initial review fee, which is to be submitted along with the plans and specifications. Other fees may be assessed by the agency in conjunction with plans and specification reviews; these fees are payable upon receipt of an agency invoice.

Section 395.1055, F.S., provides the general rulemaking authority for the Agency for Health Care Administration under chapter 395, F.S. This provision directs the agency to adopt and enforce rules that provide reasonable and fair minimum standards for licensure of hospitals and ambulatory surgical centers. At present, paragraph 395.1055(1)(d), F.S., requires the agency to

adopt regulations that ensure that all facilities regulated under chapter 395, F.S., are structurally capable of serving as shelters and equipped to be self-supporting during and immediately following disasters.

Chapter 93-211, Laws of Florida, broadened the authority of the agency relating to emergency management requirements for hospitals and ambulatory surgical centers. Until this legislation was enacted, AHCA only had authority to require such health care facilities to have available for implementation an emergency management plan that would adequately protect patient care and safety. However, section 24 of chapter 93-211, Laws of Florida, deleted the reference to an emergency management plan and added to the agency's rulemaking authority a requirement that the agency adopt and enforce rules to ensure that hospitals and ambulatory surgical centers are structurally capable of serving as shelters and equipped to be self-supporting during and immediately following disasters. The law, in its broadest interpretation could reasonably be understood to obligate hospitals and ambulatory surgical centers to provide shelter accommodations for their respective communities as well as their patients.

Implementation of this statutory authority would require significant renovations of existing hospitals and ambulatory surgical centers to meet various engineering, architectural, and other modification requirements. Also, costs associated with meeting the requirements of the law for newly constructed facilities could be significant.

Hospital-owned facilities which are regulated under s. 395.0163, F.S., also are subject to local building code regulation. Yet, the same type facility being constructed in the same city by a physician or other non-hospital entity is subject only to local building code regulation. This is significant because both state and local reviews, of necessity, involve delays during the construction cycle. The State review adds another layer of costs for hospital-owned projects, creates an additional layer of delays for hospital-owned projects (cumulative to local code review), and is, generally, more cumbersome than local code review because of architectural and engineering standards that have been used to modify the State Minimum Building Codes AHCA enforces. Therefore, identical facilities are reviewed under what has developed into a bifurcated review system that is based on the ownership of the facility and not the services rendered at the facility.

The Office of Program Performance and Governmental Accountability (OPPAGA) issued Report No. 96-66, *Review of the Office of Plans and Construction Within the Agency for Health Care Administration* (March 1997). In that report, OPPAGA concluded that:

- Reviews and inspections performed by the Agency for Health Care Administration overlap the scope of some local reviews and inspections; but, the overlap may be a subtle and inseparable part of the process.

- State regulation of some facilities may be unnecessary and the agency proposes exempting these facilities, saving the regulated industry about $60,000 per year.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Section 381.026, F.S., establishes the Florida Patient's Bill of Rights and Responsibilities. Sections 381.026 and 381.0261, F.S., provide that patients have a right to express grievances to the appropriate state licensing agency regarding alleged violations of patient rights. Further, patients have the right to know procedures for expressing grievances to their health care provider or health care facility. Acknowledgment of patient responsibilities in receiving health care services and for the payment of health-related charges are also provided. No sanctions are authorized for violation of a patient's rights as provided under the Florida Patient's Bill of Rights and Responsibilities.

INTERNAL RISK MANAGEMENT

As a licensure requirement, each hospital and ambulatory surgical center is required, at a minimum, under s. 395.0197, F.S., to establish an internal risk management program. Such a program is considered to be part of what is known as the quality assurance process that hospitals and ambulatory surgical centers use in their day-to-day operations to ensure that "adverse incidents," service-related accidents, and patient dissatisfaction are conscientiously examined on a continuous basis. (Health maintenance organizations and other health care providers are also required to establish similar quality assurance programs under other provisions of law.) At a minimum, an internal risk management program must provide for: 1) the investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients; 2) the development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including specifying the circumstances under which staff may have access to patients in a recovery room subject to alternative surveillance measures; 3) the analysis of patient grievances that relate to patient care and the quality of medical services; and 4) the development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed facility to report adverse incidents.

The governing board is responsible for the internal risk management program. The board is required to engage a risk manager to implement and oversee the program. Risk managers are exempted from liability and legal action for activities they undertake in implementing an internal risk management program that is in conformity with law as long as they are not intentionally fraudulent in their conduct.

