1988

Session Law 88-394

Florida Senate & House of Representatives

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I. SUMMARY:

A. Present Situation:

Chapter 395, part II, Florida Statutes, "Health Care Cost Containment Act of 1979" created the Hospital Cost Containment Board (board). In 1984, the board was given regulatory authority pursuant to the Health Care Access Act. The board is made up of 11 members appointed by the Governor and confirmed by the Senate. Members serve 3 year staggered terms and represent various groups including major purchasers of health care, providers of health care, consumers, and nursing homes.

The board has the responsibility for promoting competition among health care providers and providing a "safety net" of regulation in an effort to control increases in health care costs. These responsibilities are carried out by gathering and disseminating health care information to consumers, providing technical assistance to various health care groups and coalitions, advising the Legislature of trends and concerns in the health care area, and reviewing all hospital budgets and
## AGENDA

**Commerce**

Toni Jennings, Chairman  
Dempsey J. Barron, Vice-chairman

**DATE:** Monday, May 16, 1988  
**TIME:** 2:00 P.M. - 5:00 P.M.  
**PLACE:** Room A, Senate Office Building

**MEMBERS:**  
W. D. Childers  
Ander Crenshaw  
Timothy Deratany  
Jack Gordon  
Mattox Hair  
Richard H. Langley  
James A. Scott  
Pat Thomas

<table>
<thead>
<tr>
<th>BILL NO. AND INTRODUCER</th>
<th>BILL DESCRIPTION AND SENATE COMMITTEE ACTIONS</th>
<th>COMMITTEE ACTION</th>
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</table>
| 1 SB 0046 Malchon et al (Similar CS/H 0299) | Smoking/Public Places; provides for enforcement by H.R.S.; requires public agencies to report violations; provides enforcement procedures; provides for civil penalties; provides for exemptions & for adoption of rules, etc. Amends 386.203,.207. | HRS 04/12/88 FAVORABLE  
COM 05/16/88  
AP |
| 2 SB 0363 Jenne et al (Compare CS/H 0470) | Child Health Assurance Act; delays until 10/01/92, sunset of provisions which require certain individual & group, blanket, or franchise health insurance policies & health care services plan contracts to provide coverage for child health supervision services. Readopts 627.6416,.6579. | COM 05/16/88  
AP |
| 3 SB 0620 Hair (Similar H 0117, Compare H 0006-E, CS/ENG/H 0007-E) | Malpractice Risk Apportionment; increases amounts of per claim & annual aggregate protection required for health care providers other than hospitals re medical malpractice risk apportionment plans operated by Joint Underwriting Association. Amends 627.351. | COM 05/16/88  
AP |
| 4 SB 0704 Margolis (Identical H 0990) | Fla. Patient's Compensation Fund; provides that fund shall be considered political subdivision for purposes of intangible personal property tax exemption. Amends 768.54. | COM 05/16/88  
FTC |
| 5 SB 0748 Langley et al (Identical H 1079, Compare CS/CS/ENG/H 0819) | Medical Malpractice Cases/Limitation; specifies action which triggers statute of limitations in medical malpractice cases & provides for extension for certain purposes. Amends 95.11. | COM 05/16/88  
JCI |
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<tr>
<td>6 SB 0879 Commerce</td>
<td>Medical Incidents; creates Medical Quality Assurance Div. within Professional Reg. Dept.; places licensing boards for various health care professions within division; provides for disciplinary proceedings against hospitals; provides civil immunity &amp; prohibition from discharge to persons reporting re incompetence, impairment, or unprofessional conduct of specified health care providers; provides for assertion of psychiatrist-patient, etc. Amends F.S.</td>
<td>COM 05/16/88 AP</td>
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<td>7 SB 0904 Commerce</td>
<td>Health Care Cost Containment; (SUNSET) provides additional duties for Health Care Cost Containment Board; deletes obsolete language; provides immunity from civil liability &amp; criminal penalties for certain actions taken re reporting patient or financial data; conforms certain provisions to redesignations of Hospital Cost Containment Board &amp; Hospital Cost Containment Trust Fund, etc. Amends/revives/readopts 395.501-.515; amends various F.S. to conform.</td>
<td>COM 05/16/88 AP</td>
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<td>8 SB 1011 Crawford</td>
<td>Group Health Insurance/Limitations; authorizes group health insurance policies with specified limitations. Amends 627.6695.</td>
<td>COM 05/16/88</td>
</tr>
<tr>
<td>9 SB 1033 Girardeau</td>
<td>Medical Malpractice Insurance; provides for additional member on board of governors of Joint Underwriting Association. Amends 627.351.</td>
<td>COM 05/16/88</td>
</tr>
<tr>
<td>10 SB 1252 Jennings</td>
<td>Insurance/Required Information; authorizes Insurance Dept. to collect certain information; deletes certain provisions re excess profits, policyholder distributions, &amp; required filings by commercial casualty property &amp; commercial casualty insurers; modifies methods for calculating &amp; procedures for reporting excess profits for insurance groups writing workers' compensation &amp; employer's liability insurance, etc. Amends Chs. 624, 627.</td>
<td>COM 05/16/88</td>
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<td>11</td>
<td>SB 1167 Deratany</td>
<td>Sales Tax/Storage Buildings/Lease; exempts lease of certain storage buildings from tax on lease or rental of real property; provides that certain subleases of such property are taxable. Amends 212.031.</td>
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<td>12</td>
<td>SB 1375 Thurman et al (Similar CS/H 0718)</td>
<td>Preneed Funeral Merchandise Contract; revises definition of term &quot;preneed contract&quot;; provides that certificateholder is not required to disclose certain information in preneed contract form; declares that funds paid to certificateholder pursuant to preneed contract are sole property of certificateholder; declares that legal relationship between purchaser of preneed contract &amp; certificateholder is debtor-creditor relationship, etc. Amends Ch. 639.</td>
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<td>13</td>
<td>SB 1304 Grizzle (Identical H 0870)</td>
<td>Mini Cabinet Job Training Committee; provides legislative intent &amp; findings; creates Mini Cabinet Job Training Committee; provides purposes, membership &amp; duties; provides for administration; requires report to Governor &amp; Legislature; provides for expiration of committee; provides for state agency funding.</td>
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<tr>
<td>14</td>
<td>SB 0993 Hair (Similar CS/H 0307)</td>
<td>Judgments &amp; Settlements/Interest; revises interest rate used for judgments &amp; settlements between insurers &amp; other persons. Amends 55.03, 627.4265.</td>
</tr>
</tbody>
</table>
COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

5/16/88
(date)

Name PHIL BLANK

Address 204 B So. Monroe St

Representing FLA. PATIENT'S COMP FUND

Lobbyist (Registered with Senate) Yes ✓ No

Speaking: For ✓ Against Information

Subject

If state employee-- Time: from ________ .m. to ________ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)
COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

5/16/88
(date)

Name James J. Brachea

Address ______________________

Representing Hospital Cost Containment Board

Lobbyist (Registered with Senate) Yes X No

Speaking: For Against Information

Subject Hospital Cost Containment

If state employee-- Time: from _______ .m. to _______ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)

COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

Name Ed Kutter

Address Suite 800 Byratt Bank

Representing Human

Lobbyist (Registered with Senate) Yes X No

Speaking: For Against Information

Subject ______________________

If state employee-- Time: from _______ .m. to _______ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)
COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

5-16-88
(date) 5904
(Bill No.)

Name RICHARD N. BROCK

Address 1924 GOLFTERRACE, TALLAHASSEE 32301

Representing AMERICAN ASSOCIATION OF RETIRED PERSONS

Lobbyist (Registered with Senate) Yes       No

Speaking: For                      Against       Information

Subject HOSPITAL COST CONTAINMENT

If state employee-- Time: from_________ .m. to_________ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)

COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

5/12/88
(date) SB 904
(Bill No.)

Name DALE HAZLETT Gerald W. Wester

Address LARSON BCDF

Representing DEPT. OF INSURANCE

Lobbyist (Registered with Senate)       Yes       No

Speaking: For                      Against       Information

Subject SENIOR CHILDREN AD SEX THREAT AMENDMENT TO SB 904

If state employee-- Time: from_________ .m. to_________ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)
COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

5/16/88
(date) S.B. 904
(Bill No.)

Name Elizabeth Rothberg

Address 1025 Connecticut Ave., N.W., Washington, D.C. 20036

Representing Health Insurance Assoc. of America

Lobbyist (Registered with Senate) Yes ✓ No __

Speaking: For Against Information ✓

Subject

If state employee-- Time: from ________ .m. to ________ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)

COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

5/16/88 S.B. 904
(date) (Bill No.)

Name Frank Jackalow

Address 9317 Belvedere Rd., West Palm Beach, FL 33405

Representing Florida Consumers Federation

Lobbyist (Registered with Senate) Yes ✓ No __

Speaking: For Against Information ✓

Subject Hospital Cost Containment Board

If state employee-- Time: from ________ .m. to ________ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)
COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

Name: Lester Abberger
Address: PO Drawer 469, Tallahassee 32302
Representing: Florida Hospital

Lobbyist (Registered with Senate): Yes [ ] No [ ]
Speaking: For [ ] Against [ ] Information [ ]
Subject: ______________________________________________________________________

If state employee-- Time: from ________ .m. to ________ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)

COMMITTEE APPEARANCE RECORD
(Submit to Committee Chairman or Secretary)

Name: Ralph Glatfelter
Address: Suite 305, First Florida Bank Bldg.
Representing: Florida League of Hospitals

Lobbyist (Registered with Senate): Yes [ ] No [ ]
Speaking: For [ ] Against [ ] Information [ ]
Subject: ______________________________________________________________________

If state employee-- Time: from ________ .m. to ________ .m.

(State employees are required to file the first copy of this form with Committee Chairman unless appearance is requested by chairman as a witness or for informational purposes.)
Remarks by Chairman.

Staff presentations and discussion of proposed committee bills.

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<tr>
<td>1</td>
<td>Sunset Review</td>
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<td>PCB #9 by Commerce Committee relating to chapter 395, part II, Health Care Cost Containment.</td>
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<td>2</td>
<td>Sundown Review</td>
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<td></td>
<td>PCB #7 by Commerce Committee relating to section 20.16(4), Florida Pari-mutuel Commission.</td>
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I. SUMMARY:

A. PRESENT SITUATION:

**Indigent Care**

Chapter 87-92, Florida Statutes, provided major initiatives to fund and increase access to health care for indigents. Specifically, it enhanced the Medicaid program by: expanding eligibility to pregnant women and children up to age 2 with incomes up to 100 percent of the federal poverty level; phasing in coverage to children up to age 5 by 1991; expanding eligibility to elderly and disabled with incomes up to 90 percent of the poverty level; increasing Medicaid provider fees, providing for a phase-in of all physician fees by 1991 and providing special fees for obstetricians and neonatologists. The law also provided for funding for the second phase of the state/county primary care program network; allowed for the creation of independent special taxing districts by counties to fund indigent health care; and, provided for a redistribution of $69.5 million to assist certain hospitals in funding uncompensated care.

**Hospital Cost Containment Board**

Part II of Chapter 395, F.S., establishes the Hospital Cost Containment Board (or board). The stated purpose of the board is to advise the Legislature on health care costs and inflationary trends in health care; to educate consumers and perform other related tasks.

Another major function of the board is to review and approve hospital budgets. Each hospital is required to annually submit to the board two detailed financial statements: a projected budget, submitted 90 days prior to the beginning of each hospital's fiscal year; and a report of actual experience, submitted to the board within 120 days after the end of each hospital's fiscal year. The board reviews each hospital's projected budget based on a comparison to the hospital's previous actual experiences, and a comparison to the performance of other hospitals of similar type. Hospitals with budgets which exceed certain standards are subjected to detailed review by the board.
The board was given authority in 1984 as a result of the Health Care Access Act (Chapter 84-35, Laws of Florida), to approve, to disapprove, or to disapprove in part, hospital budgets based on an established maximum allowable rate of increase for hospital gross revenue. If a hospital's gross revenue is in the lower 50 percent for its group or, the lower 80 percent of its group and the hospital has a rate of increase in gross revenues below the maximum allowable rate of increase, then the hospital's budget is approved without further action by the board. All other hospitals must have their budgets approved by the board, based on patient-payer mix or other standards listed in the law. The law provides penalties for hospitals which exceed the MARI or their approved budgets. Penalties include a prospective reduction to the hospital's budget, fines to be paid into the Public Medical Assistance Trust Fund and possible revocation of a hospital's license.

The membership of the board consists of 11 members which are appointed by the Governor and confirmed by the Senate. Four members of the board are consumers, four members are providers (two of whom must represent hospitals, one of whom must be a nursing home provider) and 3 members are purchasers. Chapter 395, Part II and the Hospital Cost Containment Board are scheduled to Sunset Review pursuant to s. 11.61, F.S., on October 1, 1988.

Sections 400.341 - 400.346, Florida Statutes, require the Hospital Cost Containment Board to collect and disseminate information relating to nursing home charges.

B. EFFECT OF PROPOSED CHANGES:

Indigent Care

This bill would complete the expansion of the state/county primary care system to all 67 counties by funding an additional $10 million dollars. It changes the name of the indigent health care special district to "health care special district" and it broadens the scope of the district by allowing the district to fund county-owned or operated hospitals; allowing the county to fund hospital services for indigents in public or public facilities; and, by allowing the county to fund its share of state or federal indigent care programs which require financial participation by the county. The bill also clarifies language requiring voter approval of any tax levy and requiring districts to comply with all reporting and compliance requirements. Districts are prohibited from issuing bonds of any type.

This bill would further the Medicaid enhancements begun in chapter 87-92, Florida Statutes, by providing for the second and subsequent phases of the physician fee increases up to the Medicare 50th percentile; increasing Medicaid coverage for children up to age 5 immediately, instead of phasing-in coverage; increasing Medicaid eligibility for elderly and disabled adults with incomes between 90 and 100 percent of poverty; increasing lengths of stay to 90 days for neonates in Regional Perinatal Intensive Care Centers or, if it is not possible to target this group only, to increase lengths of stay for all children under 21 participating in the Medicaid Early Periodic Screening Diagnosis and Treatment Program; and, by extending the Sunset Review of the Medicaid Medically Needy Program for one year. Finally, the bill allows for a redistribution of up to $70 million dollars of Public Medical Assistance Trust Fund surplus dollars to hospitals providing a minimum of 2 percent of its gross revenues in charity care.
Health Care Cost Containment Board

This bill re-enacts Chapter 395, Part II, Florida Statutes relating to the Hospital Cost Containment Board which was scheduled to be repealed on October 1, 1988 pursuant s. 11.61, F.S. The bill accomplishes this by transferring the entire part into a newly created chapter, (Chapter 407), and rearranging, amending, and renumbering the sections. In addition, sections 400.314 - 400.246, Florida Statutes are also transferred, renumbered and amended into Chapter 407, which is re-titled Health Care Cost Containment, and changes the name of the Hospital Cost Containment Board to the "Health Care Cost Containment Board."

This bill simplifies and streamlines the methodology by which a hospital would have to file its annual budget with the board, and be subject to detail budget review or penalties. Specifically, the bill changes the budget review process in 5 major ways.

1. Requires only hospitals requesting an increase in charges (gross revenues per adjusted admission, GR/AA) which exceed the maximum allowable rate of increase (MARI) for similar hospitals in its group or, are requesting budget amendments which would cause the hospital to exceed the MARI, to file projected budgets and be subject to detailed budget review.

2. Hospitals not requesting increases above the MARI only file a "budget letter" which stipulates what the hospital's projected GR/AA for its next fiscal year will be, and affirms that the hospital intends to stay within the MARI for its group.

3. Allows a hospital, whose actual audited experience at the end of the fiscal year indicates it came in below the MARI, to "bank" up to a cumulative total of 3 percentage points to be used in the future.

4. Changes the definition of maximum allowable rate of increase (MARI), by changing the methodology for calculating "plus points" which a hospital can add onto the market basket index (NHIPI) to determine its MARI. Allows hospitals falling in the upper third of its group to add either 2 plus points to the NHIPI or 25 percent of the NHIPI, whichever is less. Those hospitals in the lower two-thirds would add either 3 plus points to the NHIPI or 50 percent of the NHIPI, whichever is less.

5. Changes the way a penalty is assessed against a hospital, for exceeding the MARI or its budget as approved by the board, by changing the penalty from being calculated on "net" revenues to "gross" revenues. It also reduces the threshold set to fine a hospital for its first occurrence, from 5 to 3 percent.

The bill provides another major change to the current law by decreasing the number of members on the board from 11 to 9 members, by removing the limit on the maximum number of terms a board member can serve, by changing the makeup of the board and, by providing that the Governor share the appointments to the board with the President of the Senate, the Speaker of the House, and the Insurance Commissioner. Specifically, the bill changes the makeup to:

3 Providers - not specified - appointed by Governor

2 Purchasers - appointed by the Insurance Commissioner

4 Consumers - each alternately appointed by the Speaker of House & President of Senate)
C. SECTION-BY-SECTION ANALYSIS:

Section 1. Title "Affordable Health Care Assurance Act"

Section 2. Amends s. 154.011, Florida Statutes relating to primary care services. Clarifies that the Legislature's intent was for a system of primary care programs to be organized in all 67 counties. Requires that each program shall provide a comprehensive mix of preventive, personal and non-institutional acute care services.

Section 3. Amends s. 154.331, Florida Statutes, relating to indigent health care districts by changing the name to health care special districts and broadening the powers and functions of the district, subject to voter approval.

