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HOUSE OF REPRESENTATIVES
AS FURTHER REVISED BY THE COMMITTEE ON
HEALTH CARE STANDARDS AND REGULATORY REFORM
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: CS/CS/CS/HB 349

RELATING TO: Regulation of Health Care Facilities

SPONSOR(S): Committee on Health Care Standards & Regulatory Reform, Committee on Health & Human Services Appropriations, Committee on Health Care Standards & Regulatory Reform, Representatives Saunders and Murman

COMPANION BILL(S): CS/SB 314 (s), CS/HB 3311 (c), HB 3565(c), SB 316 (c), SB 714 (c), SB 1060(c)

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:
(1) HEALTH CARE STANDARDS & REGULATORY REFORM YEAS 6 NAYS 0
(2) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 10 NAYS 0
(3) HEALTH CARE STANDARDS AND REGULATORY REFORM YEAS 7 NAYS 0

I. SUMMARY:

CS/CS/CS/HB 349 eliminates the hospital review program and the Health Care Board. All other functions of the Health Care Board are transferred to the Agency for Health Care Administration (agency). All of the activities transferred to the agency are already being performed by agency staff. The bill removes the Health Care Board's oversight function.

The bill authorizes the agency to conduct studies and make recommendations to the Legislature and the Governor regarding the effectiveness of limitations of referrals, restrictions on investment interests and compensation arrangements, and the public disclosure.

The bill amends hospital and ambulatory surgical center physical plant requirements so that only new facilities or new additions to existing facilities must comply with the rules promulgated by the agency to ensure that these facilities are structurally capable of serving as shelters and equipped to be self-supporting during and immediately following disasters. It also states that these facilities must provide shelter during emergency situations only for patients, staff, and families of staff. The bill will allow medical facilities normally reviewed as business occupancies to be exempt from review by the agency when they are not attached or located in such close proximity to the hospital facility that they will be a fire/life safety hazard to the facility. It further clarifies those facilities which will continue to be reviewed.

An appropriation of 1 FTE and $100,281 is provided to administer the provisions of the Act.

This bill was carried over to the 1998 Session pursuant to House Rule 96, referred to the Health and Human Services Appropriations Committee, and referred back to the Committee on Health Care Standards and Regulatory Reform.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

Paragraph 20.42(2)(d), 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 board was first established under the Department of Insurance as the Hospital Cost Containment Board in 1979 by chapter 79-106, Laws of Florida, the Health Care Cost Containment Act of 1979. 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 empowered to disseminate to the public information on hospital rates and charges and was authorized to hold public hearings on certain hospital budgets. The only regulatory control under this scheme was the political pressure brought on hospitals through public exposure of their higher-than-average charges and rates. Chapter 82-182, Laws of Florida, provided legislative intent for broadening the board's scope beyond that of 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 Chapter 84-35, Laws of Florida, 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 Chapter 85-298, Laws of Florida, 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 moved from the Office of the Governor to the Department of Health and Rehabilitative Services under Chapter 87-92, Laws of Florida. In Chapter 88-394, Laws of Florida, 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.

Under its delegated authority to conduct special studies, the 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., 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, physical therapy, comprehensive rehabilitative, diagnostic imaging, and radiation therapy services--by health care providers with a financial interest in the service is absolutely prohibited effective October 1, 1994, although certain health care providers of designated health services could continue these otherwise prohibited referrals until October 1,1996, as provided in section 15 of Chapter 93-129, Laws of Florida. Section 407.61, F. S., authorizes the board to collect provider referral data.

Chapter 92-33, Laws of Florida, provided for joint exercise of the powers, duties, and functions of the former Health Care Cost Containment Board, which had been administratively located in the Department of Health and Rehabilitative Services, by the agency and the newly created Health Care Board, both of which were created under Chapter 92-33, Laws of Florida. However, the board was assigned exclusive jurisdiction over a revised hospital budget review process and some health care provider and consumer assistance cost containment programs. Subsequently, in 1993, Chapter 93-129, Laws of Florida, provided for joint jurisdiction over hospital budget review between the Division of Health Policy and Cost Control and the Health Care Board.