A plan-of-action, based on filing of incident reports with the risk manager or a specifically designated person, must be adopted to correct or prevent the future occurrence of the same or similar events. Each hospital and ambulatory surgical center must report within 15 working days certain specified adverse or untoward incidents that occur in the facility or that arise from health care prior to admission in the facility. These reports are not available to the public, except that a health care professional against whom probable cause of violation of the law has been established, upon written request, may obtain the records on which the determination of probable cause was made.

The Agency for Health Care Administration, in consultation with the Department of Insurance, is delegated authority to adopt rules that govern the establishment of internal risk management programs. As specified under s. 395.0197, F.S., each licensed facility must submit an annual report to the agency summarizing the incident reports filed in the facility that year. The agency is required to publish an annual report containing certain specified data that summarizes the information in the various annual reports and serious incident reports submitted by the licensed facilities throughout that year. Any facility that violates the reporting requirements is subject to a maximum $5,000 administrative penalty assessable by AHCA. Persons who maliciously or intentionally seek to discredit or harm a facility or another person or who make a false allegation of sexual misconduct against a member of a facility's personnel are guilty of a second degree misdemeanor.

The agency is authorized access to all facility records necessary to investigate a reported incident. However, any reports or records generated from such an investigation are unavailable to the public, except that a health care professional against whom probable cause of violation of the law has been established, upon written request, may obtain the records on which the determination of probable cause was made.

In 1985, the Legislature delegated the Department of Insurance regulatory jurisdiction over health care risk managers under ch. 85-175, L.O.F., codified as part IX of chapter 626, F.S. Part IX of chapter 626, F.S., authorizes the Insurance Commissioner to appoint a five-member health care risk manager advisory council to advise the department of issues relating to that profession. Additionally, this part specifies: 1) powers and duties of the department with respect to health care risk managers; 2) qualifications of health care risk managers; 3) grounds for disciplinary actions against a health care risk manager's license; and 4) administrative sanctions.

III. Effect of Proposed Changes:

Sections 1-4 and 8-20. Repeal s. 408.003, F.S., that establishes the HCB, and s. 408.072, F.S., that provides for review of hospital budgets and delete references throughout the Florida Statutes to the HCB or the Health Care Cost Containment Board, the predecessor entity to the HCB; hospital budget review; and the terms used by the HCB relating to hospital budget review. These sections of the bill also provide for transfer of duties from the Board to AHCA, including authority to conduct data-based studies and evaluations relating to certain business practices of health care providers. The repeal of hospital budget review is applied retroactively to any hospital budget prepared for a fiscal year that ended during the 1996 calendar year.

Section 5. Amends subsection 395.0163(1), F.S., which provides for regulation of hospital and ambulatory surgical center construction plans and other construction-related activities, to specify that all outpatient facilities that provide surgical treatments requiring general anesthesia or IV conscious sedation, that provide cardiac catheterization services, or that are to be licensed as ambulatory surgical centers must submit plans and specifications to AHCA for review. However, plans and specifications relating to the construction or alteration of outpatient facilities that are physically detached from the hospital on whose campus it is located, have no utility connections

with the hospital, and do not block emergency egress from or create a fire hazard to the hospital are exempted from review. The deregulation of plans and specifications review as provided in this section apply to all applications pending review on or after July 1, 1998. Presently, non-hospital owned facilities are not required to submit plans to AHCA. This provision would allow outpatient facilities, owned by hospitals, to be exempt from AHCA's review, if the facility did not provide certain services enumerated in the bill.

Sections 6 and 7. Amends s. 395.1055, F.S., to revise AHCA's rulemaking and enforcement authority with respect to emergency preparedness (primarily targeting hurricanes) for hospitals. The agency's authority is restricted to new facilities and new wings and floors added to an existing facility after July 1, 1999. Also, the facilities may serve as shelters for only patients, staff, and families of staff and patients. The agency, along with input from affected persons, is required to submit a report of its recommendations for cost-effective renovation standards for existing facilities by April 1, 1998, to the Governor and the Legislature.

Sections 21 and 22. Amend ss. 381.026 and 381.0261, F.S., providing for the Florida Patient's Bill of Rights and Responsibilities. Section 381.026, F.S., is amended to require health care providers who treat patients in hospitals or ambulatory surgical centers licensed under chapter 395, F.S., that provide emergency services and care or outpatient services and care to a patient to make available to such a patient a written statement of the rights and responsibilities of patients that includes certain specified information.

