By the Committee on Health Care Services and Representative Peaden

1 A bill to be entitled
2 An act relating to health care services;
3 amending s. 455.654, F.S.; providing
4 definitions of additional terms; creating s.
5 455.6545, F.S., relating to permitted outside
6 referrals to sole providers or group practices
7 for diagnostic imaging services; specifying the
8 circumstances under which referrals may occur
9 and to what extent; providing penalties;
10 amending ss. 408.704 and 641.316, F.S.;
11 correcting cross references; amending s.
12 817.505, F.S., relating to the definition of
13 the term "health care provider or health care
14 facility" for purposes of prohibited patient
15 brokering; specifying the applicability of the
16 provision to providers licensed by the
17 Department of Health; conforming a reference to
18 the Department of Children and Family Services;
19 directing the Agency for Health Care
20 Administration to conduct a study relating to
21 quality-of-care standards for group practices
22 providing designated health care services;
23 specifying study topics; authorizing the use of
24 a technical assistance panel; requiring a
25 report of findings and recommendations;
26 requiring a study by the Agency for Health Care
27 Administration, relating to outpatient
28 designated health care services; specifying
29 study topics; requiring certain providers to
30 register with the agency; requiring a report;
31 providing an effective date.

1 Be It Enacted by the Legislature of the State of Florida:
2
3 Section 1. Section 455.654, Florida Statutes, 1998
4 Supplement, is amended to read:
5 455.654 Financial arrangements between referring
6 health care providers and providers of health care services.--
7 (1) SHORT TITLE.--This section may be cited as the
8 "Patient Self-Referral Act of 1992."
9 (2) LEGISLATIVE INTENT.--It is recognized by the
10 Legislature that the referral of a patient by a health care
11 provider to a provider of health care services in which the
12 referring health care provider has an investment interest
13 represents a potential conflict of interest. The Legislature
14 finds these referral practices may limit or eliminate
15 competitive alternatives in the health care services market,
16 may result in overutilization of health care services, may
17 increase costs to the health care system, and may adversely
18 affect the quality of health care. The Legislature also
19 recognizes, however, that it may be appropriate for providers
20 to own entities providing health care services, and to refer
21 patients to such entities, as long as certain safeguards are
22 present in the arrangement. It is the intent of the
23 Legislature to provide guidance to health care providers
24 regarding prohibited patient referrals between health care
25 providers and entities providing health care services and to
26 protect the people of Florida from unnecessary and costly
27 health care expenditures.
28 (3) DEFINITIONS.--For the purpose of this section <u>and</u>
29 <u>s. 455.6545</u>, the word, phrase, or term:
30 (a) "Board" means any of the following boards relating
31 to the respective professions: the Board of Medicine as

1 created in s. 458.307; the Board of Osteopathic Medicine as
2 created in s. 459.004; the Board of Chiropractic Medicine as
3 created in s. 460.404; the Board of Podiatric Medicine as
4 created in s. 461.004; the Board of Optometry as created in s.
5 463.003; the Board of Pharmacy as created in s. 465.004; and
6 the Board of Dentistry as created in s. 466.004.
7 (b) "Comprehensive rehabilitation services" means
8 services that are provided by health care professionals
9 licensed under part I or part III of chapter 468 or chapter
10 486 to provide speech, occupational, or physical therapy
11 services on an outpatient or ambulatory basis.
12 (c) "Designated health services" means, for purposes
13 of this section, clinical laboratory services, physical
14 therapy services, comprehensive rehabilitative services,
15 diagnostic-imaging services, and radiation therapy services.
16 (d) "Diagnostic imaging services" means magnetic
17 resonance imaging; nuclear medicine; angiography;
18 arteriography; computed tomography; positron emission
19 tomography; digital vascular imaging; bronchography;
20 lymphangiography; splenography; and ultrasound.
21 (e) "Direct supervision" means supervision by a
22 physician who is present in the office suite and immediately
23 available to provide assistance and direction throughout the
24 time services are being performed.
25 (f)(d) "Entity" means any individual, partnership,
26 firm, corporation, or other business entity.
27 (g)(e) "Fair market value" means value in arms length
28 transactions, consistent with the general market value, and,
29 with respect to rentals or leases, the value of rental
30 property for general commercial purposes, not taking into
31 account its intended use, and, in the case of a lease of