Allows districts to fund county owned or operated hospitals, institutional care for indigents in privately or publicly owned facilities and, the county's share of state or federal indigent health care programs which require financial participation by the county. Clarifies and strengthens the language relating to levying taxes; relating to the requirements placed on the districts to comply with s. 200.065, F.S., (which is millage requirements); and, relating to all reporting and compliance requirements currently required under Chapter 21B, Part III, F.S., or any other statute. Changes the appointment of the board from all members being appointed by the county governing body to the Governor appointing 2 members and the county governing body appointing the remainder. Provides that districts may be dissolved pursuant to current statutory requirements under s. 165.051, F.S., or by the county governing body if approved by the voters. Prohibits tax districts from issuing bonds of any type.


Section 5. Amends, transfers and renumbers s. 395.502, F.S., relating to definitions, to s. 407.002, F.S. Changes the definition of "Board" from Hospital Cost Containment Board to Health Care Cost Containment Board. Changes the definition of "plus points" to mean: for those hospitals in the upper 33 1/3 % of GR/AA for their group, plus points shall be either 2 points or the market basket index times 25% whichever is less; for hospitals in the lower 66 2/3% of GR/AA for their group, plus points shall be either 3 points or the market basket index times 50%, whichever is less. Adds a definition of "rate of return" which may include, but not be limited to four financial indicators which the board would use to determine reasonableness of the financial requirements of a hospital.

Section 6. Amends, transfers and renumbers s. 395.5025, F.S., relating to the Legislature's intent, to s. 407.003, F.S. Broadens the intent of the board: to promote improved consumer and purchaser understanding of government funded programs and third party reimbursement; and to recommend to the Legislature appropriate strategies to foster health care cost containment and improve access. Declares that the rising cost of health care, and cost shifting and cross subsidization by hospitals to increase revenues regardless of the cause, is of vital concern to the people of the state.

Section 7. Amends, transfers and renumbers s. 395.503, F.S., relating to the Hospital Cost Containment Board, to s. 407.01, F.S. Changes the name to Health Care Cost Containment Board. Determines board shall be a separate budget entity from the Department of Health and Rehabilitative Services and that the executive director shall be its agency head for all purposes. Provides that the board shall not be subject to the control, supervision or direction by the department. Decreases
membership from 11 to 9 members effective with appointments after January 1, 1989. Changes makeup from 4 providers, 3 purchasers and 4 consumers to, 3 providers, 2 purchasers and 4 consumers. Allows Insurance Commissioner to appoint 2 purchaser members; Speaker of House and President of Senate to alternately appoint each consumer member; and, the Governor to appoint the provider members. Removes the limit on the maximum number of terms a board member can serve.

Section 8. Amends, transfers and renumbers s. 395.504, F.S., dealing with powers and duties of board, to s. 407.02, F.S. Limits board's authority to approve, amend or disapprove budgets to only those hospitals requesting increases above the maximum allowable rate of increase (MARI). Strikes and transfers the language dealing with publishing physician data obtained from the Department of Insurance to s. 407.70, F.S. Empowers the board to investigate consumer complaints regarding problems with hospital billing practices and to issue reports in cases where the board determines the hospital engaged in erroneous billing practices.

Section 9. Creates a new section 407.025, F.S., providing immunity to hospitals and other reporting entities for providing patient data to board.

Section 10. Amends, transfers and renumbers s. 395.505, F.S., relating to rules to s. 407.03, F.S. Makes technical changes to replace the word "part" with the word "chapter".

Section 11. Amends, transfers and renumbers s. 395.5051, F.S., relating to effect of act on existing rules, to s. 407.035, F.S. Provides that nothing contained in the act would change rules promulgated to enact chapter 84-35, Laws of Florida, unless in direct conflict with this act. Provides that all budgets or budget amendments beginning prior to February 1, 1989 shall be filed and reviewed subject to chapter 84-35, Laws of Florida.

Section 12. Amends, transfers and renumbers s. 395.512, F.S., relating to the budget of the board to s. 407.04, F.S. Requires the board to submit its final legislative budget request directly to the Governor by November 1 of each even numbered year.

Section 13. Amends, transfers and renumbers s. 395.507, F.S., relating to uniform system of financial reporting for hospitals, to s. 407.05, F.S. Requires only hospitals requesting approval of a rate of increase in gross revenue per adjusted admission (GR/AA) in excess of the maximum allowable rate of increase (MARI) to file budgets for detailed review.

Section 14. Amends transfers and renumbers s. 395.514, F.S., relating to hospital violation of rules, to s. 407.06, F.S. Makes technical changes by correcting references from violations of "part" to violations of "chapter".

Section 15. Amends, transfers and renumbers s. 395.508, F.S., relating to hospital costs and finances; analysis, studies and reports, to s. 407.07, F.S. Changes section title from "hospital" to "health care". Adds authority for board to study effects of Medicare, Medicaid and other government reimbursement mechanisms. Gives the board authority to conduct analysis and research on impact of uncompensated care on hospitals budget. Gives the board authority to conduct analysis and research on the state's role in funding indigent care.

Section 16. Amends, transfers and renumbers s. 395.513, F.S., relating to program accountability, to s. 407.08, F.S. Expands the requirements of the board's annual report to include an analysis of the reasons for existing levels of cross
subsidization. Expands the report to include the extent to which public funding policies may be affecting health care costs. Also expands the report to include the extent to which other factors, such as uncompensated care, skilled employee shortages, changes in technology and shifts from institutional to ambulatory care may be affecting health care costs.

**Section 17.** Amends, transfers and renumbers s. 395.5085, F.S., relating to collection and dissemination of hospital charge information, to s. 407.09, F.S. Allows board to distribute information utilizing the Consumer Information and Advisory Council created in s. 407.10, F.S., or by any other appropriate means available. Strikes language relating to Consumer Information Network and moves most of the language into s. 407.10, F.S.

**Section 18.** Creates s. 407.10, F.S., relating to the Consumer Information and Advisory Council, previously known as the Consumer Information Network. In addition to responsibilities previously handled by Consumer Information Network, it allows the council to conduct or sponsor consumer information or education seminars at locations throughout the state. It further gives the Council authority to hold public hearings in order to solicit consumer concerns or complaints relating to health care costs and as a result of those hearings, make recommendations to the board for study, action or investigation.

**Section 19.** Amends, transfers and renumbers s. 395.5042, F.S., relating to the Office of Technical Assistance, to s. 407.11, F.S. Expands the responsibilities of the office to include: developing cost containment strategies for providers, employers and consumers; serving as a clearinghouse for information concerning federal and state legislative initiatives affecting health care delivery system and government health care programs; and, developing an outreach program to assist small business to include cost containment initiatives for small business insurance plans.

**Section 20.** Transfers and renumbers s. 395.511, F.S., relating to Quality Assurance Programs to s. 407.12, F.S. Requires hospitals to provide the board with information necessary to evaluate the quality of care provided by the hospital. Provides that the results of accreditation surveys be provided to the board on request.

**Section 21.** Amends, transfers and renumbers s. 395.515., F.S., relating to prospective payment arrangements, to s. 407.13, F.S. Provides for technical changes to name of board.

**Section 22.** Amends, transfers and renumbers s. 400.341, F.S., relating to legislative intent - nursing home costs, to s. 407.30, F.S. Provides for technical changes.

**Section 23.** Amends, transfers and renumbers s. 400.343, F.S., relating to uniform system of financial reporting for nursing homes to s. 407.31, F.S. Provides technical changes in statutory cites.

**Section 24.** Amends, transfers and renumbers s. 400.344, F.S., relating to nursing home revenues and financial analysis, studies and reports, to s. 407.32., F.S. Provides technical changes relating to other statutory cites. Allows the board to prepare and file supplementary studies and reports based on information analyzed relating to nursing home data.
Section 25. Amends, transfers and renumbers s. 400.345, F.S., relating to nursing home assessments to fund the budget of board to conduct nursing home financial disclosure program to s. 407.33., F.S. Provides for technical changes.

Section 26. Amends, transfers and renumbers s. 400.346, F.S., relating to nursing homes violations of law or rules, to s. 407.34, F.S. Provides technical changes to other statutory cites.

Section 27. Substantially amends, transfers and renumbers s. 395.509, F.S., relating to review of hospital budgets, to s. 407.50, F.S. Eliminates hospitals from filing a detailed budget with the board unless the hospital wishes to exceed the maximum allowable rate of increase (MARI). Requires, as an alternative, for hospitals to file a "budget letter" which specifies what the hospitals expected gross revenues per adjusted admission will be for its next fiscal year, and a statement affirming it intends to stay within the MARI. Requires all hospitals which exceed the MARI, either through submission of a budget request or by filing a budget amendment, to be subject to detailed budget review regardless of where they fall in their group. Allows hospitals staying below the MARI to "bank" percentage points to be used in the future, up to a cumulative maximum of 3 points. Changes the "a" through "k" review criteria and prioritizes them.

Section 28. Amends, transfers and renumbers s. 395.5094, F.S., relating to exceeding approved budget...penalties, to s. 407.51, F.S. Places a hospital in a potential penalty situation when its actual gross revenues per adjusted admission exceeds the previous year's actual by more than the MARI, or exceeds the projected budget as approved by the board. Reduces the threshold set to fine hospitals for first occurrences from 5 to 3 percent. Allows the board to reduce a hospital's budget by the amount of excess up to 3 percent and, if the excess is greater than 3 percent, the hospital must pay a cash fine for the difference.

Section 29. Transfers and renumbers s. 395.5125, F.S., relating to operating costs; non deductible items, to s. 407.52, F.S. Leaves the original language intact.

Section 30. Transfers and renumbers s. 395.5135, F.S., relating to burden of proof, to s. 407.53, F.S. Leaves the original language intact.

Section 31. Amends, transfers and renumbers s. 395.5092, F.S., relating to duty of Public Council; to s. 407.54, F.S. Clarifies that Public Council may represent consumers before the board, its advisory panels, in administrative hearings or before any other state and federal agencies or courts in any issue related to budget review.

Section 32. Amends, transfers and renumbers s. 395.52, F.S., relating to information on physician's charges, to s. 407.70, F.S. Moves current language dealing with physician information to this section. Specifically, it exempts physicians from any provisions of this act if the physician bills his services independently of the hospital, and moves current language from s. 395.504(9)(b), F.S., relating to information on physician charges obtained from the Department of Insurance to this section.

Section 33. Amends subsections (7) and (8) of section 409.266, F.S. relating to the Medicaid program. Allocates an additional $10 million from Public Medical Assistance Trust for expansion of primary care system for Medicaid and other low income persons. Increases Medicaid eligibility to elderly and disabled persons from 90 to 100 percent of the poverty level. Increases Medicaid coverage for children up
II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

Indigent Care

Utilizing projections made on caseloads by the February 1988 Medicaid revenue estimating conference, the indigent care programs proposed in this bill are estimated to cost as follows:
<table>
<thead>
<tr>
<th>PMATF</th>
<th>GEN REV</th>
<th>FEDERAL</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician fee 2nd phase</td>
<td>$4.1</td>
<td>$6.2</td>
<td>$12.8</td>
</tr>
<tr>
<td>Children Age 3 to 5</td>
<td>1.9</td>
<td>-0-</td>
<td>2.4</td>
</tr>
<tr>
<td>Elderly &amp; Disabled 90-100%</td>
<td>4.4</td>
<td>-0-</td>
<td>5.4</td>
</tr>
<tr>
<td>Extend LOS for Kids *</td>
<td>-0-</td>
<td>6.3</td>
<td>7.7</td>
</tr>
<tr>
<td>Primary Care-phase 3</td>
<td>10.0</td>
<td>-0-</td>
<td>-0-</td>
</tr>
<tr>
<td>Reenact Medically Needy</td>
<td>34.6</td>
<td>-0-</td>
<td>42.3</td>
</tr>
<tr>
<td>Hospital Indigent Relief</td>
<td>70.0</td>
<td>-0-</td>
<td>-0-</td>
</tr>
</tbody>
</table>

**TOTALS:** $125.0 $12.5 $70.6 $208.1

* There is no provision in the bill indicating where the funding is to come from, therefore it is assumed it would be a general revenue consequence.

**Health Care Cost Containment Board**

Because this bill significantly alters the boards regulatory function, particularly as it relates to reviewing budgets, it would be difficult to accurately predict the number of hospitals which may be subject to budget review under the new system, and therefore have an impact on the current workload. Because the new budget reporting requirements are not effective until the hospitals fiscal years beginning on or after February 1, 1989, the present staff at a minimum would be needed to continue to review budgets under the current system. Once the new system is implemented, the board staffing requirements would be dependent on how many hospitals exceed the MARI and submit detailed budgets for review.

In 1987:

- 293 hospitals submitted budgets which were reviewed by staff
- 20 hospitals were exempt from board review and approval under current law because they were state or rehab hospitals
- 152 hospitals were automatically approved under the current law because of where they were in their group, even though they may have exceeded the MARI
- 121 hospitals were subject to detailed review

The board's staff estimates the additional data collection, analysis and research requirements contained in the bill would require 3 additional positions estimated at a cost of $121,300. This money would come from the Health Care Cost Containment Trust Fund. There would also be some minor expense associated with the name change from Hospital Cost Containment Board to Health Care Cost Containment Board.

**B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:**

**Indigent Care**

**PRIMARY CARE** - There is no fiscal consequences mandated on the counties for receiving grant money to establish primary care programs. The counties should benefit by the infusion of state primary care dollars into this area.

**HEALTH CARE SPECIAL TAX DISTRICTS** - Counties are given a potential revenue source to fund current and future indigent health care obligations or initiatives, if the voters approve creation of the district.
ELDERLY AND DISABLED, AND KIDS FROM 3 TO 5 - Counties would be expected to pay 35% of the cost of hospital inpatient services for these groups with lengths of stays between the 12 and 45 day.

EXTEND MEDICAID LENGTH OF STAY FOR KIDS TO 90 DAYS - Counties would pay 35% of the cost for the additional length of stay from the 45th to the 90th day, estimated to be $4.9 million.

**Health Care Cost Containment Board**

There should be no fiscal cost to the counties as a result of the continuation of the board. Counties may receive an indirect benefit however, if the rate of increase in hospital charges is slowed or reduced because of the costs most counties pay toward health care benefits for county employees or the cost they pay for hospital care for indigents if the county funds such a program.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

**Indigent Care**

Except for the hospital assessment paid into the Public Medical Assistance Trust Fund which is required under current law to fund indigent care, there should not be any additional direct private sector cost.

The **hospitals** are estimated to directly benefit from the indigent care parts of the legislation as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of redistribution</td>
<td>$70.0</td>
</tr>
<tr>
<td>100% of LOS for kids</td>
<td>$14.0</td>
</tr>
<tr>
<td>75% elderly/disabled</td>
<td>$7.4</td>
</tr>
<tr>
<td>50% kids 3 to 5</td>
<td>$7.0</td>
</tr>
<tr>
<td>80% Medically Needy</td>
<td>$61.5</td>
</tr>
</tbody>
</table>

$159.9

Physicians are estimated to directly benefit as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of physician fees</td>
<td>$23.1</td>
</tr>
<tr>
<td>10% elderly &amp; disabled</td>
<td>$1.0</td>
</tr>
<tr>
<td>45% kids 3 to 5</td>
<td>$1.9</td>
</tr>
<tr>
<td>15% Medically Needy</td>
<td>$11.5</td>
</tr>
<tr>
<td>5% primary care</td>
<td>$.5</td>
</tr>
</tbody>
</table>

$38.0

Pharmacies and other providers should directly benefit as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>15% elderly and disabled</td>
<td>$1.5</td>
</tr>
<tr>
<td>5% kids 3 to 5</td>
<td>$.2</td>
</tr>
<tr>
<td>5% Medically Needy</td>
<td>$3.8</td>
</tr>
</tbody>
</table>

$5.5
Health Care Cost Containment Board

This bill does not place any additional direct financial obligation on hospitals as a result of the change in budget review methodology, and should in fact, cause a reduction somewhat in costs for those hospitals coming in under the MARI because they no longer need to submit budgets. According to survey results conducted by the Health Care Committee for purposes of sunset review, hospitals reported an average of approximately $33,000 per year to comply with all the requirements of the law relating to budget review. Assuming one-half of the 293 hospitals which filed budgets in fiscal year 1987-88 did not exceed the MARI as established in this bill, there is potential for saving administrative costs of approximately 15 to 25 percent, depending on how many hospitals are subject to budget review.

Because all budgets exceeding the MARI would be subject to budget review under this bill versus less than 50 percent under the current system, it is conceivable hospitals not subject to board scrutiny in the past because of where they fell within their group, may now incur additional costs for justifying their need for increases above the MARI.

III. LONG RANGE CONSEQUENCES:

Indigent Care

The indigent care sections of this bill are consistent with the goals of the State Comprehensive Plan to improve access to health care services for indigent persons and should, in conjunction with the changes implemented in chapter 87-92, Laws of Florida, provide a positive long term policy change in the way the state has historically targeted and funded health care programs for its medically indigent population.

Generally, the bill continues to place emphasis on funding primary and preventive care services which were key components of the 1987 law, and which are ultimately more beneficial and cost effective. By continuing and completing the phase-in of the programs implemented in chapter 87-92, Laws of Florida, the state will have moved into the position of having a baseline system of two compatible and integrated health care programs (Primary Care and Medicaid) -- one or both of which will be available to persons with incomes below the federal poverty line. In addition, the state is assisted in the funding of these programs by the federal and county governments, and the hospital industry through the assessment on their gross revenues. The long range impact of the policy decisions made in the indigent care parts of this bill should be beneficial to both the state and the citizens it serves. These benefits should increase over time as indigent persons learn of and begin to utilize basic and preventive health care services in lieu of waiting until health problems are more serious and more costly.