Section 409.2673, F. S., provides for shared county and state reimbursement to hospitals for health care services rendered to certain low-income persons. Section 409.9113, F. S., provides for a Medicaid disproportionate share program for teaching hospitals. The 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 of fees and other charges for such treatment, care, and attendance provided by a hospital or other health care provider from exceeding the amounts provided by the uniform schedule of maximum reimbursement allowances or the most recent average maximum allowable rate of increase for hospitals, as determined by the board. In addition to regulating hospital revenues, the board also collected 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 involve over 800 health care facilities.

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 non-existent. 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 state 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.” In fact, the heading for s. 409.9122, F. S., is “Mandatory Medicaid managed care enrollment.” As a consequence, the hospital industry considers the impact of fixed-price reimbursement for hospital services to have rendered the regulation of gross revenues "fruitless."

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. 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 in accordance with the uniform system of financial reporting using audited financial statements.

Chapter 395, F. S., provides the authority under which hospitals and ambulatory surgical centers are regulated. 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 board is empowered with the authority to fine or penalize hospitals that fail to comply with, or otherwise violate, the assessment requirement.

Under s. 395.0197, F.S., each hospital and ambulatory surgical center, as a licensure requirement, must, at a minimum, under s. 395.0197, Florida Statutes, 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, ambulatory surgical centers, and other health care providers (for example, health maintenance organizations) 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. Minimally, 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 responsibility for the internal risk management program is with the governing board. The board is required to hire 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 so 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, 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. 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.

B. EFFECT OF PROPOSED CHANGES:

The bill eliminates the hospital budget review process. Hospitals will be free to annually increase their gross or net revenue per adjusted admission in excess of the current allowable rates of increase.

The bill transfers language from Chapter 407, F.S., to Chapter 408, F.S.; with this transfer, the previous authority for the Health Care Cost Containment Board to conduct studies specifically focused on the effectiveness of limitations on referrals, effectiveness of restrictions on investment interests and compensation arrangements, and effectiveness of public disclosure, is added to the agency's current authority to conduct research, analyses, and studies, as provided in s. 408.062, F.S.

The bill requires that only new facilities and a new wing or floor added to an existing facility after July 1, 1998, must meet the standards to be structurally capable as serving as shelters and equipped to be self-supporting during and immediately following disasters.

It further restricts those for whom the health care facility must shelter to specify only the patients, staff, and families of patients and staff. It does not prohibit the health care facility from making and abiding by other transfer agreements with county or private facilities.

The bill requires that the agency shall work with those affected by this act and shall report to the Governor and Legislature by March 1, 1999, its recommendations for cost-effective renovation standards for existing facilities.

Certain detached outpatient facilities are exempted from review by the agency, such as medical walk-in clinics, cardiac rehabilitation clinics, sports medicine facilities, physical and occupational rehabilitation facilities, MRI facilities, radiographic facilities, outpatient psychiatric facilities, non-surgical endoscopy facilities, renal dialyses facilities, senior health centers, and workers' compensation centers, as long as they do not adversely effect the fire/life safety of the hospital. Facilities providing procedures which render patients incapable of self- preservation such as surgical treatments requiring general anesthesia, I.V., sedation, or cardiac catheterization will still be subject to review. The bill does not specifically require ambulatory surgical centers to be reviewed, whether or not they use general anesthesia. It is not clear that all outpatient facilities not detached require review.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

   a. Does the bill create, increase or reduce, either directly or indirectly:

      (1) any authority to make rules or adjudicate disputes?

      The bill eliminates the hospital budget review program and the Health Care Board.

      (2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

      N/A

      (3) any entitlement to a government service or benefit?

      N/A

   b. If an agency or program is eliminated or reduced:

      (1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

      Aside from the hospital budget review program, all other functions of the Health Care Board are transferred to the agency.

      (2) what is the cost of such responsibility at the new level/agency?

      Indeterminate.

      (3) how is the new agency accountable to the people governed?

      N/A

2. Lower Taxes:

   a. Does the bill increase anyone's taxes?

   N/A

b. Does the bill require or authorize an increase in any fees?

N/A

c. Does the bill reduce total taxes, both rates and revenues?

N/A

d. Does the bill reduce total fees, both rates and revenues?

The bill removes hospitals from the budget review process and the possibility of cash fines.

e. Does the bill authorize any fee or tax increase by any local government?