Section 381.0261, F.S., providing for preparation and distribution of a summary of the patient's bill of rights, is amended to: 1) require health care providers and health care facilities to provide patients with information, if requested, about the state agencies responsible for responding to complaints about alleged provider or facility noncompliance with licensure requirements; 2) require health care providers and facilities to adopt policies and procedures that ensure inpatients are provided the opportunity during their hospital stay to be informed of their rights and how to file a complaint with the facility and the appropriate state regulatory agencies; and 3) authorize AHCA to impose an administrative fine on a health care provider or health care facility for failure to make available to patients a summary of their rights as required by law. An initial nonwillful violation shall be subject to corrective action and is not subject to an administrative fine.

The agency is authorized to levy, applying certain standards specified in subsection (5), an administrative fine against a health care facility of up to $5,000 for nonwillful violations of the requirement to make available to patients a summary of their rights, and an administrative fine of up to $25,000 for intentional and willful violations, with each intentional and willful violation constituting a separate offense. Additionally, the agency is authorized to levy, applying certain standards specified in subsection (5), an administrative fine against a health care provider of up to $100 for nonwillful violations of the requirement to make available to patients a summary of their rights, and an administrative fine of up to $500 for willful violations; each willful violation constitutes a separate violation that is subject to a separate fine.

Section 24. Amends s. 395.0193, F.S., providing regulatory requirements pertaining to peer review and disciplinary actions in hospitals and ambulatory surgical centers and the relationships between medical staff and hospitals to: 1) specify that the enumerated grounds for discipline are not the only grounds for discipline of a practitioner; 2) delete a requirement that hospital or ambulatory surgical center governing board disciplinary action procedures must conform with standards established by various accreditation organizations, the Medicare/Medicaid Conditions of Participation, AHCA rules, and HRS rules; 3) delete a requirement that disciplinary action procedures be adopted as provided in hospital bylaws; 4) require hospitals and ambulatory surgical centers, in accordance with statutory guidelines relating to the reporting of physician disciplinary actions, to report to AHCA within 30 days after the initial occurrence, regardless of pendency of appeals, any disciplinary action taken against a physician having staff or clinical privileges with the facility, and to report all final disciplinary actions that differ from initial disciplinary actions within 10 working days; 5) expand the list of parties absolved of liability for actions taken without intentional fraud relating to disciplinary proceedings involving a physician's staff or clinical privileges in a hospital or ambulatory surgical center to include a committee of a hospital; 6) require AHCA to "first seek to obtain" corrective action for a single incident or a series of isolated incidents that are nonwillful violations of the reporting requirement relating to disciplinary actions against physicians prior to levying an administrative fine; 7) authorize a fine of up to $5,000 per violation for failure to meet time frames for implementing corrective action, or if there is a pattern of nonwillful violations of this section, nonwillful violations may be sanctioned by administrative fines of up to $10,000 per violation, and intentional and willful violations are sanctionable up to $25,000 per day to a maximum of $250,000; and 8) expand the list of parties whose investigations, proceedings, and records relating to health care professionals are made unavailable for discovery or introduction into evidence in civil and administrative actions to include a committee of a hospital.

Sections 23 and 25. Amend ss. 395.002 and 395.0197, F.S., relating to internal risk management programs. Section 395.002, F.S., providing definitions relating to hospital and ambulatory surgical center regulation, is amended to repeal the definition of the terms: "adverse or untoward incident" and "injury."

Section 395.0197, F.S., providing standards for internal risk management programs in hospitals and ambulatory surgical centers, is amended to: (1) define the term "adverse incident"; (2) expand the adverse incidents subject to investigation and analysis to include all such occurrences; (3) require agents and employees of hospitals and ambulatory surgical centers to report adverse incidents, through such facilities' statutorily required incident reporting system, to the facility's risk manager, or the risk manager's designee, within 3 business days after the occurrence of the incident; and (4) require licensed facilities to notify AHCA of certain specified adverse incidents within 1 business day after the facility's risk manager has determined that such adverse incidents have occurred, whether prior to admission or following admission of a patient to the facility.

The annual notification reports to AHCA are confidential and are not available to the public, pursuant to s. 119.07(1), F.S., or any other law providing access to public records. (Senate Bill 316 makes this notification exempt from the Public Records Law). The report is not discoverable

or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. The section is further amended to: 1) require that certain adverse incidents be reported to AHCA within 15 calendar days; 2) change the term "adverse or untoward incident" to "adverse incident" and define that term for purposes of facility-submitted annual summary reports, facility notification to AHCA of certain adverse incidents, and facility reporting to AHCA of certain adverse incidents; and 3) authorize AHCA to grant extensions exceeding 15 days for the reporting of adverse incidents upon justification submitted in writing by the facility administrator. The reporting requirement relating to disciplinary action against medical staff is cross-referenced to s. 395.0193, F.S., as modified in this bill, and language providing for such reporting under internal risk management program requirements is deleted.