HEALTH CARE COST CONTAINMENT BOARD

The reenactment of Chapter 395, Part II, Florida Statutes (proposed Chapter 407, Florida Statutes) is consistent with the State Comprehensive Plan which sets as a goal the need to help assure access to affordable, quality health care and to reduce health care cost as a percentage of the total financial resources available to the state and its citizens. The long range impact of keeping a process in place which
requires hospitals to justify any increase in charges over certain established thresholds should provide some assurance that the ratio between costs and charges for hospital care is fair and equitable, and that the public's right to affordable health care is protected. This assurance becomes even more critical at least until the current volatile and rapidly changing health care delivery system begins to settle down and stabilize.

IV. **COMMENTS:**

V. **AMENDMENTS:**

VI. **SIGNATURES:**

**SUBSTANTIVE COMMITTEE:**
Prepared by: Cathie Herndon

**FINANCE & TAXATION:**
Prepared by:

**APPROPRIATIONS:**
Prepared by:

Staff Director: Michael P. Hansen
I. SUMMARY:

A. PRESENT SITUATION:

**Indigent Care**

Chapter 87-92, Florida Statutes, provided major initiatives to fund and increase access to health care for indigents. Specifically, it enhanced the Medicaid program by: expanding eligibility to pregnant women and children up to age 2 with incomes up to 100 percent of the federal poverty level; phasing in coverage to children up to age 5 by 1991; expanding eligibility to elderly and disabled with incomes up to 90 percent of the poverty level; increasing Medicaid provider fees, providing for a phase-in of all physician fees by 1991 and providing special fees for obstetricians and neonatologists. The law also provided for funding for the second phase of the state/county primary care program network; allowed for the creation of independent special taxing districts by counties to fund indigent health care; and, provided for a redistribution of $69.5 million to assist certain hospitals in funding uncompensated care.

**Hospital Cost Containment Board**

Part II of Chapter 395, F.S., relates to hospital cost containment, and creates the Hospital Cost Containment Board (or board). The stated purpose of the board is to advise the Legislature on health care costs and inflationary trends in health care; to educate consumers and perform other related tasks.

Another major function of the board is to review and approve hospital budgets. Each hospital is required to annually submit to the board two detailed financial statements: a projected budget, submitted 90 days prior to the beginning of each hospital's fiscal year; and a report of actual experience, submitted to the board within 120 days after the end of each hospital's fiscal year. The board reviews each hospital's projected budget based on a comparison to the hospital's previous actual experiences, and a comparison to the performance of
other hospitals of similar type. Hospitals with budgets which exceed certain standards are subjected to detailed review by the board.

The board was given authority in 1984 as a result of the Health Care Access Act (Chapter 84-35, Laws of Florida), to approve, to disapprove, or to disapprove in part, hospital budgets based on an established maximum allowable rate of increase for hospital gross revenue. If a hospital's gross revenue is in the lower 50 percent of its group or, the lower 80 percent of its group and the hospital has a rate of increase in gross revenues below the maximum allowable rate of increase, then the hospital's budget is approved without further action by the board. All other hospitals must have their budgets approved by the board, based on patient-payer mix or other standards listed in the law. The law provides penalties for hospitals which exceed the MARI or their approved budgets. Penalties include a prospective reduction to the hospital's budget, fines to be paid into the Public Medical Assistance Trust Fund and possible revocation of a hospital's license.

The membership of the board consists of 11 members which are appointed by the Governor and confirmed by the Senate. Four members of the board are consumers, four members are providers (two of whom must represent hospitals, one of whom must be a nursing home provider) and 3 members are purchasers. Chapter 395, Part II and the Hospital Cost Containment Board are scheduled to Sunset Review pursuant to s. 11.61, F.S., on October 1, 1988, subject to Legislative review and re-enactment.

Sections 400.341 - 400.346, Florida Statutes, require the Hospital Cost Containment Board to collect and disseminate information relating to nursing home charges.

B. EFFECT OF PROPOSED CHANGES:

Indigent Care

This bill would complete the expansion of the state/county primary care system to all 67 counties by funding an additional $10 million dollars. It changes the name of the indigent health care special district to "health care special district" and it broadens the scope of the district by allowing the district to fund county-owned or operated hospitals; allowing the county to fund hospital services for indigents in public or public facilities; and, by allowing the county to fund its share of state or federal indigent care programs which require financial participation by the county. The bill also clarifies language requiring voter approval of any tax levy and requires districts to comply with all reporting and compliance requirements. Districts are prohibited from issuing bonds of any type.

This bill would further the Medicaid enhancements begun in chapter 87-92, Laws of Florida, by providing for the second and subsequent phases of the physician fee increases up to the Medicare 50th percentile; increasing Medicaid coverage for children up to age 5 immediately, instead of phasing-in coverage; increasing Medicaid eligibility for elderly and disabled adults with incomes between 90
and 100 percent of poverty; increasing lengths of stay to 90 days for
neonates in Regional Perinatal Intensive Care Centers or, if it is not
possible to target this group only, to increase lengths of stay for
all children under 21 participating in the Medicaid Early Periodic
Screening Diagnosis and Treatment Program; and, by extending the
Sunset Review of the Medicaid Medically Needy Program for one year.
Finally, the bill allows for a redistribution of up to $70 million
dollars of Public Medical Assistance Trust Fund surplus dollars to
hospitals providing a minimum of 2 percent of its gross revenues in
charity care.

Health Care Cost Containment Board

This bill re-enacts Chapter 395, Part II, Florida Statutes relating to
the Hospital Cost Containment Board which was scheduled to be repealed
on October 1, 1988 pursuant s. 11.61, F.S. The bill accomplishes this
by transferring the entire part into a newly created chapter, (Chapter
407), and rearranging, amending, and renumbering the sections. In
addition, sections 400.314 - 400.246, Florida Statutes are also
transferred, renumbered and amended into Chapter 407, F.S. The
chapter is titled Health Care Cost Containment, and the name of the
Hospital Cost Containment Board has been changed to the "Health Care
Cost Containment Board."

This bill simplifies and streamlines the methodology by which a
hospital would have to file its annual budget with the board, and be
subject to detail budget review or penalties. Specifically, the bill
changes the budget review process in 5 major ways.

1. Requires only hospitals requesting an increase in charges (gross
revenues per adjusted admission, GR/AA) which exceed the maximum
allowable rate of increase (MARI) or, are requesting budget
amendments which would cause the hospital to exceed the MARI, to
file projected budgets and be subject to detailed budget review.

2. Hospitals not requesting increases above the MARI only file a
"budget letter" which stipulates what the hospital's projected
GR/AA for its next fiscal year will be, and affirms that the
hospital intends to stay within the MARI for its group.

3. Allows a hospital, whose actual audited experience at the end of
the fiscal year indicates it came in below the MARI, to "bank" up
to a cumulative total of 3 percentage points to be used in the
future.

4. Changes the definition of maximum allowable rate of increase
(MARI), to be the market basket index, which for Florida has been
the National Hospital Input Price Index (NHIPI). The effect of
this change is to eliminate the additional 3 "plus points" or
inflation points which hospitals were allowed to increase their
revenues by to adjust for the Florida experience.

5. Changes the way a penalty is assessed against a hospital, for
exceeding the MARI or its budget as approved by the board, by
changing the penalty from being calculate on "net" revenues to

STANDARD FORM 3/88
'"gross" revenues. It also reduces the threshold set to fine a hospital for its first occurrence, from 5 to 3 percent.

The bill provides another major change to the current law by providing for a full time board. Board members would be salaried state employees within the senior management system. In addition, the bill decreases the number of members on the board from 11 to 3 members, removes the limit on the maximum number of terms a board member can serve, expands the terms from 3 to 4 years, and eliminates the provider members from the board. The new board would consist of two consumers and one member with experience as a major purchaser of health care services.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Title "Affordable Health Care Assurance Act"

Section 2. Amends s. 154.011, Florida Statutes relating to primary care services. Clarifies that the Legislature's intent was for a system of primary care programs to be organized in all 67 counties. Requires that each program shall provide a comprehensive mix of preventive, personal and non-institutional acute care services.

Section 3. Amends s. 154.331, Florida Statutes, relating to indigent health care districts by changing the name to health care special districts and broadening the powers and functions of the district, subject to voter approval. Specifically, it allows districts to fund county owned or operated hospitals, institutional care for indigents in privately or publicly owned facilities and, the county's share of state or federal indigent health care programs which require financial participation by the county. Clarifies and strengthens the language relating to levying taxes; relating to the requirements placed on the districts to comply with s. 200.065, F.S., (which is millage requirements); and, relating to all reporting and compliance requirements currently required under Chapter 218, Part III, F.S., or any other statute. Changes the appointment of the board from all members being appointed by the county governing body to the Governor appointing 2 members and the county governing body appointing the remainder. Provides that districts may be dissolved pursuant to current statutory requirements under s. 165.051, F.S., or by the county governing body if approved by the voters. Prohibits tax districts from issuing bonds of any type.


Section 5. Amends, transfers and renumbers s. 395.502, F.S., relating to definitions, to s. 407.002, F.S. Changes the definition of "Board" from Hospital Cost Containment Board to Health Care Cost Containment Board. Changes the definition of "maximum allowable rate of increase" (MARI) to mean: the market basket index used to measure the inflation in hospital input prices. Currently this index is known as the National Hospital Input Price Index (NHIPI). Eliminates any additional "plus points" which hospitals are currently allowed to add to the NHIPI to adjust for the Florida specific experience. Adds a definition of "rate of return" which may include, but not be limited
to four financial indicators which the board would use to determine reasonableness of the financial requirements of a hospital.

Section 6. Amends, transfers and renumbers s. 395.5025, F.S., relating to the Legislature's intent, to s. 407.003, F.S. Broadens the intent of the board: to promote improved consumer and purchaser understanding of government funded programs and third party reimbursement; and to recommend to the Legislature appropriate strategies to foster health care cost containment and improve access. Declares that the rising cost of health care, and cost shifting and cross subsidization by hospitals to increase revenues regardless of the cause, is of vital concern to the people of the state.

Section 7. Amends, transfers and renumbers s. 395.503, F.S., relating to the Hospital Cost Containment Board, to s. 407.01, F.S. Changes the name to Health Care Cost Containment Board. Determines board shall be a separate budget entity from the Department of Health and Rehabilitative Services and that the executive director shall be its agency head for all purposes. Provides that the board shall not be subject to the control, supervision or direction by the department. Decreases membership from 11 to 3 members effective with appointments after January 1, 1989. Provides that the board shall be full time salaried state employees and part of the state senior management system. Changes the board makeup from 4 providers, 3 purchasers and 4 consumers to no providers, 1 purchaser and 2 consumers. Expands the term of the board from 3 to 4 years and removes the limit on the maximum number of terms a board member can serve.

Section 8. Amends, transfers and renumbers s. 395.504, F.S., dealing with powers and duties of board, to s. 407.02, F.S. Limits board's authority to approve, amend or disapprove budgets to only those hospitals requesting increases above the maximum allowable rate of increase (MARI). Strikes and transfers the language dealing with publishing physician data obtained from the Department of Insurance to s. 407.70, F.S. Empowers the board to investigate consumer complaints regarding problems with hospital billing practices and to issue reports in cases where the board determines the hospital engaged in erroneous billing practices.

Section 9. Creates a new section 407.025, F.S., providing immunity to hospitals and other reporting entities for providing patient data to board.

Section 10. Amends, transfers and renumbers s. 395.505, F.S., relating to rules to s. 407.03, F.S. Makes technical changes to replace the word "part" with the word "chapter".

Section 11. Amends, transfers and renumbers s. 395.5051, F.S., relating to effect of act on existing rules, to s. 407.035, F.S. Provides that nothing contained in the act would change rules promulgated to enact chapter 84-35, Laws of Florida, unless in direct conflict with this act. Provides that all budgets or budget amendments beginning prior to February 1, 1989 shall be filed and reviewed subject to chapter 84-35, Laws of Florida.
Section 12. Amends, transfers and renumbers s. 395.512, F.S., relating to the budget of the board to s. 407.04, F.S. Requires the board to submit its final legislative budget request directly to the Governor by November 1 of each even numbered year.

Section 13. Amends, transfers and renumbers s. 395.507, F.S., relating to uniform system of financial reporting for hospitals, to s. 407.05, F.S. Requires only hospitals requesting approval of a rate of increase in gross revenue per adjusted admission (GR/AA) in excess of the maximum allowable rate of increase (MARI) to file budgets for detailed review.

Section 14. Amends transfers and renumbers s. 395.514, F.S., relating to hospital violation of rules, to s. 407.06, F.S. Makes technical changes by correcting references from violations of "part" to violations of "chapter".

Section 15. Amends, transfers and renumbers s. 395.508, F.S., relating to hospital costs and finances; analysis, studies and reports, to s. 407.07, F.S. Changes section title from "hospital" to "health care". Adds authority for board to study effects of Medicare, Medicaid and other government reimbursement mechanisms. Gives the board authority to conduct analysis and research on impact of uncompensated care on hospitals budget. Gives the board authority to conduct analysis and research on the state's role in funding indigent care.

Section 16. Amends, transfers and renumbers s. 395.513, F.S., relating to program accountability, to s. 407.08, F.S. Expands the requirements of the board's annual report to include an analysis of the reasons for existing levels of cross subsidization. Expands the report to include the extent to which public funding policies may be affecting health care costs. Also expands the report to include the extent to which other factors, such as uncompensated care, skilled employee shortages, changes in technology and shifts from institutional to ambulatory care may be affecting health care costs.

Section 17. Amends, transfers and renumbers s. 395.5085, F.S., relating to collection and dissemination of hospital charge information, to s. 407.09, F.S. Allows board to distribute information utilizing the Consumer Information and Advisory Council created in s. 407.10, F.S., or by any other appropriate means available. Strikes language relating to Consumer Information Network and moves most of the language into s. 407.10, F.S.

Section 18. Creates s. 407.10, F.S., relating to the Consumer Information and Advisory Council, previously known as the Consumer Information Network. In addition to responsibilities previously handled by Consumer Information Network, it allows the council to conduct or sponsor consumer information or education seminars at locations throughout the state. It further gives the Council authority to hold public hearings in order to solicit consumer concerns or complaints relating to health care costs and as a result of those hearings, make recommendations to the board for study, action or investigation.
Section 19. Amends, transfers and renumbers s. 395.5042, F.S., relating to the Office of Technical Assistance, to s. 407.11, F.S. Expands the responsibilities of the office to include: developing cost containment strategies for providers, employers and consumers; serving as a clearinghouse for information concerning federal and state legislative initiatives affecting health care delivery system and government health care programs; and, developing an outreach program to assist small business to include cost containment initiatives for small business insurance plans.

Section 20. Transfers and renumbers s. 395.511, F.S., relating to Quality Assurance Programs to s. 407.12, F.S. Requires hospitals to provide the board with information necessary to evaluate the quality of care provided by the hospital. Provides that the results of accreditation surveys be provided to the board on request.

Section 21. Amends, transfers and renumbers s. 395.515., F.S., relating to prospective payment arrangements, to s. 407.13, F.S. Provides for technical changes to name of board.

Section 22. Amends, transfers and renumbers s. 400.341, F.S., relating to legislative intent - nursing home costs, to s. 407.30, F.S. Provides for technical changes.

Section 23. Amends, transfers and renumbers s. 400.343, F.S., relating to uniform system of financial reporting for nursing homes to s. 407.31, F.S. Provides technical changes in statutory cites.

Section 24. Amends, transfers and renumbers s. 400.344, F.S., relating to nursing home revenues and financial analysis, studies and reports, to s. 407.32., F.S. Provides technical changes relating to other statutory cites. Allows the board to prepare and file supplementary studies and reports based on information analyzed relating to nursing home data.

Section 25. Amends, transfers and renumbers s. 400.345, F.S., relating to nursing home assessments to fund the board of directors to conduct nursing home financial disclosure program to s. 407.33., F.S. Provides for technical changes.

Section 26. Amends, transfers and renumbers s. 400.346, F.S., relating to nursing homes violations of law or rules, to s. 407.34, F.S. Provides technical changes to other statutory cites.

Section 27. Substantially amends, transfers and renumbers s. 395.509, F.S., relating to review of hospital budgets, to s. 407.50, F.S. Eliminates hospitals from filing a detailed budget with the board unless the hospital wishes to exceed the maximum allowable rate of increase (MARI). Requires, as an alternative, for hospitals to file a "budget letter" which specifies what the hospitals expected gross revenues per adjusted admission will be for its next fiscal year, and a statement affirming it intends to stay within the MARI. Requires all hospitals which exceed the MARI, either through submission of a budget request or by filing a budget amendment, to be subject to detailed budget review regardless of where they fall in their group. Allows hospitals staying below the MARI to "bank" percentage points to
be used in the future, up to a cumulative maximum of 3 points. Changes the "a" through "k" review criteria and prioritizes them.

Section 28. Amends, transfers and renumbers s. 395.5094, F.S., relating to exceeding approved budget...penalties, to s. 407.51, F.S. Places a hospital in a potential penalty situation when its actual gross revenues per adjusted admission exceeds the previous year's actual by more than the MARI, or exceeds the projected budget as approved by the board. Reduces the threshold set to fine hospitals for first occurrences from 5 to 3 percent. Allows the board to reduce a hospital's budget by the amount of excess up to 3 percent and, if the excess is greater than 3 percent, the hospital must pay a cash fine for the difference.

Section 29. Transfers and renumbers s. 395.5125, F.S., relating to operating costs; non deductible items, to s. 407.52, F.S. Leaves the original language intact.

Section 30. Transfers and renumbers s. 395.5135, F.S., relating to burden of proof, to s. 407.53, F.S. Leaves the original language intact.