N/A

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

N/A

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

N/A

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

The bill eliminates government regulation and increases corporate freedom.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

N/A

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

STATUTES AFFECTED:

Chapters 20, 154, 212, 240, 381, 394, 395, 400, 408, 409, 440, 458, 459, 468, 625, 626, 641 and 766, F.S.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Amends s. 20.42(2)(b), (d), and (e), and (6) and (7), F.S., to eliminate the Health Care Board and the hospital budget review program.

Section 2. Amends s. 154.304(1), and (8), F.S., to shift the responsibility for defining hospital charity care, as used in the Health Care Responsibility Act for Indigents, from the Health Care Board to the agency.

Section 3. Amends s. 154.306(4), F.S., to shift responsibility for health care for indigent persons from the Health Care Board to the agency.

Section 4. Amends s. 154.312, F.S., to shift the responsibility for procedures for settlement of disputes as it relates to health care for indigent persons from the Health Care Board to the agency.

Section 5. Amends s. 394.4788(2) and (3), F.S., to transfer the responsibility for calculating the rate of reimbursement for inpatient mental health services from PMATF funds, from the Health Care Cost Containment Board to the agency. The calculations are based on the annual audit cost reports submitted by each hospital to the agency.

Section 6. Amends s. 395.0163(1), F.S., to require outpatient facilities that provide surgical treatments requiring general anesthesia or intravenous conscious sedation or that provide cardiac catheterization services shall submit plans and specification to the agency for review.

Section 7. Amends s. 395.1055(1)(d), F.S., to require only new facilities or those with a new wing or floor added to an existing facility after July 1, 1999 must serve as shelters.

Section 8. Requires the agency to work with those affected by this act and to report to the Governor and Legislature by March 1, 1999, with recommendations for cost-effective renovation standards.

Section 9. Amends s. 395.401(1)(a) and (b), F.S., to specify the agency as being the Agency for Health Care Administration.

Section 10. Amends s. 395.403(6) (b), F.S., to transfer duties of the Health Care Board to the agency, as it relates to reimbursement of state-sponsored trauma centers.

Section 11. Amends s. 395.605(6), F.S., relating to emergency care hospitals, to transfer duties of the Health Care Board to the agency.

Section 12. Amends s. 395.701(1), (2), (3), and (4), F.S., to transfer the responsibility for certifying a hospital's net revenue for the purpose of determining the PMATF assessment from the Health Care Board and changes other references from department to agency.

Section 13. Amends s. 395.7015(3) (a), F.S., to transfer duties of the Health Care Board to the agency as it relates to annual assessment on health care entities.

Section 14. Amends s. 395.806(3), F.S., to transfer duties of the Health Care Board to the agency as it relates to designation of family practice teaching hospitals.

Section 15. Amends s. 408.05(1), (3)(e) and (f), (6), and (7)(c) and (d), F.S., related to the Center for Health Statistics, changing all references from department to agency.

Section 16. Amends s. 408.061(10) and (11), F.S., related to agency data collection activities, changing references from department or board to agency.

Section 17. Amends s. 408.062(2) and (5), F.S., changing the responsibility for nursing home data collection from the Health Care Board to the agency. Amends s. 408.062(5), F.S., to authorize the agency to conduct studies and make recommendations to the Legislature and Governor regarding the effectiveness of limitations on referrals, of restrictions on investment interests and compensation arrangements, and of public disclosure.

Section 18. Amends s. 408.063(1), F.S., shifting responsibility for dissemination of health care information from the Health Care Board to the agency.

Section 19. Amends s. 408.07, F.S., shifting all responsibilities for collecting hospital financial reports from the Health Care Board to the agency. Eliminates budget review, but maintains the hospital financial data reporting requirement.

Section 20. Amends s. 408.08, F.S., eliminating a reference to hospital budget review.

Section 21. Amends s. 408.40, F.S., eliminating a reference to hospital budget review.

Section 22. Amends s. 408.50(1), F.S., transferring the responsibilities of prospective payment arrangements from the Health Care Board to the agency.

Section 23. Amends s. 409.2673(10)(e) and (14), F.S., relating to the shared county and state program for low income persons. Transfers rule making responsibility from the Health Care Cost Containment Board to the agency.

Section 24. Amends s. 409.9113, F.S., transferring the responsibilities for making disproportionate share payments to teaching hospitals from the Department of Health and Rehabilitative Services to the agency. Transfers responsibility for computing the Service Index from the Health Care Board to the agency.

Section 25. Repeals ss. 395.403(9), 407.61, 408.003, 408.085, and 408.072, F. S., eliminating the budget review program.