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1 space, not adjusted to reflect the additional value the
2 prospective lessee or lessor would attribute to the proximity
3 or convenience to the lessor where the lessor is a potential
4 source of patient referrals to the lessee.
5 (h) ~~(f)~~ "Group practice" means a group of two or more
6 health care providers legally organized as a partnership,
7 professional corporation, or similar association:
8 1. In which each health care provider who is a member
9 of the group provides substantially the full range of services
10 which the health care provider routinely provides, including
11 medical care, consultation, diagnosis, or treatment, through
12 the joint use of shared office space, facilities, equipment,
13 and personnel;
14 2. For which substantially all of the services of the
15 health care providers who are members of the group are
16 provided through the group and are billed in the name of the
17 group and amounts so received are treated as receipts of the
18 group; and
19 3. In which the overhead expenses of and the income
20 from the practice are distributed in accordance with methods
21 previously determined by members of the group.
22 (i) ~~(g)~~ "Health care provider" means any physician
23 licensed under chapter 458, chapter 459, chapter 460, or
24 chapter 461, or any health care provider licensed under
25 chapter 463 or chapter 466.
26 (j) ~~(h)~~ "Immediate family member" means a health care
27 provider's spouse, child, child's spouse, grandchild,
28 grandchild's spouse, parent, parent-in-law, or sibling.
29 (k) ~~(i)~~ "Investment interest" means an equity or debt
30 security issued by an entity, including, without limitation,
31 shares of stock in a corporation, units or other interests in

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1 a partnership, bonds, debentures, notes, or other equity
2 interests or debt instruments. The following investment
3 interests shall be excepted from this definition:
4 1. An investment interest in an entity that is the
5 sole provider of designated health services in a rural area;
6 2. An investment interest in notes, bonds, debentures,
7 or other debt instruments issued by an entity which provides
8 designated health services, as an integral part of a plan by
9 such entity to acquire such investor's equity investment
10 interest in the entity, provided that the interest rate is
11 consistent with fair market value, and that the maturity date
12 of the notes, bonds, debentures, or other debt instruments
13 issued by the entity to the investor is not later than October
14 1, 1996.
15 3. An investment interest in real property resulting
16 in a landlord-tenant relationship between the health care
17 provider and the entity in which the equity interest is held,
18 unless the rent is determined, in whole or in part, by the
19 business volume or profitability of the tenant or exceeds fair
20 market value; or
21 4. An investment interest in an entity which owns or
22 leases and operates a hospital licensed under chapter 395 or a
23 nursing home facility licensed under chapter 400.
24 (l)~~(j)~~ "Investor" means a person or entity owning a
25 legal or beneficial ownership or investment interest, directly
26 or indirectly, including, without limitation, through an
27 immediate family member, trust, or another entity related to
28 the investor within the meaning of 42 C.F.R. s. 413.17, in an
29 entity.
30 (m) "Outside referral for diagnostic imaging services"
31 means a referral of a patient to a group practice for

diagnostic imaging services by a physician who is not a member of the group practice and who does not have an investment interest in the group practice, for which the group practice billed for both the technical and the professional fee for the patient, and the patient did not become a patient of the group practice.

(n) "Patient of a group practice" means a patient who receives a physical examination, evaluation, diagnosis, and development of a treatment plan from a physician who is a member of the group practice.