Section 31. Amends, transfers and renumbers s. 395.5092, F.S., relating to duty of Public Council; to s. 407.54, F.S. Clarifies that Public Council may represent consumers before the board, its advisory panels, in administrative hearings or before any other state and federal agencies or courts in any issue related to budget review.

Section 32. Amends, transfers and renumbers s. 395.52, F.S., relating to information on physician's charges, to s. 407.70, F.S. Moves current language dealing with physician information to this section. Specifically, it exempts physicians from any provisions of this act if the physician bills his services independently of the hospital, and moves current language from s. 395.504(9)(b), F.S., relating to information on physician charges obtained from the Department of Insurance to this section.

Section 33. Amends subsections (7) and (8) of section 409.266, F.S. relating to the Medicaid program. Allocates an additional $10 million from Public Medical Assistance Trust for expansion of primary care system for Medicaid and other low income persons. Increases Medicaid eligibility to elderly and disabled persons from 90 to 100 percent of the poverty level. Increases Medicaid coverage for children up to age 5 with incomes below 100 percent of poverty level immediately, instead of the scheduled phase-in. Requires DHRS to prepare a report by March 1, 1989 on all programs funded through PMATF, with emphasis on the Medically Needy Program. Outlines the next 4 phases of physician fee increases as provided for in chapter 87-92, Laws of Florida. Extends hospital length of stay for Medicaid eligible neonates in Regional Perinatal Intensive Care Centers to 90 days. If HCFA does not allow Florida to single out this subgroup of children, then the department is directed to extend hospital length of stay to 90 days for all Medicaid eligible children under 21, through the Early Pediatric Screening Diagnosis and Treatment Program.
Section 34. Amends s. 409.2663, F.S., relating to a redistribution of Public Medical Assistance Trust Funds to hospitals providing a minimum amount of charity care. Distributes $70 million dollars in 4 quarterly installments to hospitals which provided a minimum of 2% of their gross revenues in verifiable charity care as reported to the Health Care Cost Containment Board for each quarter beginning in April 1988. Places a cap at 80 percent of Medicaid per diem and pays for no longer than 12 days length of stay. No hospital can receive more than 1/3 of each quarterly payment.

Section 35. Extends Medically Needy Program repeal date as provided for in section 50, chapter 87-92, Laws of Florida, to October 1, 1989, unless reenacted by the Legislature.

Section 36. Repeals section 24, chapter 82-182, Laws of Florida, relating to Sunset Review of chapter 395, Part II, Florida Statutes, and reenacts the Hospital Cost Containment Board as amended and transferred to chapter 407, F.S., subject to future review pursuant to s. 11.61, F.S.

Section 37. Repeals s. 400.342, F.S., relating to definitions for nursing home financial reporting. This definition was incorporated into the definition section of s. 407.002, F.S.

Section 38. Instructs the Division of Statutory Revision and Index of the Joint Legislative Management Committee to change the name of the "Hospital Cost Containment Board" to Health Care Cost Containment Board" whenever it appears in statutes.

Section 39. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

**Indigent Care**

Utilizing projections made on caseloads by the February 1988 Medicaid revenue estimating conference, the indigent care programs proposed in this bill are estimated to cost as follows:
Physician fee 2nd phase $ 4.1 $ 6.2 $ 12.8 $23.1
Children Age 3 to 5 1.9 -0- 2.4 4.3
Elderly & Disabled 90-100% 4.4 -0- 5.4 9.8
Extend LOS for Kids * -0- 6.3 7.7 14.0
Primary Care-phase 3 10.0 -0- -0- 10.0
Reenact Medically Needy 34.6 -0- 42.3 76.9
Hospital Indigent Relief 70.0 -0- -0- 70.0

TOTALS: $125.0 $12.5 $70.6 $208.1

* There is no provision in the bill indicating where the funding is to come from, therefore it is assumed it would be a general revenue consequence.

Health Care Cost Containment Board

Because this bill significantly alters the boards regulatory function, particularly as it relates to reviewing budgets, it would be difficult to accurately predict the number of hospitals which may be subject to budget review under the new system, and therefore have an impact on the current workload. Because the new budget reporting requirements are not effective until the hospitals fiscal years beginning on or after February 1, 1989, the present staff at a minimum would be needed to continue to review budgets under the current system. Once the new system is implemented, the board staffing requirements would be dependent on how many hospitals exceed the MARI and submit detailed budgets for review.

In 1987: 293 hospitals submitted budgets which were reviewed by staff

20 hospitals were exempt from board review and approval under current law because they were state or rehab hospitals

152 hospitals were automatically approved under the current law because of where they were in their group, even though they may have exceeded the MARI

121 hospitals were subject to detailed review

The board's staff estimates the additional data collection, analysis and research requirements contained in the bill would require 3 additional staff positions estimated at a cost of $121,300. This money would come from the Health Care Cost Containment Trust Fund. There would also be some minor expense associated with the name change from Hospital Cost Containment Board to Health Care Cost Containment Board.

It is estimated that the three full time salaried board members with 3 secretaries would cost approximately $320,000. This figure assumes the board members would be paid at $72,000 each, (slightly higher than the current average for all other regulatory boards, such as the Public Service Commission, PERC, Human Relations Commission, and the Parole and Probation Commission), and the secretaries would start at approximately $16,000. Also included in the figure are estimates of employee benefit costs and travel.
B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

Indigent Care

PRIMARY CARE - There is no fiscal consequences mandated on the counties for receiving grant money to establish primary care programs. The counties should benefit by the infusion of state primary care dollars into this area.

HEALTH CARE SPECIAL TAX DISTRICTS - Counties are given a potential revenue source to fund current and future indigent health care obligations or initiatives, if the voters approve creation of the district.

ELDERLY AND DISABLED, AND KIDS FROM 3 TO 5 - Counties would be expected to pay 35% of the cost of hospital inpatient services for these groups with lengths of stays between the 12 and 45 day.

EXTEND MEDICAID LENGTH OF STAY FOR KIDS TO 90 DAYS - Counties would pay 35% of the cost for the additional length of stay from the 45th to the 90th day, estimated to be $4.9 million.

Health Care Cost Containment Board

There should be no fiscal cost to the counties as a result of the continuation of the board. Counties may receive an indirect benefit however, if the rate of increase in hospital charges is slowed or reduced because of the costs most counties pay toward health care benefits for county employees or the cost they pay for hospital care for indigents if the county funds such a program.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indigent Care

Except for the hospital assessment paid into the Public Medical Assistance Trust Fund which is required under current law to fund indigent care, there should not be any additional direct private sector cost.

The hospitals are estimated to directly benefit from the indigent care parts of the legislation as follows:

- 100% of redistribution: $70.0
- 100% of LOS for kids: 14.0
- 75% elderly/disabled: 7.4
- 50% kids 3 to 5: 7.0
- 80% Medically Needy: 61.5

Total: $159.9

STANDARD FORM 3/88
Physicians are estimated to directly benefit as follows:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>100% of physician fees</td>
<td>$23.1</td>
</tr>
<tr>
<td>10% elderly &amp; disabled</td>
<td>1.0</td>
</tr>
<tr>
<td>45% kids 3 to 5</td>
<td>1.9</td>
</tr>
<tr>
<td>15% Medically Needy</td>
<td>11.5</td>
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<tr>
<td>5% primary care</td>
<td>.5</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$38.0</strong></td>
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Pharmacies and other providers should directly benefit as follows:

<table>
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<th>Amount</th>
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<tr>
<td>15% elderly and disabled</td>
<td>$1.5</td>
</tr>
<tr>
<td>5% kids 3 to 5</td>
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<tr>
<td>5% Medically Needy</td>
<td>3.8</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$5.5</strong></td>
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</tbody>
</table>

**Health Care Cost Containment Board**

This bill does not place any additional direct financial obligation on hospitals as a result of the change in budget review methodology, and should in fact, cause a reduction somewhat in costs for those hospitals coming in under the MARI because they no longer need to submit budgets. According to survey results conducted by the Health Care Committee for purposes of sunset review, hospitals reported an average of approximately $33,000 per year to comply with all the requirements of the law relating to budget review. Assuming one-half of the 293 hospitals which filed budgets in fiscal year 1987-88 did not exceed the MARI as established in this bill, there is potential for saving administrative costs of approximately 15 to 25 percent, depending on how many hospitals are subject to budget review.

Because all budgets exceeding the MARI would be subject to budget review under this bill versus less than 50 percent under the current system, it is conceivable hospitals not subject to board scrutiny in the past because of where they fell within their group, may now incur additional costs for justifying their need for increases above the MARI.

**III. LONG RANGE CONSEQUENCES:**

**Indigent Care**

The indigent care sections of this bill are consistent with the goals of the State Comprehensive Plan to improve access to health care services for indigent persons and should, in conjunction with the changes implemented in chapter 87-92, Laws of Florida, provide a positive long term policy change in the way the state has historically targeted and funded health care programs for its medically indigent population.
Generally, the bill continues to place emphasis on funding primary and preventive care services which were key components of the 1987 law, and which are ultimately more beneficial and cost effective. By continuing and completing the phase-in of the programs implemented in chapter 87-92, Laws of Florida, the state will have moved into the position of having a baseline system of two compatible and integrated health care programs (Primary Care and Medicaid) -- one or both of which will be available to persons with incomes below the federal poverty line. In addition, the state is assisted in the funding of these programs by the federal and county governments, and the hospital industry through the assessment on their gross revenues. The long range impact of the policy decisions made in the indigent care parts of this bill should be beneficial to both the state and the citizens it serves. These benefits should increase over time as indigent persons learn of and begin to utilize basic and preventive health care services in lieu of waiting until health problems are more serious and more costly.

Health Care Cost Containment Board

The reenactment of Chapter 395, Part II, Florida Statutes (proposed Chapter 407, Florida Statutes) is consistent with the State Comprehensive Plan which sets as a goal the need to help assure access to affordable, quality health care and to reduce health care cost as a percentage of the total financial resources available to the state and its citizens. The long range impact of keeping a process in place which requires hospitals to justify any increase in charges over certain established thresholds should provide some assurance that the ratio between costs and charges for hospital care is fair and equitable, and that the public's right to affordable health care is protected. This assurance becomes even more critical at least until the current volatile and rapidly changing health care delivery system begins to settle down and stabilize.

IV. COMMENTS:

V. AMENDMENTS:

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Cathie Herndon

Staff Director: Mike Hansen

FINANCE & TAXATION:
Prepared by: 

Staff Director:
Bill #: PCB HC 88-08
Date: April 12, 1988

APPROPRIATIONS:
Prepared by: 

Staff Director:
### Revenues

<table>
<thead>
<tr>
<th>Description</th>
<th>PMATF</th>
<th>Gen Rev</th>
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**TOTAL REVENUES:**

|                    | $342.1 | $12.5  | $184.5  | $539.1 |

### 1988-89 Initiatives

#### 1. PCB HC 88-08 Initiatives

<table>
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<tr>
<th>Description</th>
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<th>Federal</th>
<th>Totals</th>
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<tr>
<td>Physician fee 2nd phase</td>
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<td>Primary Care-. Phase 3</td>
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<tr>
<td>Hospital Indigent Relief</td>
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**Subtotal New Programs:**

|                    | $125.0 | $12.5  | $70.6   | $208.1 |

#### 2. 1988 Current Programs

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<tr>
<th>Description</th>
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<td>Primary Care Demo</td>
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<td>Small Business Demo</td>
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**Subtotal Current Programs:**

|                    | $121.6 | $0     | $113.9  | $235.5 |

**TOTAL EXPENDITURES**

|                    | $246.6 | $12.5  | $184.5  | $443.6 |

**Cash Balance:**

|                    | $95.5  | $0     | $0      | $95.5  |

** Counties could contribute up to 35% of the cost based on current law**
I. SUMMARY:

This bill reenacts the Hospital Cost Containment Board with its regulatory powers, continues the indigent care and certificate of need initiatives implemented in Chapter 87-92, Laws of Florida, and establishes a policy for assisting rural hospitals.

A. PRESENT SITUATION:

Chapter 87-92, Laws of Florida, provided major initiatives to fund and increase access to health care for indigents. Specifically, it enhanced the Medicaid program by: expanding eligibility to pregnant women and children up to age 2 with incomes up to 100 percent of the federal poverty level; phasing in coverage to children up to age 5 by 1991; expanding eligibility to elderly and disabled with incomes up to 90 percent of the poverty level; increasing Medicaid provider fees, requiring DHRS to develop a plan for a phase-in of all physician fees by 1991, and providing special fees for obstetricians and neonatologists. The law also provided for funding for the second phase of the state/county primary care program network and four types of demonstration projects aimed at increasing access for indigents and low income persons to affordable health care; allowed for the creation of independent special taxing districts by counties to fund indigent health care; and, provided for a redistribution of $69.5 million to assist certain hospitals in funding uncompensated care. Chapter 87-92, Laws of Florida, also provided a major rewrite of the certificate of need regulation, including a restructuring and streamlining of the procedures with the intent of providing for more timely and accountable decisions.

Chapter 395, Part II and the Hospital Cost Containment Board are scheduled to Sunset Review pursuant to s. 11.61, F.S., on October 1, 1988, subject to Legislative review and re-enactment. Part II of Chapter 395, F.S., relates to hospital cost containment, and creates the Hospital Cost Containment Board (or board). The stated purpose of the board is to advise the Legislature on health care costs and inflationary trends in health care; to educate consumers and perform
other related tasks. Another major function of the board is to review and approve hospital budgets. Each hospital is required to annually submit to the board two detailed financial statements: a projected budget, submitted 90 days prior to the beginning of each hospital's fiscal year; and a report of actual experience, submitted to the board within 120 days after the end of each hospital's fiscal year. The board reviews each hospital's projected budget based on a comparison to the hospital's previous actual experiences, and a comparison to the performance of other hospitals of similar type. Hospitals with budgets which exceed certain standards are subjected to detailed review by the board.

The board was given authority in 1984 as a result of the Health Care Access Act (Chapter 84-35, Laws of Florida), to approve, to disapprove, or to disapprove in part, hospital budgets based on an established maximum allowable rate of increase (MARI) for hospital gross revenue. If a hospital's gross revenue is in the lower 50 percent of its group or, the lower 80 percent of its group and the hospital has a rate of increase in gross revenues below the MARI, then the hospital's budget is approved without further action by the board. All other hospitals must have their budgets approved by the board, based on patient-payor mix or other standards listed in the law. The law provides penalties for hospitals which exceed the MARI or their approved budgets. Penalties include a prospective reduction to the hospital's budget, fines to be paid into the Public Medical Assistance Trust Fund and possible revocation of a hospital's license. The membership of the board consists of 11 members which are appointed by the Governor and confirmed by the Senate. Four members of the board are consumers, four members are providers (two of whom must represent hospitals, one of whom must be a nursing home provider) and 3 members are purchasers.

Sections 400.341 - 400.346, Florida Statutes, require the Hospital Cost Containment Board to collect and disseminate information relating to nursing home charges.

Rural hospitals in Florida are responsible for meeting many of the health care needs of citizens living in the more remote regions of the state. These hospitals have been undergoing experiences quite different from their urban counterparts in recent years, which threaten the continued financial viability of the rural hospital. Many of these problems have been documented by the Department of Health and Rehabilitative Services (DHRS) on a state-wide level, and by national research organizations and the federal government on a national level. In Florida, one half of the 30 hospitals identified by the DHRS as rural, face serious economic difficulties. Inpatient occupancy rates fell from 54.6% in 1982 to 34.7% in 1986. In three of the four years between 1982 and 1985, 14 of the 30 rural hospitals reported operating losses. In 1985 alone, 17 out of 30 of the predominately smaller rural hospitals reported losses. Additionally, the economic instability experienced by these hospitals has been exacerbated by volatility in ownership: four out of every five of these facilities have been leased or sold within the past six years. Direct negative effects on rural hospitals have a similar causal impact on the health of rural citizens. For example, 7 out of 20 rural hospitals have discontinued obstetrical services since 1981.
These services are now available in only 38% of the state's 34 rural counties, compared to 59% in 1981.

B. EFFECT OF PROPOSED CHANGES:

Indigent Care

This bill would complete the expansion of the state/county primary care system to all 67 counties by funding an additional $10 million dollars. It changes the name of the indigent health care special district to "health care special district;" broadens the scope of the district by allowing the district to fund county-owned or operated hospitals; allows the district to fund hospital services for indigents in private or public facilities and allows the county to fund its share of state or federal indigent care programs which require financial participation by the county. The bill also clarifies language requiring voter approval of any tax levy and requires districts to comply with all reporting and compliance requirements. The bill prohibits health care districts from issuing bonds of any type. The bill also provides an exception to the definition of independent special district to allow certain county governing bodies to be the governing body of a health care special district.

This bill would further the Medicaid enhancements begun in Chapter 87-92, Laws of Florida, by providing for the second and subsequent phases of the physician fee increases up to the Medicare 50th percentile; increasing Medicaid coverage for children up to age 5 immediately, instead of phasing-in coverage; providing for a phase-in of Medicaid coverage for children from age 6 to 8 beginning October 1, 1989; increasing Medicaid eligibility for elderly and disabled adults with incomes between 90 and 100 percent of poverty; increasing lengths of stay to 90 days for neonates in Regional Perinatal Intensive Care Centers or, if it is not possible to target this group only, to increase lengths of stay for all children under 21 participating in the Medicaid Early Periodic Screening Diagnosis and Treatment Program; adding two additional primary care health training demonstration projects; and, by extending the Sunset Review of the Medicaid Medically Needy Program for one year. Finally, the bill allows for a redistribution of up to $70 million dollars of Public Medical Assistance Trust Fund surplus dollars to hospitals providing a minimum of 2 percent of its gross revenues in charity care, and provides the funding for the third and final phase of the state's primary care system.