Section 26. Retroactively applies the repeal of the hospital budget review program to any budget submitted to the agency by a hospital with a fiscal year end during the 1995 calendar year.

Section 27. Amends s. 381.026(6), F.S., providing a summary of the Florida Patient's Bill of Rights and Responsibilities.

Section 28, Amends s. 381.0261, F.S., providing the agency's requirements for administering the Patient's Bill of Rights.

Section 29. Repeals s. 395.002(2) and (15), F.S., relating to definitions for adverse incidents.

Section 30. Amends s. 395.0193(3), (4), (5), and (7), F.S., and renumbers.

Section 31. Amends s. 395.0197, F.S., relating to adverse incidents.

Section 32. Renumbers s. 626.941, F.S., as s. 395.10971, F.S., effective January 1, 1999.

Section 33. Renumbers s. 626.942, F.S., as s. 395.10972, F.S., effective January 1, 1999, and amends to designate the agency head as the designee for appointments for the Health Care Risk Manager Advisory Council instead of the Insurance Commissioner.

Section 34. Renumbers and amends s. 625.943, F.S., as s. 395.10973, F.S., clarifying the agency instead of the department as having authority over the Advisory Council.

Section 35. Renumbers and amends s. 626.944, F.S., as s. 395.10974, F.S., clarifying the agency instead of the department as having authority over the Advisory Council, and providing for application and licensure fees.

Section 36. Renumbers and amends s. 626.945, F.S., as s. 395.10975, F.S., clarifying the agency instead of the department.

Section 37. Amends s. 394.4787(7), F.S.; technical.

Section 38. Amends s. 395.602(2)(c), F.S.; technical.

Section 39. Amends s. 400.051(1)(b), F.S.; technical.

Section 40. Amends s. 409.905(8), F.S., technical.

Section 41. Amends s. 440.13(1)(g), F.S.; technical.

Section 42. Amends s. 458.331(9), F.S.; technical.

Section 43. Amends s. 459.015(9), F.S.; technical.

Section 44. Amends s. 468.505(1)(l), F.S.; technical.

Section 45. Amends s. 641.55(2), F.S., effective January 1, 1999; technical.

Section 46. Amends s. 766.1115(4)(c), F.S., technical.

Section 47. Provides that effective January 1, 1999, all functions currently under the Department of Insurance related to the health care risk manager licensure program (Chapter 626, Part IX, F.S.) are to be transferred by a type-two transfer to the Agency for Health Care Administration.

Section 48. Provides an appropriation of $100,218 in lump sum from the Health Care Trust Fund to the Agency for Health Care Administration to fund one full-time position to administer the provisions of the bill.

Section 49. Except as otherwise provided, the effective date of the bill is July 1 of the year in which enacted.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

Risk Managers Licensure Program
Section 48 of the bill contains an appropriation of one FTE and $100,281 from the Health Care Trust Fund to administer the provisions of the bill. The risk managers licensure program is being transferred from the Department of Insurance by TYPE II transfer. Under TYPE II transfer provisions, the Department of Insurance must

transfer all resources (FTE, equipment, revenues, trust fund balances, etc.) associated with the licensure program.

Agency for Health Care Administration (AHCA):

	FY 98-99	FY 99-2000
Expense (2 FTE X $2,132)	4,264	
Operating Capital Outlay (2 FTE X $3,167)	6,334	
Total Nonrecurring:	10,598	

Department of Insurance: -0-

2. Recurring Effects:

Risk Manager Licensure Program

	FY 98-99	FY 99-2000
Agency for Health Care Administration:		
Salaries and Benefits (1 FTE PG 26, 1FTE PG 25)	$110,974	$110,974
Expense (2 FTE X $13,189)	26,614	26,614
Total Recurring Expenditures:	$137,588	$137,588
Department of Insurance:	-0-	-0-

Budget Review Function

Agency for Health Care Administration:
(One FTE and related expenses may be reduced from the budget for elimination of the budget review function).

Salaries and Benefits (1 FTE Regulatory Analyst II)	$(36,848)	$(36,848)
Expense (1 FTE X $11,057)	(11,057)	(11,057)
Total Recurring Expenditures:	($47,905)	($47,905)

3. Long Run Effects Other Than Normal Growth:

None.