(o)~~(k)~~ "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

1. The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service; or

2. The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

3. The following orders, recommendations, or plans of care shall not constitute a referral by a health care provider:

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and

1 equipment used in connection therewith to treat such patient
2 for cancer and the complications thereof.
3 d. By a cardiologist for cardiac catheterization
4 services.
5 e. By a pathologist for diagnostic clinical laboratory
6 tests and pathological examination services, if furnished by
7 or under the supervision of such pathologist pursuant to a
8 consultation requested by another physician.
9 f. By a health care provider who is the sole provider
10 or member of a group practice for designated health services
11 or other health care items or services that are prescribed or
12 provided solely for such referring health care provider's or
13 group practice's own patients, and that are provided or
14 performed by or under the direct supervision of such referring
15 health care provider or group practice.
16 g. By a health care provider for services provided by
17 an ambulatory surgical center licensed under chapter 395.
18 h. By a health care provider for diagnostic clinical
19 laboratory services where such services are directly related
20 to renal dialysis.
21 i. By a urologist for lithotripsy services.
22 j. By a dentist for dental services performed by an
23 employee of or health care provider who is an independent
24 contractor with the dentist or group practice of which the
25 dentist is a member.
26 k. By a physician for infusion therapy services to a
27 patient of that physician or a member of that physician's
28 group practice.
29 l. By a nephrologist for renal dialysis services and
30 supplies.
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1 (p)~~(1)~~ "Rural area" means a county with a population
2 density of no greater than 100 persons per square mile, as
3 defined by the United States Census.
4 (q) "Sole provider" means a health care provider
5 licensed under chapter 458, chapter 459, chapter 460, or
6 chapter 461, who maintains a medical practice separate from
7 any other health care provider and who bills for his or her
8 services separately from the services provided by any other
9 health care provider.
10 (4) PROHIBITED REFERRALS AND CLAIMS FOR
11 PAYMENT.--Except as provided in this section:
12 (a) A health care provider may not refer a patient for
13 the provision of designated health services to an entity in
14 which the health care provider is an investor or has an
15 investment interest.
16 (b) A health care provider may not refer a patient for
17 the provision of any other health care item or service to an
18 entity in which the health care provider is an investor
19 unless:
20 1. The provider's investment interest is in registered
21 securities purchased on a national exchange or
22 over-the-counter market and issued by a publicly held
23 corporation:
24 a. Whose shares are traded on a national exchange or
25 on the over-the-counter market; and
26 b. Whose total assets at the end of the corporation's
27 most recent fiscal quarter exceeded $50 million; or
28 2. With respect to an entity other than a publicly
29 held corporation described in subparagraph 1., and a referring
30 provider's investment interest in such entity, each of the
31 following requirements are met:

1 a. No more than 50 percent of the value of the
2 investment interests are held by investors who are in a
3 position to make referrals to the entity.
4 b. The terms under which an investment interest is
5 offered to an investor who is in a position to make referrals
6 to the entity are no different from the terms offered to
7 investors who are not in a position to make such referrals.
8 c. The terms under which an investment interest is
9 offered to an investor who is in a position to make referrals
10 to the entity are not related to the previous or expected
11 volume of referrals from that investor to the entity.
12 d. There is no requirement that an investor make
13 referrals or be in a position to make referrals to the entity
14 as a condition for becoming or remaining an investor.
15 3. With respect to either such entity or publicly held
16 corporation:
17 a. The entity or corporation does not loan funds to or
18 guarantee a loan for an investor who is in a position to make
19 referrals to the entity or corporation if the investor uses
20 any part of such loan to obtain the investment interest.
21 b. The amount distributed to an investor representing
22 a return on the investment interest is directly proportional
23 to the amount of the capital investment, including the fair
24 market value of any preoperational services rendered, invested
25 in the entity or corporation by that investor.
26 4. Each board and, in the case of hospitals, the
27 Agency for Health Care Administration, shall encourage the use
28 by licensees of the declaratory statement procedure to
29 determine the applicability of this section or any rule
30 adopted pursuant to this section as it applies solely to the
31 licensee. Boards shall submit to the Agency for Health Care

Administration the name of any entity in which a provider investment interest has been approved pursuant to this section, and the Agency for Health Care Administration shall adopt rules providing for periodic quality assurance and utilization review of such entities.

(c) No claim for payment may be presented by an entity to any individual, third-party payor, or other entity for a service furnished pursuant to a referral prohibited under this section.

(d) If an entity collects any amount that was billed in violation of this section, the entity shall refund such amount on a timely basis to the payor or individual, whichever is applicable.

(e) Any person that presents or causes to be presented a bill or a claim for service that such person knows or should know is for a service for which payment may not be made under paragraph (c), or for which a refund has not been made under paragraph (d), shall be subject to a civil penalty of not more than $15,000 for each such service to be imposed and collected by the appropriate board.