The bill further amends the internal risk management program requirements to: 1) expand the alternative surveillance measures for staff access to patients in a recovery room to apply to ambulatory surgical centers as well as hospitals by changing reference to "hospitals" to "licensed facilities"; 2) relocate within the same subsection language relating to notification of family members or a guardian of a victim that allegations of sexual misconduct have been made and are being investigated; and 3) include minors within a definition of "sexual abuse" used in this section. Provisions pertaining to sanctions are revised to 1) mandate that AHCA require a written plan of corrective action from a facility in addition to any penalty imposed; 2) authorize AHCA to levy an administrative fine of up to $5,000 per violation for failure to meet time frames of an agreed to corrective action, or if there is a pattern of nonwillful violations of this section, nonwillful violations may be sanctioned by administrative fines of up to $10,000 per violation, and intentional and willful violations are sanctionable up to $25,000 per day to a maximum of $250,000; and 3) require AHCA to include summary information in its annual incident report relating to hospital and ambulatory surgical center practitioner disciplinary actions reported to AHCA. A reference to "serious incident reports" and to "serious incidents" is deleted since the terminology has become obsolete.

Sections 26-30, and 42. Renumber ss. 626.941, 626.942, 626.943, 626.944, and 626.945, F.S., as ss. 395.10971, 395.10972, 395.10973, 395.10974, and 395.10975, F.S., respectively, effective January 1, 1999, and amends these sections to: 1) make various technical revisions that conform these statutory provisions to reflect AHCA's regulatory authority over the licensure of health care risk managers as transferred from the Department of Insurance to AHCA; 2) authorize a Type II transfer of all powers, duties, rules, records, property, personnel and unexpended balances of appropriations, or other funds from the Department of Insurance to AHCA for the health care risk manager licensure program; 3) provide for application fees of no more than $75, a fingerprinting fee of no more than $75, a license fee of no more than $100; 4) authorize rulemaking for AHCA to establish fees and procedures for the issuance, biennial renewal, and cancellation of risk manager licenses; and 5) delete obsolete language.

Section 31. Amends s. 766.101, F.S., providing for immunity from liability for medical review committees, to include within the meaning of the term "medical review committee" or

"committee" a committee of a physician-hospital organization, provider-sponsored organization, and an integrated delivery system.

Sections 32-41. Correct cross references and make other technical and conforming changes.

Section 43. Provides for an appropriation of $100,281 from the Health Care Trust Fund to AHCA and one full-time equivalent position is authorized for the administration of the provisions of the bill.

Section 44. Provides a July 1, 1998, effective date, except as otherwise specified in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

This bill includes changes to provisions that currently exempt certain information from disclosure under the Public Records Law. These provisions relate to incident reports required under the internal risk management program that hospitals and ambulatory surgical centers must maintain, as provided under s. 395.0197, F.S. Senate Bill 316 is the "linked" bill that revises the related public records exemption in accordance with the requirements of Subsection 24(a) of Article I of the Florida Constitution. The provisions have no impact on open meetings issues under the requirements of Subsection 24(b) of Article I of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

No tax impact; however, see Private Sector Impact Section for discussion of fee impact.

B. Private Sector Impact:

Repeal of the hospital budget review requirement will eliminate hospital costs associated with the budget review and approval process and reporting requirements. To comply with the

budget review process and minimize the possibility of being sanctioned with penalties, most hospitals over the years have engaged financial advisors or accountants, attorneys, and staff, who specialize in filing requirements and who monitor budget-related developments throughout the budget year.

Hospitals will realize some cost savings from deregulated construction plan review. Private sector entities may realize a significant savings to the extent that they decide to pursue building or purchasing detached outpatient facilities that are currently subject to the regulatory requirements of chapter 395, F.S. The savings would result from avoidance of costs under s. 395.0163, F.S., which authorizes AHCA to charge a non-refundable $2,000 fee for initial review of plans and construction on all projects. Also, an additional fee that may not exceed 1 percent of the estimated construction cost or the actual cost of review, whichever is less, may be charged for inspection activities relating to initial review through the initial revised construction document review. Furthermore, the agency is authorized to collect its actual costs on all reviews and construction inspections subsequent to the initial revised construction document review.