Health Care Cost Containment Board

This bill re-enacts Chapter 395, Part II, Florida Statutes relating to the Hospital Cost Containment Board which was scheduled to be repealed on October 1, 1988 pursuant s. 11.61, F.S. The bill accomplishes this by transferring the entire part into a newly created chapter, (Chapter 407), and rearranging, amending, and renumbering the sections. In addition, sections 400.314 - 400.246, Florida Statutes relating to nursing home reporting are also transferred, renumbered and amended into Chapter 407, F.S. The chapter is titled Health Care Cost Containment, and the name of the Hospital Cost Containment Board has been changed to the "Health Care Cost Containment Board."

STANDARD FORM 3/88
This bill simplifies and streamlines the methodology by which a hospital would have to file its annual budget with the board, and be subject to detail budget review or penalties. Specifically, the bill changes the budget review process in 8 major ways.

1. Subjects all hospitals to budget review (except those exempted under current law, and certain rural hospitals) if they exceed the maximum allowable rate of increase (MARI).

2. Requires only hospitals requesting an increase in charges (gross revenues per adjusted admission, GR/AA) which exceed the MARI or, are requesting budget amendments which would cause the hospital to exceed the MARI, to file projected budgets and be subject to detailed budget review.

3. Hospitals not requesting increases above the MARI only file a "budget letter" which stipulates what the hospital's projected GR/AA for its next fiscal year will be, and affirms that the hospital intends to stay within the MARI for its group.

4. Allows a hospital, whose actual audited experience at the end of the fiscal year indicates it came in below the MARI, to "bank" up to a cumulative total of 3 percentage points to be used in the future.

5. Changes the definition of maximum allowable rate of increase (MARI), by allowing hospitals to increase charges by the market basket index (currently the National Hospital Input Price Index, NHIPPI) plus two points as the base, and then allows for additional points to be added to the base depending on each hospital's specific experience by giving 50% credit for the proportion of Medicare days to total days, 100% credit for uncompensated charity care days to total days, and 100% credit for the proportion of Medicaid days to total days.

6. Allows budget amendments to be retroactive in certain circumstances.

7. Prioritizes review criteria ranking reasonable rate of return as the first priority, and allows the hospitals to use this criteria to justify increased charges.

8. Gives the board some discretion in using review criteria to evaluate penalty situations.

The bill also changes the current law by decreasing the number of members on the board from 11 to 9 members. The new board would consist of three providers, including one representative of the for-profit hospitals, one representative of the not-for-profit hospitals and one representative of the nursing home industry; three members who are major purchasers of health care; and, three members who are consumers, provided, one consumer member must be 60 years of age or older.

The bill provides for a three-phase 18 month study to be conducted by the University of Florida, to determine a Florida specific measure of
hospital expenses (FHIPI), to make recommendations for a statistical measure or index for severity of illness for acute care hospitals and, to make a separate recommendation for a severity index for psychiatric hospitals.

Finally, the bill provides for another sunset review of the Health Care Cost Containment Act (Chapter 407) in 1992.

Rural Hospitals

This bill creates the Rural Hospital Act of 1988 which strengthens the ability of rural hospitals to operate at "full strength" in terms of services and staffing, and helps to ensure that the health of our rural residents is provided for. Specifically, it defines a rural hospital as a hospital with 85 beds or less which has certain population, density and distance limits as compared to other hospitals. The bill requires coordination of state primary care programs and state programs for the aged with rural hospitals when feasible; extends Medicaid funding to rural hospital swing bed services; authorizes a study of rural hospital manpower shortages and certification and licensure requirements; and finally, the bill provides for a $100,00 appropriation to the Medical Education Tuition Reimbursement Program to reimburse health care practitioners employed by rural hospitals and rural area health education centers (AHEC's).

Certificate of Need

This bill contains several revisions to the state's certificate of need law, as follows: provides expedited review for a single facility which either combines or divides two or more CON's for services or beds; gives health care facilities which are part of the state university system standing to intervene in an administrative hearing for a CON within the same service area of the facility, upon showing that the facility will be substantially affected by the issuance of a CON to a competing facility; extends the validity period for a CON from the current one to two years for certain nursing home multi-facility projects; and, provides for expedited review for certain nursing homes to increase their beds by 50 percent provided they have been operating in the state for at least 60 years.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Title "Affordable Health Care Assurance Act"

Section 2. Amends S. 154.01, F.S., relating to the public health unit delivery system. Allows counties the option of relinquishing ownership of public health facilities and equipment to the Department of Health and Rehabilitative Services by mutual consent of the parties in the contract.

Section 3. Amends s. 154.011, F.S., relating to primary care services. Clarifies that the Legislature's intent was for a system of primary care programs to be organized in all 67 counties. Requires that each program shall provide a comprehensive mix of preventive, personal and non-institutional acute care services.
Section 4. Amends s. 154.331, F.S., relating to indigent health care districts by changing the name to health care special districts and broadening the powers and functions of the district, subject to voter approval. Specifically, it allows districts to fund county owned or operated hospitals, institutional care for indigents in privately or publicly owned facilities and, the county's share of state or federal indigent health care programs which require financial participation by the county. Clarifies and strengthens the language relating to levying taxes; relating to the requirements placed on the districts to comply with s. 200.065, F.S., (truth in millage); and, relating to all reporting and compliance requirements currently required under Chapter 218, Part III, F.S., or any other statute. Changes the appointment of the board from all members being appointed by the county governing body to the Governor appointing 2 members and the county governing body appointing the remainder. Provides that districts may be dissolved pursuant to current statutory requirements under s. 165.051, F.S., or by the county governing body if approved by the voters. Prohibits tax districts from issuing bonds of any type. Allows for the county governing body, when acting as the governing body of a health care special district, to have the same powers and duties and be subject to the same requirements and limitations as an independent board acting as the governing body of such district.

Section 5. Amends s. 200.001, F.S., relating to millage, and definitions. Provides for an exception to the definition of independent special district to allow certain county governing bodies to be the governing body of a health care special district.

Section 6. Amends s. 381.701, F.S., relating to CON definitions. Defines multi-facility project as a unit of a specified size with nursing home beds, adult congregate living facility (ACLF) beds and independent living units.

Section 7. Amends s. 381.705, F.S., relating to review criteria for the issuance of a CON. Specifies that the department must approve an application for a CON to consolidate or divide nursing home beds or services, unless the application fails to meet the test for financial feasibility or unless the consolidation would result in the beds being moved by more than 15 miles from their original location.

Section 8. Amends s. 381.706, F.S., relating to projects subject to CON review. Includes in expedited review the following projects: a 50 percent increase in nursing home beds for nursing homes connected to a residential campus which has been operating in the state for more than 60 years; and the combination or division of nursing home beds or services within a service district when authorized by two or more CON's.

Section 9. Amends s. 381.709, F.S., relating to the CON review process. Gives standing in an administrative hearing for a CON to health care facilities located on the campus of a state university, upon showing that the facility would be substantially affected by the issuance of the CON to a competing facility. Certain additional restrictions apply.
Section 10. Amends s. 381.710, F.S., relating to conditions and monitoring for CON. Extends the validity period for a CON from the current length of one year, to two years for multi-facility projects as defined in s. 381.701, F.S., as amended by this act. Extends the validity period on a CON for consolidation or division of nursing home beds or services as provided for in s. 381.706, F.S., as amended by this act.


Section 12. Amends, transfers and renumbers s. 395.502, F.S., relating to definitions, to s. 407.002, F.S. Changes the definition of "Board" from Hospital Cost Containment Board to Health Care Cost Containment Board. Changes the definition of "maximum allowable rate of increase" (MARI), by establishing a base index to which a hospital specific adjustment can be added, to reach an individual MARI for each hospital. Adds a definition of "rate of return" which may include, but not be limited to four financial indicators which the board would use to determine reasonableness of the financial requirements of a hospital, and adds a definition for "rural hospital."

Section 13. Amends, transfers and renumbers s. 395.5025, F.S., relating to the Legislature's intent, to s. 407.003, F.S. Broadens the intent of the board: to promote improved consumer and purchaser understanding of government funded programs and third party reimbursement; and to recommend to the Legislature appropriate strategies to foster health care cost containment and improve access. Declares that the rising cost of health care, and cost shifting and cross subsidization by hospitals to increase revenues regardless of the cause, is of vital concern to the people of the state.

Section 14. Amends, transfers and renumbers s. 395.503, F.S., relating to the Hospital Cost Containment Board, to s. 407.01, F.S. Changes the name to Health Care Cost Containment Board. Determines board shall be a separate budget entity from the Department of Health and Rehabilitative Services and that the executive director shall be its agency head for all purposes. Decreases membership from 11 to 9 members effective with appointments after January 1, 1989. Changes the board makeup to 3 providers, one of which is a representative of the for-profit hospitals, one of which is a representative of the not-for-profit hospitals, and one of which is a representative of the nursing home industry; 3 consumers, one of which is 60 years of age or older; and 3 major purchasers.

Section 15. Amends, transfers and renumbers s. 395.504, F.S., dealing with powers and duties of board, to s. 407.02, F.S. Limits board's authority to approve, amend or disapprove budgets to only those hospitals requesting increases above the maximum allowable rate of increase (MARI). Strikes and transfers the language dealing with publishing physician data obtained from the Department of Insurance to s. 407.70, F.S. Empowers the board to investigate consumer complaints regarding problems with hospital billing practices and to issue reports in cases where the board determines the hospital engaged in unreasonable and unfair billing practices.
Section 16. Creates a new section 407.025, F.S., providing immunity to hospitals and other reporting entities for providing patient data to the board.

Section 17. Amends, transfers and renumbers s. 395.505, F.S., relating to rules to s. 407.03, F.S. Makes technical changes to replace the word "part" with the word "chapter".

Section 18. Amends, transfers and renumbers s. 395.5051, F.S., relating to effect of act on existing rules, to s. 407.035, F.S. Provides that nothing contained in the act would change rules promulgated to enact chapter 84-35, Laws of Florida, unless in direct conflict with this act. Provides that all budgets or budget amendments beginning prior to February 1, 1989 shall be filed and reviewed subject to chapter 84-35, Laws of Florida.

Section 19. Amends, transfers and renumbers s. 395.512, F.S., relating to the board to submit its final legislative budget request directly to the Governor by November 1 of each even numbered year.

Section 20. Amends, transfers and renumbers s. 395.507, F.S., relating to uniform system of financial reporting for hospitals, to s. 407.05, F.S. Requires only hospitals requesting approval of a rate of increase in gross revenue per adjusted admission (GR/AA) in excess of the maximum allowable rate of increase (MARI) to file budgets for detailed review. Allows for the establishment of not more than 15 groups for the purpose of comparison in the budget review process.

Section 21. Amends transfers and renumbers s. 395.514, F.S., relating to hospital violation of rules, to s. 407.06, F.S. Makes technical changes by correcting references from violations of "part" to violations of "chapter".

Section 22. Amends, transfers and renumbers s. 395.508, F.S., relating to hospital costs and finances; analysis, studies and reports, to s. 407.07, F.S. Changes section title from "hospital" to "health care". Adds authority for board to study effects of Medicare, Medicaid and other government reimbursement mechanisms. Gives the board authority to conduct analysis and research on impact of uncompensated care on hospital budgets. Gives the board authority to conduct analysis and research on the state's role in funding indigent care.

Section 23. Amends, transfers and renumbers s. 395.513, F.S., relating to program accountability, to s. 407.08, F.S. Expands the requirements of the board's annual report to include an analysis of the reasons for existing levels of cross subsidization. Expands the report to include the extent to which public funding policies may be affecting health care costs. Also expands the report to include the extent to which other factors, such as uncompensated care, skilled employee shortages, changes in technology and shifts from institutional to ambulatory care may be affecting health care costs.

Section 24. Amends, transfers and renumbers s. 395.5085, F.S., relating to collection and dissemination of hospital charge
information, to s. 407.09, F.S. Allows board to distribute information utilizing the Consumer Information and Advisory Council created in s. 407.10, F.S., or by any other appropriate means available. Strikes language relating to Consumer Information Network and moves most of the language into s. 407.10, F.S.

**Section 25.** Creates s. 407.10, F.S., relating to the Consumer Information and Advisory Council, previously known as the Consumer Information Network. In addition to responsibilities previously handled by Consumer Information Network, it allows the council to conduct or sponsor consumer information or education seminars at locations throughout the state. It further gives the Council authority to hold public hearings in order to solicit consumer concerns or complaints relating to health care costs and as a result of those hearings, make recommendations to the board for study, action or investigation.

**Section 26.** Amends, transfers and renumbers s. 395.5042, F.S., relating to the Office of Technical Assistance, to s. 407.11, F.S. Expands the responsibilities of the office to include: developing cost containment strategies for providers, employers and consumers; serving as a clearinghouse for information concerning federal and state legislative initiatives affecting health care delivery system and government health care programs; and, developing an outreach program to assist small business to include cost containment initiatives for small business insurance plans.

**Section 27.** Transfers and renumbers s. 395.511, F.S., relating to Quality Assurance Programs to s. 407.12, F.S. Requires hospitals to provide the board with information necessary to evaluate the quality of care provided by the hospital. Provides that the results of accreditation surveys be provided to the board on request.

**Section 28.** Amends, transfers and renumbers s. 395.515., F.S., relating to prospective payment arrangements, to s. 407.13, F.S. Provides for technical changes to name of board.

**Section 29.** Amends, transfers and renumbers s. 400.341, F.S., relating to legislative intent - nursing home costs, to s. 407.30, F.S. Provides for technical changes.

**Section 30.** Amends, transfers and renumbers s. 400.343, F.S., relating to uniform system of financial reporting for nursing homes to s. 407.31, F.S. Provides technical changes in statutory cites.

**Section 31.** Amends, transfers and renumbers s. 400.344, F.S., relating to nursing home revenues and financial analysis, studies and reports, to s. 407.32., F.S. Provides technical changes relating to other statutory cites. Allows the board to prepare and file supplementary studies and reports based on information analyzed relating to nursing home data.

**Section 32.** Amends, transfers and renumbers s. 400.345, F.S., relating to nursing home assessments to fund the budget of board to conduct nursing home financial disclosure program, to s. 407.33., F.S. Provides for technical changes.
Section 33. Amends, transfers and renumbers s. 400.346, F.S., relating to nursing homes violations of law or rules, to s. 407.34, F.S. Provides technical changes to other statutory cites.

Section 34. Substantially amends, transfers and renumbers s. 395.509, F.S., relating to review of hospital budgets, to s. 407.50, F.S. Eliminates hospitals from filing a detailed budget with the board unless the hospital wishes to exceed the maximum allowable rate of increase (MARI). Requires, as an alternative, for hospitals to file a "budget letter" which specifies what the hospitals expected gross revenues per adjusted admission will be for its next fiscal year, and a statement affirming it intends to stay within the MARI. Requires all hospitals which exceed the MARI, either through submission of a budget request or by filing a budget amendment, to be subject to detailed budget review regardless of where they fall in their group. Allows hospitals staying below the MARI to "bank" percentage points to be used in the future, up to a cumulative maximum of 3 points. Changes the "a" through "k" review criteria and prioritizes them. Exempts from budget review certain rural hospitals, those hospitals exempted under current law, and any hospital in which at least 90 percent of its admissions are contracted through a prospective payment system.

Section 35. Amends, transfers and renumbers s. 395.5094, F.S., relating to exceeding approved budget and penalties, to s. 407.51, F.S. Retains current law which places a hospital in a potential penalty situation when its actual net revenues per adjusted admission exceeds the previous year's actual by more than the MARI, or exceeds the projected budget as approved by the board. Requires the board to establish a proxy for psychiatric case mix to reduce the amount of excess a psychiatric hospital may be liable for. Allows the board to reduce the a hospital's excess in certain unforeseen circumstances which occurred in the last three months of a hospital's fiscal year or, if the imposition of the penalty would have a severe adverse effect which would jeopardize the continued existence of an otherwise economically viable hospital.

Section 36. Transfers and renumbers s. 395.5125, F.S., relating to operating costs; non-deductible items, to s. 407.52, F.S. Leaves the original language intact.

Section 37. Transfers and renumbers s. 395.5135, F.S., relating to burden of proof, to s. 407.53, F.S. Leaves the original language intact.

Section 38. Amends, transfers and renumbers s. 395.5092, F.S., relating to duty of Public Council; to s. 407.54, F.S. Clarifies that Public Council may represent consumers before the board, its advisory panels, in administrative hearings or before any other state and federal agencies or courts in any issue related to budget review.

Section 39. Amends, transfers and renumbers s. 395.52, F.S., relating to information on physician's charges, to s. 407.70, F.S. Moves current language dealing with physician information to this section. Specifically, it exempts physicians from any provisions of this act if the physician bills his services independently of the hospital, and
Section 40. Requires the board to contract with the University of Florida to conduct a study which would develop and recommend a Florida specific hospital input price index (FHIPI) to measure hospital expenses and, a statistical indicator or index to measure severity of illness for acute care hospitals and psychiatric hospitals.

Section 41. Amends subsections (7) and (8) of section 409.266, F.S., relating to the Medicaid program. Allocates an additional $10 million from Public Medical Assistance Trust for expansion of primary care system for Medicaid and other low income persons. Increases Medicaid eligibility to elderly and disabled persons from 90 to 100 percent of the poverty level. Increases Medicaid coverage for children up to age 5 with incomes below 100 percent of poverty level immediately, instead of the scheduled phase-in; and, phases-in eligibility for children from age 6 to age 8 beginning October 1, 1989. Requires DHRS to prepare a report by March 1, 1989 on all programs funded through PMATF, with emphasis on the Medically Needy Program. Outlines the next 4 phases of physician fee increases as provided for in chapter 87-92, Laws of Florida. Extends hospital length of stay for Medicaid eligible neonates in Regional Perinatal Intensive Care Centers to 90 days. If HCFA does not allow Florida to single out this subgroup of children, then the department is directed to extend hospital length of stay to 90 days for all Medicaid eligible children under 21, through the Early Pediatric Screening Diagnosis and Treatment Program.