(f) Any health care provider or other entity that enters into an arrangement or scheme, such as a cross-referral arrangement, which the physician or entity knows or should know has a principal purpose of assuring referrals by the physician to a particular entity which, if the physician directly made referrals to such entity, would be in violation of this section, shall be subject to a civil penalty of not more than $100,000 for each such circumvention arrangement or scheme to be imposed and collected by the appropriate board.

(g) A violation of this section by a health care provider shall constitute grounds for disciplinary action to

1 be taken by the applicable board pursuant to s. 458.331(2), s.
2 459.015(2), s. 460.413(2), s. 461.013(2), s. 463.016(2), or s.
3 466.028(2). Any hospital licensed under chapter 395 found in
4 violation of this section shall be subject to the rules
5 adopted by the Agency for Health Care Administration pursuant
6 to s. 395.0185(2).
7 (h) Any hospital licensed under chapter 395 that
8 discriminates against or otherwise penalizes a health care
9 provider for compliance with this act.
10 (i) The provision of paragraph (a) shall not apply to
11 referrals to the offices of radiation therapy centers managed
12 by an entity or subsidiary or general partner thereof, which
13 performed radiation therapy services at those same offices
14 prior to April 1, 1991, and shall not apply also to referrals
15 for radiation therapy to be performed at no more than one
16 additional office of any entity qualifying for the foregoing
17 exception which, prior to February 1, 1992, had a binding
18 purchase contract on and a nonrefundable deposit paid for a
19 linear accelerator to be used at the additional office. The
20 physical site of the radiation treatment centers affected by
21 this provision may be relocated as a result of the following
22 factors: acts of God; fire; strike; accident; war; eminent
23 domain actions by any governmental body; or refusal by the
24 lessor to renew a lease. A relocation for the foregoing
25 reasons is limited to relocation of an existing facility to a
26 replacement location within the county of the existing
27 facility upon written notification to the Office of Licensure
28 and Certification.
29 (j) A health care provider who meets the requirements
30 of paragraphs (b) and (i) must disclose his or her investment
31 interest to his or her patients as provided in s. 455.701.

1 Section 2. Section 455.6545, Florida Statutes, is
2 created to read:
3 455.6545 Permitted outside referrals to sole providers
4 and group practices for diagnostic imaging
5 services.--Notwithstanding the provision of s. 455.654, a sole
6 provider or a group practice that has relied upon the
7 declaratory statements issued by the Board of Medicine in 1993
8 or in 1995 relating to referrals under s. 455.654 and that
9 accepted outside referrals for diagnostic imaging services may
10 be permitted to accept outside referrals for diagnostic
11 imaging services, provided the group practice or sole provider
12 meets the following requirements:
13 (1) The group practice or sole provider submits to the
14 Agency for Health Care Administration a report detailing the
15 number of outside referrals for diagnostic imaging services
16 the group or sole provider accepted, and the total number of
17 patients of the group practice or sole provider who received
18 diagnostic imaging services, for the timeframe which covers
19 the period of October 1, 1996, to September 30, 1997.
20 (2) The group practice or sole provider submits to the
21 Agency for Health Care Administration documentation, in a form
22 and manner to be specified by the agency, that the group
23 practice or sole provider relied upon the declaratory
24 statements issued by the Board of Medicine described in this
25 section, prior to accepting any outside referrals for
26 diagnostic imaging services.
27 (3) Upon receipt of the information required in
28 subsections (1) and (2), a percentage level of outside
29 referrals for diagnostic imaging shall be established for each
30 group practice or sole provider. The percentage level for
31 outside referrals shall be established by a fraction, the