4. Total Revenues and Expenditures:

Total Expenditures for Budget Review and Licensure Programs (AHCA):	1 FTE	$100,281	$89,683

Total Revenues

	FY 98-99	FY 99-2000
Agency for Health Care Administration:		
Licensure Program*:	$77,860	11,900
Loss in facility plan review fees:	($80,000)	($80,000)

Revenues from licenses will fund only a portion of the risk manager licensure program in AHCA. The balance of the revenues needed ($70,326 in FY- 99 and $125,688 in FY- 2000) will come from surplus revenues from hospital and ambulatory service center licensure fees. The amount of accumulated revenues from license fees, if any, to be transferred with the program from the Department of Insurance is not known at this time.

Department of Insurance:		
Licensure Program*	($77,860)	($11,900)

*Note: Revenues from risk manager fees are biennial. Revenues in FY-2000 are new licensees only.

Budget Review Function
Section 23 provides that the repeal of penalties is retroactive to hospitals with fiscal years ending in calendar year 1995. The agency reports that approximately $238,000 in penalties collected or currently owed are affected by the repeal of these sections. Revenues from penalties are deposited in the Public Medical Assistance Trust Fund (PMATF). To the extent that revenues to the PMATF are reduced, there may be an impact on General Revenue.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   N/A

2. Direct Private Sector Benefits:

   The cost savings to the industry should be minimal, as all reporting requirements except budget letters and budget amendments remain in place.

   This will aid the lessening of physical plant damage done by hurricanes and other disasters.

   Reduces Private Sector plan review fees.

3. Effects on Competition, Private Enterprise and Employment Markets:

   Indeterminate.

D. FISCAL COMMENTS:

The agency indicates that “repeal of hospital budget review provisions is premature at this time. In the face of increased mergers and consolidations in the hospital industry, the hospital budget review program acts as an important safety net to counteract potentially non-competitive pricing practices in highly consolidated markets for hospital services. The existing system is an exception-based approach and the limits on increases in hospital revenues are liberal enough to permit operation of hospital markets without extensive and intrusive budget regulation by the state. Only in the most extreme situations will the budget review process be triggered. If the future continues to demonstrate the price competitive nature of hospital markets, then repeal of hospital budget review would be appropriate.”

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

CS/CS/CS/HB 349 is a carryover bill from the 1997 Legislative Session. See comments below for the amendatory history of the bill.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The differences between the original bill and the first Committee Substitute by Health Care Standards and Regulatory Reform are:

- The Patient's Bill of Rights was strengthened to ensure that patients are provided information and instruction on the procedure for filing complaints;
- Current law was strengthened to improve facility reports of disciplinary action taken against physicians by a facility;
- Revisions were made to current law on risk management programs to streamline and clarify definitions of adverse incidents that are required to be reported to the agency. Current requirements for reporting the most serious incidents were strengthened to ensure that the agency is notified and can take appropriate response when necessary;
- The licensure program for healthcare risk managers was transferred from the Department of Insurance to the agency, to be administered in conjunction with the regulation of facility risk management programs in order to achieve administrative efficiencies and enhance the overall effectiveness of these regulatory programs; and

- Administrative fines were established to provide adequate and meaningful enforcement authority of quality care indicators in hospitals and ambulatory surgical centers.

The differences between the first committee substitute by the Health Care Standards and Regulatory Reform Committee and the second committee substitute by the Health & Human Services Appropriations Committee reflect technical changes as necessary to update the bill which has been carried forward from the 1997 session. The only substantive change was an adjustment to the appropriation made to the Agency for Health Care Administration in Section 48 of the bill.

The differences between the second committee substitute by the Health & Human Services Committee and the third committee substitute by the Health Care Standards and Regulatory Reform Committee are:

A section relating to patient record copying fees was deleted;

Language was included which ensures that not only patients, but also their families, may be provided shelter in facilities during emergency situations; and

A number of technical changes were made.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE STANDARDS & REGULATORY REFORM:
Prepared by: Legislative Research Director:

Terri L. Paddon Robert W. Coggins

AS REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:
Prepared by: Legislative Research Director:

Eliza Hawkins Lynn S. Dixon

AS FURTHER REVISED BY THE COMMITTEE ON HEALTH CARE STANDARDS AND REGULATORY REFORM:

Prepared by: TERRI L. PADDON

Legislative Research Director: ROBERT W. COGGINS