Section 42. Amends s. 409.2661, F.S., relating to medically indigent demonstration projects. Allows for the addition of one more rural and one more urban primary care health training project to be added to the two projects which were funded in Chapter 87-92, Laws of Florida. Provides for $2 million dollars to be appropriated from the Public Medical Assistance Trust Fund to be used to fund the additional projects.

Section 43. Amends s. 409.2663, F.S., relating to a redistribution of Public Medical Assistance Trust Fund to hospitals providing a minimum amount of charity care. Distributes $70 million dollars in 4 quarterly installments to hospitals which provided a minimum of 2% of their gross revenues in documented charity care as reported to the Health Care Cost Containment Board for each quarter beginning in April 1988. Places a cap at 80 percent of Medicaid per diem and pays for no longer than 12 days length of stay. No hospital can receive more than 1/3 of each quarterly payment.

Section 44. Amends s. 627.9175, F.S., relating to reports of information relating to health insurance. Requires insurers to provide information related to physician charges directly to the Health Care Cost Containment Board as well as the Department of Insurance, instead of the board having to wait for the department to compile the data and then transfer it to the board.

Section 45. Creates, the "Rural Hospital Act of 1988," which is contained in sections 45 through 53 of the bill.
Section 46. Establishes legislative findings and intent relating to rural hospitals. Provides that sharply declining occupancy rates, increasing dependence on Medicaid and Medicare reimbursements, liability concerns, frequent changes in ownership, high level of bad debt, greater competition on more sophisticated levels with urban hospitals, and physician and personnel staffing problems are threatening the existence of rural hospitals, and therefore it is the intent of the Legislature to ease this burden.

Section 47. Provides definitions for "rural hospital," "rural Area Health Education Center" and "swing-bed". Defines "rural hospital" to mean a hospital which has 85 beds or less, and which meets at least one of the following requirements: It must be the only provider in a county with no greater than 100 persons per square mile; or, it must be the only acute care hospital within 30 minutes of travel time in a county with no greater than 100 persons per square mile; or, it must be a provider served by a tax district encompassing a population of no greater than 100 persons per square mile. Defines "swing-beds," according to federal regulations, as beds which can be used interchangeably for hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) services. Defines "Rural Area Health Education Centers" (RAHEC's), to mean those centers as authorized by P.L. 94-484, which provide services in counties with population densities of no greater than 100 persons per square mile.

Section 48. Requires the Department of Health and Rehabilitative Services to fully utilize and coordinate primary care programs with the outpatient services at rural hospitals.

Section 49. Appropriates $100,000 from General Revenue funds for the Medical Education Tuition Reimbursement Program (METRP) as created in s. 240.4067, F.S., and limits reimbursement to primary care physicians and nurses employed by or affiliated with rural hospitals or Rural Area Health Education Centers (RAHEC's).

Section 50. Extends Medicaid funding to rural hospital swing-beds for 30 day lengths of stay.

Section 51. Requires the Department of Health and Rehabilitative services to fully utilize and coordinate the department's Aging and Adult Services Program Office with rural hospitals, when cost effective and feasible.

Section 52. Requires the Department of Health and Rehabilitative Services to conduct a manpower shortage study in rural hospitals.

Section 53. Authorizes the Department of Health and Rehabilitative Services to adopt rules necessary to implement the provisions of the Rural Hospital Act which allows for swing beds to be utilized by rural hospitals.

Section 54. Extends Medically Needy Program repeal date as provided for in section 50, chapter 87-92, Laws of Florida, to October 1, 1989, unless reenacted by the Legislature.
Section 55. Repeals section 24, chapter 82-182, Laws of Florida, relating to Sunset Review of chapter 395, Part II, Florida Statutes, and reenacts the Hospital Cost Containment Board as amended and transferred to chapter 407, F.S., but provides that the act shall stand repealed on October 1, 1992, subject to future review pursuant to s. 11.61, F.S.

Section 56. Repeals s. 400.342, F.S., relating to definitions for nursing home financial reporting. This definition was incorporated into the definition section of s. 407.002, F.S.

Section 57. Instructs the Division of Statutory Revision and Index of the Joint Legislative Management Committee to change the name of the "Hospital Cost Containment Board" to Health Care Cost Containment Board whenever it appears in statutes.

Section 58. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

**Indigent Care**

Utilizing projections made on caseloads by the February 1988 Medicaid revenue estimating conference, new indigent care fiscal needs proposed in this bill for 1988/89 are estimated to cost as follows:

<table>
<thead>
<tr>
<th></th>
<th>PMATF</th>
<th>GEN REV</th>
<th>FEDERAL</th>
<th>TOTALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician fee 2nd phase</td>
<td>$ 4.1</td>
<td>$ 6.2</td>
<td>$ 12.8</td>
<td>$23.1</td>
</tr>
<tr>
<td>Children Age 3 to 5</td>
<td>2.6</td>
<td>0</td>
<td>3.1</td>
<td>5.7</td>
</tr>
<tr>
<td>Elderly &amp; Disabled 90-100%</td>
<td>4.4</td>
<td>0</td>
<td>5.4</td>
<td>9.8</td>
</tr>
<tr>
<td>Extend LOS for Kids *</td>
<td>0.0</td>
<td>6.3</td>
<td>7.7</td>
<td>14.0</td>
</tr>
<tr>
<td>Primary Care-phase 3</td>
<td>10.0</td>
<td>0</td>
<td>0</td>
<td>10.0</td>
</tr>
<tr>
<td>Hospital Indigent Relief</td>
<td>70.0</td>
<td>0</td>
<td>0</td>
<td>70.0</td>
</tr>
<tr>
<td>Administrative Costs</td>
<td>1.7</td>
<td>0</td>
<td>1.3</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**TOTALS:** $92.8 $12.5 $30.3 $135.6

* There is no provision in the bill indicating where the funding is to come from, therefore it is assumed in would be a general revenue consequence.

**Health Care Cost Containment Board**

Because this bill significantly alters the boards regulatory function, particularly as it relates to reviewing budgets, it would be difficult to accurately predict the number of hospitals which may be subject to budget review under the new system, and therefore have an impact on the current workload. Because the new budget reporting requirements are not effective until the hospitals fiscal years beginning on or after February 1, 1989, the present staff at a minimum would be needed to continue to review budgets under the current system. Once the new system is implemented, the board staffing requirements would be
dependent on how many hospitals exceed the MARI and submit detailed budgets for review.

In 1987: 293 hospitals submitted budgets which were reviewed by staff

20 hospitals were exempt from board review and approval under current law because they were state or rehab hospitals

152 hospitals were automatically approved under the current law because of where they were in their group, even though they may have exceeded the MARI

121 hospitals were subject to detailed review because they exceeded the MARI or requested budget amendments

The board's staff estimates the additional data collection, analysis and research requirements contained in the bill would require 3 additional staff positions estimated at a cost of $121,300. This money would come from the Health Care Cost Containment Trust Fund. There would also be some minor expense associated with the name change from Hospital Cost Containment Board to Health Care Cost Containment Board. In addition, the board staff estimates the 18 month study by the University of Florida to determine a Florida specific inflation index and the severity of illness indexes, to cost approximately $88,000. There is no provision in the bill as to where the revenue to fund this study would come from.

<table>
<thead>
<tr>
<th>Rural Hospitals</th>
<th>Gen Rev</th>
<th>Feds</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Med Ed Tuition Program:</td>
<td>$.1</td>
<td>.0</td>
<td>$.1</td>
</tr>
<tr>
<td>Rural Hospital Swing Beds:</td>
<td>.6</td>
<td>.8</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$.7</strong></td>
<td><strong>$.8</strong></td>
<td><strong>$1.5</strong></td>
</tr>
</tbody>
</table>

**Certificate of Need**

The only fiscal impact on a state agency may be the legal costs incurred by a health care facility which is part of the state's university system should it initiates or intervenes in an administrative hearing. It is not possible to estimate what these costs might be.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

PRIMARY CARE - There is no fiscal consequences mandated on the counties for receiving grant money to establish primary care programs. The counties should benefit by the infusion of state primary care dollars into this area.

HEALTH CARE SPECIAL TAX DISTRICTS - Counties are given a potential revenue source to fund current and future indigent health care obligations or initiatives, if the voters approve creation of the district.
ELDERLY AND DISABLED, AND KIDS FROM 3 TO 5 - Counties are required to pay 35% of the cost of hospital inpatient services for these groups with lengths of stays between the 12 and 45 day.

EXTEND MEDICAID LENGTH OF STAY FOR KIDS TO 90 DAYS - Counties are exempted from paying 35% of the cost for the additional length of stay.

HOSPITAL COST CONTAINMENT BOARD - There should be no fiscal cost to the counties as a result of the continuation of the board. Counties may receive an indirect benefit however, if the rate of increase in hospital charges is slowed or reduced, because of the amount most counties pay toward health care benefits for county employees or the amount they pay for hospital care for indigents if the county funds such a program.

RURAL HOSPITALS - The bill does not specifically exempt the county's obligations to contribute to the Medicaid Program as required for in s. 409.267, F.S. DHRS indicates it would bill the county for the county's share of the Medicaid costs, depending on how the hospital submits its bill to Medicaid (either a hospital per deim or a nursing home per deim). For the 901 patients DHRS estimates would be eligible for rural hospital swing beds, the counties maximum liability would be approximately $49,555 per year (based on a 30 day maximum length of stay). These estimates assumes the maximum liability a county must contribute for nursing home care is $55.00 per month times the 901 potentially eligible patients.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

INDIGENT CARE - Except for the hospital assessment paid into the Public Medical Assistance Trust Fund which is required under current law to fund indigent care, there should not be any additional direct private sector cost.

The hospitals are estimated to directly benefit from the new or continued initiatives contained in the legislation as follows:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of redistribution</td>
<td>$ 70.0</td>
</tr>
<tr>
<td>100% of LOS for kids</td>
<td>$ 14.0</td>
</tr>
<tr>
<td>75% elderly/disabled</td>
<td>$ 7.4</td>
</tr>
<tr>
<td>50% kids 3 to 5</td>
<td>$ 2.9</td>
</tr>
<tr>
<td>80% Medically Needy</td>
<td>$ 61.5</td>
</tr>
<tr>
<td>100% Medicaid swing bed</td>
<td>$ 1.4</td>
</tr>
<tr>
<td>total</td>
<td>$157.2</td>
</tr>
</tbody>
</table>

Physicians are estimated to directly benefit as follows:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of physician fees</td>
<td>$ 23.1</td>
</tr>
<tr>
<td>10% elderly &amp; disabled</td>
<td>$ 1.0</td>
</tr>
<tr>
<td>45% kids 3 to 5</td>
<td>$ 2.6</td>
</tr>
<tr>
<td>15% Medically Needy</td>
<td>$ 11.5</td>
</tr>
<tr>
<td>5% primary care</td>
<td>$ .5</td>
</tr>
<tr>
<td>total</td>
<td>$ 38.7</td>
</tr>
</tbody>
</table>
Pharmacies and other providers should directly benefit as follows:

<table>
<thead>
<tr>
<th>Group</th>
<th>Savings ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15% elderly and disabled</td>
<td>1.5</td>
</tr>
<tr>
<td>5% kids 3 to 5</td>
<td>0.2</td>
</tr>
<tr>
<td>5% Medically Needy</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>5.5</td>
</tr>
</tbody>
</table>

HEALTH CARE COST CONTAINMENT BOARD - This bill does not place any additional direct financial obligation on hospitals as a result of the change in budget review methodology, and should in fact, cause a reduction somewhat in costs for those hospitals submitting budgets within the MARI, because they would no longer be required to submit budgets. According to survey results conducted by the Health Care Committee for purposes of sunset review, hospitals reported an average of approximately $33,000 per year to comply with all the requirements of the law relating to budget review. Assuming one-half of the 293 hospitals which filed budgets in fiscal year 1987-88 did not exceed the MARI as established in this bill, there is potential for saving administrative costs of approximately 15 to 25 percent, depending on how many hospitals are subject to budget review. Because all budgets exceeding the MARI would be subject to budget review under this bill versus less than 50 percent under the current system, it is conceivable hospitals not subject to board scrutiny in the past because of where they fell within their group, may now incur additional costs for justifying their need for increases above the MARI.

III. LONG RANGE CONSEQUENCES:

Indigent Care

The indigent care sections of this bill are consistent with the goals of the State Comprehensive Plan to improve access to health care services for indigent persons and should, in conjunction with the changes implemented in chapter 87-92, Laws of Florida, provide a positive long term policy change in the way the state has historically targeted and funded health care programs for its medically indigent population.

Generally, the bill continues to place emphasis on funding primary and preventive care services which were key components of the 1987 law, and which are ultimately more beneficial and cost effective. By continuing and completing the phase-in of the programs implemented in chapter 87-92, Laws of Florida, the state will have moved into the position of having a baseline system of two compatible and integrated health care programs (Primary Care and Medicaid) -- one or both of which will be available to persons with incomes below the federal poverty line. In addition, the state is assisted in the funding of these programs by the federal and county governments, and the hospital industry through the assessment on their gross revenues. The long range impact of the policy decisions made in the indigent care parts of this bill should be beneficial to both the state and the citizens it serves. These benefits should increase over time as indigent persons learn of and begin to utilize basic and preventive health care
services in lieu of waiting until health problems are more serious and more costly.

**Health Care Cost Containment Board**

The reenactment of Chapter 395, Part II, Florida Statutes (proposed Chapter 407, Florida Statutes) is consistent with the State Comprehensive Plan which sets as a goal the need to help assure access to affordable, quality health care and to reduce health care cost as a percentage of the total financial resources available to the state and its citizens. The long range impact of keeping a process in place which requires hospitals to justify any increase in charges over certain established thresholds should provide some assurance that the ratio between costs and charges for hospital care is fair and equitable, and that the public's right to affordable health care is protected. This assurance becomes even more critical at least until the current volatile and rapidly changing health care delivery system begins to settle down and stabilize.

**Rural Hospitals**

The measures provided for in this bill should provide some measure of relief for rural hospitals, however, they are not sufficient to ensure the continued financial health of rural hospitals. As competition with urban facilities increases and unforeseen changes in the market occur, rural hospitals must diversify in order to be competitive and remain attractive to rural residents. The adoption of non-traditional and sometimes non-medical services should help the rural hospitals to stay viable, particularly if they are able to fill the unmet needs of the rural residents and especially the unmet needs of the elderly.

**IV. COMMENTS:**

Clearly the most controversial sections of this bill deal with the Health care Cost Containment Board, and specifically with the regulatory powers conferred on the Board. The major debate has centered on 4 major issues.

**GROSS VERSUS NET REGULATION** - The first and probably the most important issue is whether to regulate hospitals on "gross revenues" or "net revenues." In hospital "lingo," gross revenue means the amount the hospital charges to patients, regardless of who pays the bill. This number is consistent across all payor groups within the hospital, and it is the number from which all revenue deductions are subtracted. Net revenue means the amount of money a hospital actually collects from all patients. This number is not consistent among payor groups and can vary significantly depending on who is paying or not paying the bill. For example, Medicare pays based on a fixed fee per diagnosis and ignores charges; charity care patients often pay nothing; and PPO and HMO payors usually pay a discounted rate. The shortfalls from these discounted payors are often cost-shifted into the gross revenue charged to private pay and insured patients.

Under the current regulatory system, which is based on gross revenues, the amount a hospital can increase charges and cost-shift the increase to private or full pay patients is limited. This is the case, because
the increase in charges is capped equally to all payor groups, regardless of what percentage the patient pays. For example, if a 10 percent increase in gross revenues is allowed, the maximum a private or full pay patient's charges can be increased is 10 percent.

Under a net review system, there is no limit on the amount a hospital can increase gross revenues (charges), and cost-shift the increase to the private pay patient. Net revenue regulation only controls the amount the hospital can collect. Because a hospital collects different revenues from each payor group, and in charity cases no revenues, the effect of a 10 percent increase in allowable collections would permit the hospital to charge the private pay patients whatever the market will bare to make up for the shortfalls in other payor collections. The result is no regulation of charges at all.

MARI - The maximum allowable rate of increase or MARI is the threshold established in law which, if exceeded by certain high charge hospitals, would place the hospital in a detailed budget review situation. The bill allows a hospital to increase its charges above the MARI if it can justify to the board that the increase is reasonable and necessary. Current law establishes the MARI at the national hospital input price index (NHIPI) plus 3 points to reflect the higher cost of proving services in Florida. The hospital industry has argued for significant increases in the MARI, which would effectively reduce the number of hospitals exceeding the threshold and therefore not need to justify increases in charges.