1 numerator of which is the total number of outside referrals
2 for diagnostic imaging services and the denominator of which
3 is the total number of persons receiving diagnostic imaging
4 services from the group practice or sole provider from October
5 1, 1996, to September 30, 1997. Upon written authorization by
6 the Agency for Health Care Administration, group practices or
7 sole providers may accept outside referrals for diagnostic
8 imaging services so long as the annual percentage does not
9 exceed the maximum established by the agency.
10 (4) All other sole providers and group practices that
11 do not fall under the provisions of subsections (1), (2), and
12 (3) may accept referrals for diagnostic imaging services for
13 no more than 15 percent of their total number of patients who
14 receive diagnostic imaging services, provided the sole
15 providers and group practices meet the provisions of this
16 section. This subsection shall stand repealed effective June
17 30, 2001, unless specifically amended by a general act of the
18 Legislature prior to that date.
19 (5) All sole providers or group practices accepting
20 outside referrals for diagnostic imaging services are required
21 to comply with the following conditions.
22 (a) Diagnostic imaging services must be provided
23 exclusively by a sole provider or group practice physician or
24 by a full-time or part-time employee of the sole provider or
25 group practice.
26 (b) All equity in the group practice accepting outside
27 referrals for diagnostic imaging must be held by the
28 physicians comprising the group practice, each of whom must
29 provide at least 75 percent of his or her professional
30 services to the group.
31

1 (c) The sole provider or group practice accepting
2 outside referrals for diagnostic imaging may not be managed by
3 the same entity or any related entity that either owns,
4 manages, or otherwise has any interest in the sole provider or
5 group practice referring the patient.
6 (d) The sole provider or group practice accepting
7 outside referrals for diagnostic imaging services must bill
8 for both the professional and technical component of the
9 service on behalf of the patient and no portion of the
10 payment, or any type of consideration, either directly or
11 indirectly, may be shared with the referring physician.
12 (e) All diagnostic imaging services provided by the
13 sole provider or group practice are subject to the assessment
14 imposed pursuant to s. 395.7015.
15 (f) Sole providers or group practices that have a
16 Medicaid provider agreement with the Agency for Health Care
17 Administration must furnish diagnostic imaging services to
18 their Medicaid patients and may not refer a Medicaid recipient
19 to a hospital for outpatient diagnostic imaging services
20 unless the referring physician furnishes the hospital with
21 documentation demonstrating the medical necessity for such a
22 referral.
23 (6) If a sole provider or group practice accepts an
24 outside referral for diagnostic imaging services in violation
25 of this section or if, based upon compliance audit findings of
26 the agency, a sole provider or group practice has provided
27 false information in reporting required information to the
28 agency, the sole provider or all members of the group practice
29 shall be subject to discipline by the applicable board
30 pursuant to s. 458.331(2), s. 459.015(2), s. 460.413(2), s.
31 461.013(2), s. 463.016(2), or s. 466.028(2). Any sole provider

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1 or group practice that accepts outside referrals for
2 diagnostic imaging services in excess of the percentage
3 limitation established in subsection (3) or subsection (4) is
4 subject to a fine imposed by the Agency for Health Care
5 Administration of $10,000 for each patient over the applicable
6 percentage limitation.
7 Section 3. Paragraph (b) of subsection (5) of section
8 408.704, Florida Statutes, 1998 Supplement, is amended to
9 read:
10 408.704 Agency duties and responsibilities related to
11 community health purchasing alliances.--The agency shall
12 assist in developing a statewide system of community health
13 purchasing alliances. To this end, the agency is responsible
14 for:
15 (5)
16 (b) The advisory data committee shall issue a report
17 and recommendations on each of the following subjects as each
18 is completed. A final report covering all subjects must be
19 included in the final Florida Health Plan to be submitted to
20 the Legislature on December 31, 1993. The report shall
21 include recommendations regarding:
22 1. Types of data to be collected. Careful
23 consideration shall be given to other data collection projects
24 and standards for electronic data interchanges already in
25 process in this state and nationally, to evaluating and
26 recommending the feasibility and cost-effectiveness of various
27 data collection activities, and to ensuring that data
28 reporting is necessary to support the evaluation of providers
29 with respect to cost containment, access, quality, control of
30 expensive technologies, and customer satisfaction analysis.
31 Data elements to be collected from providers include prices,