The estimated fiscal impact of administrative fines that AHCA will be authorized to impose on hospitals and ambulatory surgical centers that fail to comply with reporting requirements relating to disciplinary action against physicians and incident reporting under internal risk management programs and health care providers who fail to advise patients of their rights and responsibilities relating to the Florida Patient's Bill of Rights and Responsibilities law are indeterminate.

Presently, health care risk managers seeking initial licensure incur a fee totaling $119 (initial application and a background screening) and $40 for a biennial renewal fee. The bill authorizes the agency to impose an initial application fee of not more than $75 and a fingerprinting fee of not more than $75, and a renewal fee of not more than $100.

C. Government Sector Impact:

The state should realize actual savings as a result of the elimination of costs associated with the HCB and hospital budget review. Repeal of hospital budget review is expected to reduce AHCA's workload by the equivalent of one FTE. Estimated expenditures related to that position are $47,905 for FY 1998-1999.

AHCA estimates that deregulation of plans and construction reviews, as provided in this bill, will reduce such review revenue by approximately $80,000 annually. The projected fee-generated revenue reduction is based on previous years' experiences of approximately 1,000 hours of work annually that will be eliminated and the current plan review fee of $80 per hour. This bill will not impact revenue collection or directly influence the work load of local governmental authorities that arise from their enforcement of construction and fire safety regulations.

The agency projects that two full-time equivalent position will be needed to administer the transferred licensure program for health care risk managers.

Expenditures	Amount Year 1 (FY 98-99)	Amount Year 2 (FY 99-00)
Salaries and Benefits (2 FTEs) Health Facilities and Services Consultant Supervisor	$57,261	$57,261
Operations and Management Consultant Manager	$53,713	$53,713
Total Salaries and Benefits for 2 FTEs	$110,974	$110,974
Expense (Agency Standard Package) for 2 FTEs 2 Professional Staff @ $11,057 per FTE	$22,114	$22,114
Recurring background screening costs	$4,500	$4,500
Total Recurring Expenses for 2 FTEs	$26,614	$26,614
Total Recurring Expenditures	$137,588	$137,588
Total Nonrecurring Expenditures	$10,598	

According to the Department of Insurance, there are no full-time equivalent positions or "capital equipment" associated with this program. However, the department estimates that the Insurance Commissioner's Regulatory Trust Fund will experience the following estimated loss of revenues (application fees, screening fees, and renewal fees) due to the transfer to AHCA:

1998-99	1999-00	2000-01
($87,615)	($96,377)	($105,015)

VI. Technical Deficiencies:

None.

VII. Related Issues:

The Legislature enacted Senate Bill 356 during the 1996 Regular Session, providing for deregulation of some hospital and outpatient facility construction plan reviews. However, the Governor vetoed this legislation on May 30, 1996, for the following stated reasons.

> By the authority vested in me as Governor of Florida, under the provisions of Article III, Section 8, of the Constitution of the State of Florida, I do hereby withhold my approval of and transmit to you with my objections, Senate Bill 356, enacted during the 28th

Session of the Legislature since the Constitution of 1968, during the Regular Session of 1996, and entitled:

An act relating to outpatient facilities; . . .

This legislation deregulates hospital outpatient facilities from the Agency for Health Care Administration's plans and construction review process. Although the agency will continue to review licensed ambulatory surgical centers, it will not have authority to review comparable outpatient surgery centers operated by licensed hospitals. While I would agree to exempt hospital outpatient facilities which do not provide surgery, this bill goes too far and can place patients at risk. Through construction review, the state ensures that acceptable electrical and medical gas systems are in place to safely support the medical and surgical procedures in such a way to protect patient safety.

The bill creates an inequitable system of review between hospital outpatient facilities and the non-hospital surgical centers. As a proponent generally of deregulation, we can address this issue again next session and correctly deregulate the non-surgical hospital outpatient facilities if either is to be deregulated.

VIII. Amendments:

#1 by Banking and Insurance:
This is a technical amendment that replaces the phrase “is able to” with “can.”

#2 by Banking and Insurance:
This is a technical amendment that clarifies when a hospital must file an adverse incident notice.

#3 by Banking and Insurance:
This amendment specifies that the penalties (fines) for violating risk management requirements, such as failing to report an adverse incident within 15 days, does not apply to the one day notice requirement for secified serious incidents.