REGULATE ALL VERSUS ONLY SOME HOSPITALS - Under the current law, hospitals ranked in the lower 50th percentile based on gross revenues per adjusted admission, are not subject to budget review and, another 30% of higher charge hospitals can escape budget review if they stay within the MARI. For non-regulated hospitals falling below the 50th percentile, the mean budgeted rate of increase in charges from 1987 to 1988 was 19.0% compared to an average mean of 8.5% for hospitals subject to regulation. This trend has persisted since the budget regulation authority was imposed on the board. The expectation that competition, rather than regulation, would help to contain increases in charges has apparently not materialized. This is evidenced by rates of increase by non-regulated hospitals equating to twice as high as increases in regulated hospitals. When analyzing the projected rates of increase from 1987-1988, it is clear that the 85 hospitals between the 50th and the 80th percentile were constrained by the MARI threshold. When the case mix allowance, (which can be added to the MARI under board rule without triggering a budget review), was deducted from the hospitals projected rate of increase, 47 hospitals submitted their budgets directly at the MARI; 9 hospitals submitted their budgets at one percent below the MARI; and, 8 hospitals submitted budgets at three percent below the MARI. In total, after deducting the case mix add-on only 9 out of the 85 hospitals falling within this range submitted budgets with rates of increases above the MARI. By staying within this threshold, all these hospitals were able to escape detailed budget review thus affirming the board's sentinel effect over rates of increase.

COMPOSITION OF BOARD - The fourth major area of controversy focuses on the make-up of the board. The American Association of Retired Persons
and the Commissioner of Insurance strongly support an autonomous full-time, non-provider board. Arguments focus on the fact that the current board appears to be provider dominated, and cannot be an effective advocate for the health care consumers. The current 11 member board consists of one member employed by a for-profit hospital chain, one member employed as an administrator of a not-for-profit hospital, one consumer member who was a former hospital administrator, one consumer member who was a former trustee on the board of a hospital, and one purchaser member who was a former finance office for a hospital. In addition, hospitals provide significant representation on various technical advisory panels which make policy recommendations to the board.

V. AMENDMENTS:

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Cathie Herndon

[Signature]

Staff Director: Mike Hansen

FINANCE & TAXATION:
Prepared by:

[Signature]

Staff Director:

APPROPRIATIONS:
Prepared by:

[Signature]

Staff Director:
1. PCB HC 88-08 Initiatives

- Physician fee 2nd phase
- Children age 3 to 5
- Elderly & Disabled 90 to 100
- Extend LOS for kids**
- Kids age 6 to 8
- Primary Care-Phase 3
- Primary Care Demo-2 Add'l
- Medicaid Swing Bed (rural)
- Hospital Indigent Relief
- Re-enact Medically Needy
- Med Ed Tuition Program
- Univ. Fla Study (FHIPI)
- Administrative Costs HRS

Subtotal New Programs: $129.5 $13.2 $73.4 $216.1

2. 1988 Current Programs

- Hospital O/P
- Categorical Eligible
- Pregnant Women
- Children to age 3
- Elderly to 90%
- Administrative Costs
- Primary Care
- Primary Care Demo
- Child Health Demo
- Drug and Alcohol Demo
- Small Business Demo
- '1987 Hospital Relief

Subtotal Current Programs: $121.6 .0 $113.9 $235.5

TOTAL EXPENDITURES $251.1 $13.2 $187.3 $451.6

Cash Balance: $92.6 .0 .0 $92.6
This bill reenacts the Hospital Cost Containment Board with its regulatory powers, continues the indigent care and certificate of need initiatives implemented in Chapter 87-92, Laws of Florida, and establishes a policy for assisting rural hospitals.

A. PRESENT SITUATION:

Chapter 87-92, Laws of Florida, provided major initiatives to fund and increase access to health care for indigents. Specifically, it enhanced the Medicaid program by: expanding eligibility to pregnant women and children up to age 2 with incomes up to 100 percent of the federal poverty level; phasing in coverage to children up to age 5 by 1991; expanding eligibility to elderly and disabled with incomes up to 90 percent of the poverty level; increasing Medicaid provider fees, requiring DHRS to develop a plan for a phase-in of all physician fees by 1991, and providing special fees for obstetricians and neonatologists. The law also provided for funding for the second phase of the state/county primary care program network and four types of demonstration projects aimed at increasing access for indigents and low income persons to affordable health care; allowed for the creation of independent special taxing districts by counties to fund indigent health care; and, provided for a redistribution of $69.5 million to assist certain hospitals in funding uncompensated care. Chapter 87-92, Laws of Florida, also provided a major rewrite of the certificate of need regulation, including a restructuring and streamlining of the procedures with the intent of providing for more timely and accountable decisions.

Chapter 395, Part II and the Hospital Cost Containment Board are scheduled to Sunset Review pursuant to s. 11.61, F.S., on October 1, 1988, subject to Legislative review and re-enactment. Part II of Chapter 395, F.S., relates to hospital cost containment, and creates the Hospital Cost Containment Board (or board). The stated purpose of the board is to advise the Legislature on health care costs and inflationary trends in health care; to educate consumers and perform other related tasks. Another major function of the board is to review and approve hospital budgets. Each hospital is required to annually submit to the board two detailed financial statements: a projected budget, submitted 90 days prior to the beginning of each hospital's fiscal year; and a report of actual experience, submitted to the
board within 120 days after the end of each hospital’s fiscal year. The board reviews each hospital’s projected budget based on a comparison to the hospital’s previous actual experiences, and a comparison to the performance of other hospitals of similar type. Hospitals with budgets which exceed certain standards are subjected to detailed review by the board.

The board was given authority in 1984 as a result of the Health Care Access Act (Chapter 84-35, Laws of Florida), to approve, to disapprove, or to disapprove in part, hospital budgets based on an established maximum allowable rate of increase (MARI) for hospital gross revenue. If a hospital’s gross revenue is in the lower 50 percent of its group or, the lower 80 percent of its group and the hospital has a rate of increase in gross revenues below the MARI, then the hospital’s budget is approved without further action by the board. All other hospitals must have their budgets approved by the board, based on patient-payor mix or other standards listed in the law. The law provides penalties for hospitals which exceed the MARI or their approved budgets. Penalties include a prospective reduction to the hospital’s budget, fines to be paid into the Public Medical Assistance Trust Fund and possible revocation of a hospital’s license. The membership of the board consists of 11 members which are appointed by the Governor and confirmed by the Senate. Four members of the board are consumers, four members are providers (two of whom must represent hospitals, one of whom must be a nursing home provider) and 3 members are purchasers.

Sections 400.341 - 400.346, Florida Statutes, require the Hospital Cost Containment Board to collect and disseminate information relating to nursing home charges.

Rural hospitals in Florida are responsible for meeting many of the health care needs of citizens living in the more remote regions of the state. These hospitals have been undergoing experiences quite different from their urban counterparts in recent years, which threaten the continued financial viability of the rural hospital. Many of these problems have been documented by the Department of Health and Rehabilitative Services (DHRS) on a state-wide level, and by national research organizations and the federal government on a national level. In Florida, one half of the 30 hospitals identified by the DHRS as rural, face serious economic difficulties. Inpatient occupancy rates fell from 54.6% in 1982 to 34.7% in 1986. In three of the four years between 1982 and 1985, 14 of the 30 rural hospitals reported operating losses. In 1985 alone, 17 out of 30 of the predominately smaller rural hospitals reported losses. Additionally, the economic instability experienced by these hospitals has been exacerbated by volatility in ownership: four out of every five of these facilities have been leased or sold within the past six years. Direct negative effects on rural hospitals have a similar causal impact on the health of rural citizens. For example, 7 out of 20 rural hospitals have discontinued obstetrical services since 1981. These services are now available in only 38% of the state’s 34 rural counties, compared to 59% in 1981.

B. EFFECT OF PROPOSED CHANGES:

**Indigent Care**

This bill would complete the expansion of the state/county primary care system to all 67 counties by funding an additional $10 million dollars. It changes the name of the indigent health care special district to "health care special district;" broadens the scope of the district by allowing the district to fund county-owned or operated hospitals; allows the district to fund hospital services for indigents in private or public facilities and allows the county to fund its share of state or federal indigent care programs which require financial participation by the county. The bill
also clarifies language requiring voter approval of any tax levy and requires districts to comply with all reporting and compliance requirements. The bill prohibits health care districts from issuing bonds of any type. The bill also provides an exception to the definition of independent special district to allow certain county governing bodies to be the governing body of a health care special district.

This bill would further the Medicaid enhancements begun in Chapter 87-92, Laws of Florida, by providing for the second and subsequent phases of the physician fee increases up to the Medicare 50th percentile; increasing Medicaid coverage for children up to age 5 immediately, instead of phasing-in coverage; providing for a phase-in of Medicaid coverage for children from age 6 to 8 beginning October 1, 1989; increasing Medicaid eligibility for elderly and disabled adults with incomes between 90 and 100 percent of poverty; increasing lengths of stay to 90 days for neonates in Regional Perinatal Intensive Care Centers or, if it is not possible to target this group only, to increase lengths of stay for all children under 21 participating in the Medicaid Early Periodic Screening Diagnosis and Treatment Program; adding two additional primary care health training demonstration projects; and, by extending the Sunset Review of the Medicaid Medically Needy Program for one year. Finally, the bill allows for a redistribution of up to $70 million dollars of Public Medical Assistance Trust fund surplus dollars to hospitals providing a minimum of 2 percent of its gross revenues in charity care, and provides the funding for the third and final phase of the state's primary care system.

Health Care Cost Containment Board

This bill re-enacts Chapter 395, Part II, Florida Statutes relating to the Hospital Cost Containment Board which was scheduled to be repealed on October 1, 1988 pursuant s. 11.61, F.S. The bill accomplishes this by transferring the entire part into a newly created chapter, (Chapter 407), and rearranging, amending, and renumbering the sections. In addition, sections 400.314 - 400.246, Florida Statutes relating to nursing home reporting are also transferred, renumbered and amended into Chapter 407, F.S. The chapter is titled Health Care Cost Containment, and the name of the Hospital Cost Containment Board has been changed to the "Health Care Cost Containment Board."

This bill simplifies and streamlines the methodology by which a hospital would have to file its annual budget with the board, and be subject to detail budget review or penalties. Specifically, the bill changes the budget review process in 8 major ways.

1. Subjects all hospitals to budget review (except those exempted under current law, and certain rural hospitals) if they exceed the maximum allowable rate of increase (MARI).

2. Requires only hospitals requesting an increase in charges (gross revenues per adjusted admission, GR/AA) which exceed the MARI or, are requesting budget amendments which would cause the hospital to exceed the MARI, to file projected budgets and be subject to detailed budget review.

3. Hospitals not requesting increases above the MARI only file a "budget letter" which stipulates what the hospital's projected GR/AA for its next fiscal year will be, and affirms that the hospital intends to stay within the MARI for its group.
4. Allows a hospital, whose actual audited experience at the end of the fiscal year indicates it came in below the MARI, to "bank" up to a cumulative total of 3 percentage points to be used in the future.

5. Changes the definition of maximum allowable rate of increase (MARI), by allowing hospitals to increase charges by the market basket index (currently the National Hospital Input Price Index, NHIPI) plus two points as the base, and then allows for additional points to be added to the base depending on each hospital's specific experience by giving 50% credit for the proportion of Medicare days to total days, 100% credit for uncompensated charity care days to total days, and 100% credit for the proportion of Medicaid days to total days.

6. Allows budget amendments to be retroactive in certain circumstances.

7. Prioritizes review criteria ranking reasonable rate of return as the first priority, and allows the hospitals to use this criteria to justify increased charges.

8. Gives the board some discretion in using review criteria to evaluate penalty situations.

The bill also changes the current law by decreasing the number of members on the board from 11 to 9 members. The new board would consist of three providers, including one representative of the for-profit hospitals, one representative of the not-for-profit hospitals and one representative of the nursing home industry; three members who are major purchasers of health care; and, three members who are consumers, provided, one consumer member must be 60 years of age or older.

The bill provides for a three-phase 18 month study to be conducted by the University of Florida, to determine a Florida specific measure of hospital expenses (FHIPI), to make recommendations for a statistical measure or index for severity of illness for acute care hospitals and, to make a separate recommendation for a severity index for psychiatric hospitals.

Finally, the bill provides for another sunset review of the Health Care Cost Containment Act (Chapter 407) in 1992.

**Rural Hospitals**

This bill creates the Rural Hospital Act of 1988 which strengthens the ability of rural hospitals to operate at "full strength" in terms of services and staffing, and helps to ensure that the health of our rural residents is provided for. Specifically, it defines a rural hospital as a hospital with 85 beds or less which has certain population, density and distance limits as compared to other hospitals. The bill requires coordination of state primary care programs and state programs for the aged with rural hospitals when feasible; extends Medicaid funding to rural hospital swing bed services; authorizes a study of rural hospital manpower shortages and certification and licensure requirements; and finally, the bill provides for a $100,000 appropriation to the Medical Education Tuition Reimbursement Program to reimburse health care practitioners employed by rural hospitals and rural area health education centers (AHEC's).

**Certificate of Need**

This bill contains several revisions to the state's certificate of need law, as follows: provides expedited review for a single facility which either combines or
divides two or more CON’s for services or beds; gives health care facilities which are part of the state university system standing to intervene in an administrative hearing for a CON within the same service area of the facility, upon showing that the facility will be substantially affected by the issuance of a CON to a competing facility; extends the validity period for a CON from the current one to two years for certain nursing home multi-facility projects; and, provides for expedited review for certain nursing homes to increase their beds by 50 percent provided they have been operating in the state for at least 60 years.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Title "Affordable Health Care Assurance Act"

Section 2. Amends S. 154.01, F.S., relating to the public health unit delivery system. Allows counties the option of relinquishing ownership of public health facilities and equipment to the Department of Health and Rehabilitative Services by mutual consent of the parties in the contract.

Section 3. Amends s. 154.011, F.S., relating to primary care services. Clarifies that the Legislature's intent was for a system of primary care programs to be organized in all 67 counties. Requires that each program shall provide a comprehensive mix of preventive, personal and non-institutional acute care services.

Section 4. Amends s. 154.331, F.S., relating to indigent health care districts by changing the name to health care special districts and broadening the powers and functions of the district, subject to voter approval. Specifically, it allows districts to fund county owned or operated hospitals, institutional care for indigents in privately or publicly owned facilities and, the county's share of state or federal indigent health care programs which require financial participation by the county. Clarifies and strengthens the language relating to levying taxes; relating to the requirements placed on the districts to comply with s. 200.065, F.S., (truth in millage); and, relating to all reporting and compliance requirements currently required under Chapter 218, Part III, F.S., or any other statute. Changes the appointment of the board from all members being appointed by the county governing body to the Governor appointing 2 members and the county governing body appointing the remainder. Provides that districts may be dissolved pursuant to current statutory requirements under s. 165.051, F.S., or by the county governing body if approved by the voters. Prohibits tax districts from issuing bonds of any type. Allows for the county governing body, when acting as the governing body of a health care special district, to have the same powers and duties and be subject to the same requirements and limitations as an independent board acting as the governing body of such district.

Section 5. Amends s. 200.001, F.S., relating to millage, and definitions. Provides for an exception to the definition of independent special district to allow certain county governing bodies to be the governing body of a health care special district.

Section 6. Amends s. 381.701, F.S., relating to CON definitions. Defines multi-facility project as a unit of a specified size with nursing home beds, adult congregate living facility (ACLF) beds and independent living units.

Section 7. Amends s. 381.705, F.S., relating to review criteria for the issuance of a CON. Specifies that the department must approve an application for a CON to consolidate or divide nursing home beds or services, unless the application fails to meet the test for financial feasibility or unless the consolidation would result in the beds being moved by more than 15 miles from their original location.
Amends s. 381.706, F.S., relating to projects subject to CON review. Includes in expedited review the following projects: a 50 percent increase in nursing home beds for nursing homes connected to a residential campus which has been operating in the state for more than 60 years; and the combination or division of nursing home beds or services within a service district when authorized by two or more CON's.

Amends s. 381.709, F.S., relating to the CON review process. Gives standing in an administrative hearing for a CON to health care facilities located on the campus of a state university, upon showing that the facility would be substantially affected by the issuance of the CON to a competing facility. Certain additional restrictions apply.

Amends s. 381.710, F.S., relating to conditions and monitoring for CON. Extends the validity period for a CON from the current length of one year, to two years for multi-facility projects as defined in s. 381.701, F.S., as amended by this act. Extends the validity period on a CON for consolidation or division of nursing home beds or services as provided for in s. 381.706, F.S., as amended by this act.

Amends s. 395.502, F.S., relating to definitions, to s. 407.002, F.S. Changes the definition of "Board" from Hospital Cost Containment Board to Health Care Cost Containment Board. Changes the definition of "maximum allowable rate of increase" (MARI), by establishing a base index to which a hospital specific adjustment can be added, to reach an individual MARI for each hospital. Adds a definition of "rate of return" which may include, but not be limited to four financial indicators which the board would use to determine reasonableness of the financial requirements of a hospital, and adds a definition for "rural hospital."

Amends s. 395.5025, F.S., relating to the Legislature's intent, to s. 407.003, F.S. Broadens the intent of the board: to promote improved consumer and purchaser understanding of government funded programs and third party reimbursement; and to recommend to the Legislature appropriate strategies to foster health care cost containment and improve access. Declares that the rising cost of health care, and cost shifting and cross subsidization by hospitals to increase revenues regardless of the cause, is of vital concern to the people of the state.

Amends, transfers and renumbers s. 395.503, F.S., relating to the Hospital Cost Containment Board, to s. 407.01, F.S. Changes the name to Health Care Cost Containment Board. Determines board shall be a separate budget entity from the Department of Health and Rehabilitative Services and that the executive director shall be its agency head for all purposes. Decreases membership from 11 to 9 members effective with appointments after January 1, 1989. Changes the board makeup to 3 providers, one of which is a representative of the for-profit hospitals, one of which is a representative of the not-for-profit hospitals, and one of which is a representative of the nursing home industry; 3 consumers, one of which is 60 years of age or older; and 3 major purchasers.