1 utilization, patient outcomes, quality, and patient
2 satisfaction. The completion of this task is the first
3 priority of the advisory data committee. The agency shall
4 begin implementing these data collection activities
5 immediately upon receipt of the recommendations, but no later
6 than January 1, 1994. The data shall be submitted by
7 hospitals, other licensed health care facilities, pharmacists,
8 and group practices as defined in s. 455.654(3)(h)~~(f)~~.
9 2. A standard data set, a standard cost-effective
10 format for collecting the data, and a standard methodology for
11 reporting the data to the agency, or its designee, and to the
12 alliances. The reporting mechanisms must be designed to
13 minimize the administrative burden and cost to health care
14 providers and carriers. A methodology shall be developed for
15 aggregating data in a standardized format for making
16 comparisons between accountable health partnerships which
17 takes advantage of national models and activities.
18 3. Methods by which the agency should collect,
19 process, analyze, and distribute the data.
20 4. Standards for data interpretation. The advisory
21 data committee shall actively solicit broad input from the
22 provider community, carriers, the business community, and the
23 general public.
24 5. Structuring the data collection process to:
25 a. Incorporate safeguards to ensure that the health
26 care services utilization data collected is reviewed by
27 experienced, practicing physicians licensed to practice
28 medicine in this state;
29 b. Require that carrier customer satisfaction data
30 conclusions are validated by the agency;
31

1 c. Protect the confidentiality of medical information
2 to protect the patient's identity and to protect the privacy
3 of individual physicians and patients. Proprietary data
4 submitted by insurers, providers, and purchasers are
5 confidential pursuant to s. 408.061; and
6 d. Afford all interested professional medical and
7 hospital associations and carriers a minimum of 60 days to
8 review and comment before data is released to the public.
9 6. Developing a data collection implementation
10 schedule, based on the data collection capabilities of
11 carriers and providers.
12 Section 4. Paragraph (b) of subsection (2) and
13 subsection (6) of section 641.316, Florida Statutes, 1998
14 Supplement, are amended to read:
15 641.316 Fiscal intermediary services.--
16 (2)
17 (b) The term "fiscal intermediary services
18 organization" means a person or entity which performs
19 fiduciary or fiscal intermediary services to health care
20 professionals who contract with health maintenance
21 organizations other than a fiscal intermediary services
22 organization owned, operated, or controlled by a hospital
23 licensed under chapter 395, an insurer licensed under chapter
24 624, a third-party administrator licensed under chapter 626, a
25 prepaid limited health service organization licensed under
26 chapter 636, a health maintenance organization licensed under
27 this chapter, or physician group practices as defined in s.
28 455.654(3)(h)~~(f)~~.
29 (6) Any fiscal intermediary services organization,
30 other than a fiscal intermediary services organization owned,
31 operated, or controlled by a hospital licensed under chapter

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1 395, an insurer licensed under chapter 624, a third-party
2 administrator licensed under chapter 626, a prepaid limited
3 health service organization licensed under chapter 636, a
4 health maintenance organization licensed under this chapter,
5 or physician group practices as defined in s.
6 455.654(3)(h)~~(f)~~, must register with the department and meet
7 the requirements of this section. In order to register as a
8 fiscal intermediary services organization, the organization
9 must comply with ss. 641.21(1)(c) and (d) and 641.22(6).
10 Should the department determine that the fiscal intermediary
11 services organization does not meet the requirements of this
12 section, the registration shall be denied. In the event that
13 the registrant fails to maintain compliance with the
14 provisions of this section, the department may revoke or
15 suspend the registration. In lieu of revocation or suspension
16 of the registration, the department may levy an administrative
17 penalty in accordance with s. 641.25.
18 Section 5. Paragraph (a) of subsection (2) of section
19 817.505, Florida Statutes, 1998 Supplement, is amended to
20 read:
21 817.505 Patient brokering prohibited; exceptions;
22 penalties.--
23 (2) For the purposes of this section, the term:
24 (a) "Health care provider or health care facility"
25 means any person or entity licensed, certified, or registered
26 with the Agency for Health Care Administration or the
27 Department of Health; any person or entity that has contracted
28 with the Agency for Health Care Administration to provide
29 goods or services to Medicaid recipients as provided under s.
30 409.907; a county health department established under part I
31 of chapter 154; any community service provider contracting

with the Department of Children and Family ~~Health and Rehabilitative~~ Services to furnish alcohol, drug abuse, or mental health services under part IV of chapter 394; any substance abuse service provider licensed under chapter 397; or any federally supported primary care program such as a migrant or community health center authorized under ss. 329 and 330 of the United States Public Health Services Act.

Section 6. (1) The Agency for Health Care Administration is directed to study issues relating to the need for quality-of-care standards applicable to group practices providing designated health care services. Issues to be addressed in the scope of this study include, but are not limited to:

(a) The parameters of quality of care with respect to the provision of ancillary services by the respective entity.

(b) The need for periodic inspection of the facilities of the entities providing designated health care services for the purpose of evaluation of the premises, operation, supervision, and procedures of the entity.

(c) The extent to which requiring group practices providing designated health care services to participate in nationally recognized accrediting organizations would enhance quality assurance processes.

(d) An assessment of how group practices providing designated health care services ensure appropriate utilization of designated health care services in order to prevent overutilization of these services.

(2) The agency may convene a technical assistance panel for purposes of this study, representative of group practices providing designated health care services, group practices generally, various professional organizations

1 representing providers and hospitals, and representatives of
2 the public.
3 (3) The agency shall submit its findings and
4 recommendations to the Governor, the President of the Senate,
5 and the Speaker of the House of Representatives by January 15,
6 2000.
7 Section 7. The Agency for Health Care Administration
8 is directed to conduct a study of outpatient designated health
9 care services, and the referral patterns for such services.
10 (1) As part of the study, the agency shall require
11 registration by all persons, including sole providers,
12 physician group practices, hospitals, hospital-owned physician
13 practices and facilities, individuals, and corporations that
14 provide outpatient designated health care services.
15 Registration information must include the name of each
16 physician in the group; medical specialty of each physician;
17 address and phone number of the group; federal unique provider
18 identification number (UPIN) for each group member; Medicare,
19 Medicaid and commercial billing numbers for the group; include
20 all ownership interests in any designated services. The agency
21 shall complete the registration by December 31, 1999.
22 (2) The study, to be conducted over a 2-year period,
23 shall include, but not be limited to:
24 (a) An assessment of revenue and patient volumes,
25 including the number of actual diagnostic tests provided for
26 each of the outpatient designated health care services.
27 (b) Payer class data for outpatient designated health
28 care services provided, including Medicare, Medicaid, health
29 maintenance organization, preferred provider organization,
30 other insurance or third-party payer, bad debt, and charity.
31

1 (c) Number of outside referrals accepted by the
2 service provider for any deregulated designated health care
3 service, the volume of diagnostic tests or patient visits
4 associated with each such referral, and associated revenue by
5 payer class.
6 (d) An assessment of payment arrangements and referral
7 patterns between hospitals and hospital-owned physician
8 practices.
9
10 To the extent possible, necessary data for the study of these
11 issues may be extracted from information currently reported by
12 providers to the state for other purposes.
13 (3) As part of this study, the agency must attempt to
14 determine what trends have occurred or are occurring since the
15 original patient referral research was conducted during the
16 period of fiscal years 1989-1990 and 1990-1991. The agency
17 shall also review the provisions of s. 455.654, Florida
18 Statutes, and related provisions to determine the need to
19 modify these provisions as part of the study's findings and
20 recommendations. The agency shall prepare a report of its
21 findings and any recommendations to the Governor, the Speaker
22 of the House of Representatives, and the President of the
23 Senate by December 15, 2000. The study shall include a
24 determination of whether there are other items of outpatient
25 service that should be considered for exemption from the
26 requirements of s. 455.654, Florida Statutes.
27 Section 8. This act shall take effect July 1, 1999.
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HOUSE SUMMARY

Provides additional definitions relating to financial arrangements between health care providers and providers of health care services. Specifies requirements and limitations relating to referrals to sole providers or group practices for diagnostic imaging services. Provides for disciplinary action against a sole provider or members of a group practice for certain violations, and provides a $10,000 fine for each referral patient accepted over applicable percentage limitations. Updates and conforms references within the definition of "health care provider or health care facility" relating to prohibited patient brokering. Directs the Agency for Health Care Administration to conduct a study relating to quality-of-care standards for group practices providing designated health care services, authorizes a technical assistance panel therefor, and requires a report to the Governor and Legislature by January 15, 2000. Directs the agency to conduct a study relating to outpatient designated health care services and referral patterns therefor, requires certain providers to register specified information with the agency, and requires a report to the Governor and Legislature by December 15, 2000. See bill for details.