Amends, transfers and renumbers s. 395.504, F.S., dealing with powers and duties of board, to s. 407.02, F.S. Limits board's authority to approve, amend or disapprove budgets to only those hospitals requesting increases above the maximum allowable rate of increase (MARI). Strikes and transfers the language dealing with
publishing physician data obtained from the Department of Insurance to s. 407.70, F.S. Empowers the board to investigate consumer complaints regarding problems with hospital billing practices and to issue reports in cases where the board determines the hospital engaged in unreasonable and unfair billing practices.

Section 16. Creates a new section 407.025, F.S., providing immunity to hospitals and other reporting entities for providing patient data to the board.

Section 17. Amends, transfers and renumbers s. 395.505, F.S., relating to rules to s. 407.03, F.S. Makes technical changes to replace the word "part" with the word "chapter".

Section 18. Amends, transfers and renumbers s. 395.5051, F.S., relating to effect of act on existing rules, to s. 407.035, F.S. Provides that nothing contained in the act would change rules promulgated to enact chapter 84-35, Laws of Florida, unless in direct conflict with this act. Provides that all budgets or budget amendments beginning prior to February 1, 1989 shall be filed and reviewed subject to chapter 84-35, Laws of Florida.

Section 19. Amends, transfers and renumbers s. 395.512, F.S., relating to the budget of the board to s. 407.04, F.S. Requires the board to submit its final legislative budget request directly to the Governor by November 1 of each even numbered year.

Section 20. Amends, transfers and renumbers s. 395.507, F.S., relating to uniform system of financial reporting for hospitals, to s. 407.05, F.S. Requires only hospitals requesting approval of a rate of increase in gross revenue per adjusted admission (GR/AA) in excess of the maximum allowable rate of increase (MARI) to file budgets for detailed review. Allows for the establishment of not more than 15 groups for the purpose of comparison in the budget review process.

Section 21. Amends transfers and renumbers s. 395.514, F.S., relating to hospital violation of rules, to s. 407.06, F.S. Makes technical changes by correcting references from violations of "part" to violations of "chapter".

Section 22. Amends, transfers and renumbers s. 395.508, F.S., relating to hospital costs and finances; analysis, studies and reports, to s. 407.07, F.S. Changes section title from "hospital" to "health care". Adds authority for board to study effects of Medicare, Medicaid and other government reimbursement mechanisms. Gives the board authority to conduct analysis and research on impact of uncompensated care on hospital budgets. Gives the board authority to conduct analysis and research on the state's role in funding indigent care.

Section 23. Amends, transfers and renumbers s. 395.513, F.S., relating to program accountability, to s. 407.08, F.S. Expands the requirements of the board's annual report to include an analysis of the reasons for existing levels of cross subsidization. Expands the report to include the extent to which public funding policies may be affecting health care costs. Also expands the report to include the extent to which other factors, such as uncompensated care, skilled employee shortages, changes in technology and shifts from institutional to ambulatory care may be affecting health care costs.

Section 24. Amends, transfers and renumbers s. 395.5085, F.S., relating to collection and dissemination of hospital charge information, to s. 407.09, F.S. Allows board to distribute information utilizing the Consumer Information and Advisory Council created in s. 407.10, F.S., or by any other appropriate means.
available. Strikes language relating to Consumer Information Network and moves most of the language into s. 407.10, F.S.

Section 25. Creates s. 407.10, F.S., relating to the Consumer Information and Advisory Council, previously known as the Consumer Information Network. In addition to responsibilities previously handled by Consumer Information Network, it allows the council to conduct or sponsor consumer information or education seminars at locations throughout the state. It further gives the Council authority to hold public hearings in order to solicit consumer concerns or complaints relating to health care costs and as a result of those hearings, make recommendations to the board for study, action or investigation.

Section 26. Amends, transfers and renumbers s. 395.5042, F.S., relating to the Office of Technical Assistance, to s. 407.11, F.S. Expands the responsibilities of the office to include: developing cost containment strategies for providers, employers and consumers; serving as a clearinghouse for information concerning federal and state legislative initiatives affecting health care delivery system and government health care programs; and, developing an outreach program to assist small business to include cost containment initiatives for small business insurance plans.

Section 27. Transfers and renumbers s. 395.511, F.S., relating to Quality Assurance Programs to s. 407.12, F.S. Requires hospitals to provide the board with information necessary to evaluate the quality of care provided by the hospital. Provides that the results of accreditation surveys be provided to the board on request.

Section 28. Amends, transfers and renumbers s. 395.515., F.S., relating to prospective payment arrangements, to s. 407.13, F.S. Provides for technical changes to name of board.

Section 29. Amends, transfers and renumbers s. 400.341, F.S., relating to legislative intent - nursing home costs, to s. 407.30, F.S. Provides for technical changes.

Section 30. Amends, transfers and renumbers s. 400.343, F.S., relating to uniform system of financial reporting for nursing homes to s. 407.31, F.S. Provides technical changes in statutory cites.

Section 31. Amends, transfers and renumbers s. 400.344, F.S., relating to nursing home revenues and financial analysis, studies and reports, to s. 407.32., F.S. Provides technical changes relating to other statutory cites. Allows the board to prepare and file supplementary studies and reports based on information analyzed relating to nursing home data.

Section 32. Amends, transfers and renumbers s. 400.345, F.S., relating to nursing home assessments to fund the budget of board to conduct nursing home financial disclosure program, to s. 407.33., F.S. Provides for technical changes.

Section 33. Amends, transfers and renumbers s. 400.346, F.S., relating to nursing homes violations of law or rules, to s. 407.34, F.S. Provides technical changes to other statutory cites.

Section 34. Substantially amends, transfers and renumbers s. 395.509, F.S., relating to review of hospital budgets, to s. 407.50, F.S. Eliminates hospitals from filing a detailed budget with the board unless the hospital wishes to exceed the maximum allowable rate of increase (MARI). Requires, as an alternative, for hospitals to file a "budget letter" which specifies what the hospitals expected gross revenues per

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adjusted admission will be for its next fiscal year, and a statement affirming it intends to stay within the MARI. Requires all hospitals which exceed the MARI, either through submission of a budget request or by filing a budget amendment, to be subject to detailed budget review regardless of where they fall in their group. Allows hospitals staying below the MARI to "bank" percentage points to be used in the future, up to a cumulative maximum of 3 points. Changes the "a" through "k" review criteria and prioritizes them. Exempts from budget review certain rural hospitals, those hospitals exempted under current law, and any hospital in which at least 90 percent of its admissions are contracted through a prospective payment system.

Section 35. Amends, transfers and renumbers s. 395.5094, F.S., relating to exceeding approved budget and penalties, to s. 407.51, F.S. Retains current law which places a hospital in a potential penalty situation when its actual net revenues per adjusted admission exceeds the previous year's actual by more than the MARI, or exceeds the projected budget as approved by the board. Requires the board to establish a proxy for psychiatric case mix to reduce the amount of excess a psychiatric hospital may be liable for. Allows the board to reduce the a hospital's excess in certain unforeseen circumstances which occurred in the last three months of a hospital's fiscal year or, if the imposition of the penalty would have a severe adverse effect which would jeopardize the continued existence of an otherwise economically viable hospital.

Section 36. Transfers and renumbers s. 395.5125, F.S., relating to operating costs; non-deductible items, to s. 407.52, F.S. Leaves the original language intact.

Section 37. Transfers and renumbers s. 395.5135, F.S., relating to burden of proof, to s. 407.53, F.S. Leaves the original language intact.

Section 38. Amends, transfers and renumbers s. 395.5092, F.S., relating to duty of Public Council; to s. 407.54, F.S. Clarifies that Public Council may represent consumers before the board, its advisory panels, in administrative hearings or before any other state and federal agencies or courts in any issue related to budget review.

Section 39. Amends, transfers and renumbers s. 395.52, F.S., relating to information on physician's charges, to s. 407.70, F.S. Moves current language dealing with physician information to this section. Specifically, it exempts physicians from any provisions of this act if the physician bills his services independently of the hospital, and moves current language from s. 395.504(9)(b), F.S., relating to information on physician charges obtained from the Department of Insurance to this section.

Section 40. Requires the board to contract with the University of Florida to conduct a study which would develop and recommend a Florida specific hospital input price index (FHIPI) to measure hospital expenses and, a statistical indicator or index to measure severity of illness for acute care hospitals and psychiatric hospitals.

Section 41. Amends subsections (7) and (8) of section 409.266, F.S., relating to the Medicaid program. Allocates an additional $10 million from Public Medical Assistance Trust for expansion of primary care system for Medicaid and other low income persons. Increases Medicaid eligibility to elderly and disabled persons from 90 to 100 percent of the poverty level. Increases Medicaid coverage for children up to age 5 with incomes below 100 percent of poverty level immediately, instead of the scheduled phase-in; and, phases-in eligibility for children from age 6 to age 8 beginning October 1, 1989. Requires DHRS to prepare a report by March 1, 1989 on all programs funded through PMATF, with emphasis on the Medically Needy Program. Outlines the next 4 phases of physician fee increases as provided for in chapter 87-92, Laws of Florida. Extends hospital length of stay for Medicaid eligible neonates in Regional
Perinatal Intensive Care Centers to 90 days. If HCFA does not allow Florida to single out this subgroup of children, then the department is directed to extend hospital length of stay to 90 days for all Medicaid eligible children under 21, through the Early Periodic Screening Diagnosis and Treatment Program.

Section 42. Amends s. 409.2661, F.S., relating to medically indigent demonstration projects. Allows for the addition of one more rural and one more urban primary care health training project to be added to the two projects which were funded in Chapter 87-92, Laws of Florida. Provides for $2 million dollars to be appropriated from the Public Medical Assistance Trust Fund to be used to fund the additional projects.

Section 43. Amends s. 409.2663, F.S., relating to a redistribution of Public Medical Assistance Trust Fund to hospitals providing a minimum amount of charity care. Distributes $70 million dollars in 4 quarterly installments to hospitals which provided a minimum of 2% of their gross revenues in documented charity care as reported to the Health Care Cost Containment Board for each quarter beginning in April 1988. Places a cap at 80 percent of Medicaid per diem and pays for no longer than 12 days length of stay. No hospital can receive more than 1/3 of each quarterly payment.

Section 44. Amends s. 627.9175, F.S., relating to reports of information relating to health insurance. Requires insurers to provide information related to physicians' charges directly to the Health Care Cost Containment Board as well as the Department of Insurance, instead of the board having to wait for the department to compile the data and then transfer it to the board.

Section 45. Creates, the "Rural Hospital Act of 1988," which is contained in sections 45 through 53 of the bill.

Section 46. Establishes legislative findings and intent relating to rural hospitals. Provides that sharply declining occupancy rates, increasing dependence on Medicaid and Medicare reimbursements, liability concerns, frequent changes in ownership, high level of bad debt, greater competition on more sophisticated levels with urban hospitals, and physician and personnel staffing problems are threatening the existence of rural hospitals, and therefore it is the intent of the Legislature to ease this burden.

Section 47. Provides definitions for "rural hospital," "rural Area Health Education Center" and "swing-bed". Defines "rural hospital" to mean a hospital which has 85 beds or less, and which meets at least one of the following requirements: It must be the only provider in a county with no greater than 100 persons per square mile: or, it must be the only acute care hospital within 30 minutes of travel time in a county with no greater than 100 persons per square mile; or, it must be a provider served by a tax district encompassing a population of no greater than 100 persons per square mile. Defines "swing-beds," according to federal regulations, as beds which can be used interchangeably for hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) services. Defines "Rural Area Health Education Centers" (RAHEC's), to mean those centers as authorized by P.L. 94-484, which provide services in counties with population densities of no greater than 100 persons per square mile.

Section 48. Requires the Department of Health and Rehabilitative Services to fully utilize and coordinate primary care programs with the outpatient services at rural hospitals.

Section 49. Appropriates $100,000 from General Revenue funds for the Medical Education Tuition Reimbursement Program (METRP) as created in s. 240.4067, F.S., and
limits reimbursement to primary care physicians and nurses employed by or affiliated with rural hospitals or Rural Area Health Education Centers (RAHEC's).

Section 50. Extends Medicaid funding to rural hospital swing-beds for 30 day lengths of stay.

Section 51. Requires the Department of Health and Rehabilitative Services to fully utilize and coordinate the department's Aging and Adult Services Program Office with rural hospitals, when cost effective and feasible.

Section 52. Requires the Department of Health and Rehabilitative Services to conduct a manpower shortage study in rural hospitals.

Section 53. Authorizes the Department of Health and Rehabilitative Services to adopt rules necessary to implement the provisions of the Rural Hospital Act which allows for swing beds to be utilized by rural hospitals.

Section 54. Extends Medically Needy Program repeal date as provided for in section 50, chapter 87-92, Laws of Florida, to October 1, 1989, unless reenacted by the Legislature.

Section 55. Repeals section 24, chapter 82-182, Laws of Florida, relating to Sunset Review of chapter 395, Part II, Florida Statutes, and reenacts the Hospital Cost Containment Board as amended and transferred to chapter 407, F.S., but provides that the act shall stand repealed on October 1, 1992, subject to future review pursuant to s. 11.61, F.S.

Section 56. Repeals s. 400.342, F.S., relating to definitions for nursing home financial reporting. This definition was incorporated into the definition section of s. 407.002, F.S.

Section 57. Instructs the Division of Statutory Revision and Index of the Joint Legislative Management Committee to change the name of the "Hospital Cost Containment Board" to Health Care Cost Containment Board" whenever it appears in statutes.

Section 58. Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT: FY 88-89 FY 89-90 FY 90-91

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:

   Expenditures:
   DHRS
   Hospital Indigent Relief $70,000,000
   Manpower Shortage Study 40,000
   Nursing Shortage Study 100,000
   Univ. of FL FHIPI Study 88,000

   TOTAL NONRECURRING EXPENDITURES: $70,228,000
2. Recurring or Annualized Continuation Effects:

Expenditures:

**DHRS**

a. Indigent Care

<table>
<thead>
<tr>
<th>Item</th>
<th>1987-88</th>
<th>1988-89</th>
<th>1989-90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Fee</td>
<td>$23,100,000</td>
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<td>$84,100,000</td>
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<td>Children Ages 3-5</td>
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<td>19,800,000</td>
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<tr>
<td>Elderly/Disabled 90-100$</td>
<td>9,800,000</td>
<td>36,700,000</td>
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<tr>
<td>Extend LOS for Children</td>
<td>14,000,000</td>
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<tr>
<td>Children Ages 6-8</td>
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<tr>
<td>Primary Care</td>
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<td>Admin. Costs</td>
<td>3,000,000</td>
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b. Health Care Cost Containment Board

<table>
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<th>1989-90</th>
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<tbody>
<tr>
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(c. Rural Hospitals

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<tr>
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<th>1987-88</th>
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<th>1989-90</th>
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<tr>
<td>Medical Education Tuition Program</td>
<td>100,000</td>
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<td>100,000</td>
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<tr>
<td>Rural Hospital Swing Beds</td>
<td>1,400,000</td>
<td>1,500,000</td>
<td>1,600,000</td>
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</table>

TOTAL RECURRING EXPENDITURES: $69,221,300 $145,621,300 $194,221,300

3. Long Run Effects Other Than Normal Growth:

None

4. Appropriations Consequences:

Expenditures:

**DHRS**

<table>
<thead>
<tr>
<th>Item</th>
<th>1987-88</th>
<th>1988-89</th>
<th>1989-90</th>
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<tbody>
<tr>
<td>Public Medical Assistance Trust Fund</td>
<td>$96,500,000</td>
<td>$52,200,000</td>
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<tr>
<td>General Revenue Fund</td>
<td>11,540,000</td>
<td>20,200,000</td>
<td>29,200,000</td>
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<tr>
<td>Health Care Cost Containment TF</td>
<td>309,300</td>
<td>121,300</td>
<td>121,300</td>
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<tr>
<td>Medical Care Trust Fund</td>
<td>31,100,000</td>
<td>73,100,000</td>
<td>100,000,000</td>
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TOTAL $139,449,300 $145,621,300 $194,221,300

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring or First Year Start-Up Effects:

None

2. Recurring or Annualized Continuation Effects:

**PRIMARY CARE** - None

**HEALTH CARE SPECIAL TAX DISTRICTS** - Indeterminate positive impact

**ELDERLY AND DISABLED/ CHILDREN AGES 3-5** - Counties would be required to pay 35% of the cost of hospital inpatient services for these groups with lengths of stays between 12 and 45 days.

**EXTEND LOS FOR CHILDREN** - None
HEALTH CARE COST CONTAINMENT BOARD - Indeterminate

RURAL HOSPITALS
Maximum Liability $49,555 $49,555 $49,555

3. Long Run Effects Other Than Normal Growth:
None

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:
None

2. Direct Private Sector Benefits:

Benefits to Hospitals:
- 100% of Redistribution $70,000,000
- 100% of LOS for kids 14,000,000
- 75% of Elderly/Disabled 7,400,000
- 50% of Children Ages 3-5 2,900,000
- 80% of Medically Needy 61,500,000
- 100% of Medicaid Swing Bed 1,400,000
Total $157,200,000

Benefits to Physicians:
- 100% of Physician Fees $23,100,000
- 10% of Elderly/Disabled 1,000,000
- 45% of Children Ages 3-5 2,600,000
- 15% of Medically Needy 11,500,000
- 5% of Primary Care 500,000
Total $38,700,000

Benefits to Pharmacies:
- 15% of Elderly/Disabled $1,500,000
- 5% of Children Ages 3-5 200,000
- 5% of Medically Needy 3,800,000
Total $5,500,000

3. Effects on Competition, Private Enterprise, and Employment Markets:
None

D. FISCAL COMMENTS:

Hospitals currently submitting budgets within the MARI should realize cost savings because they would no longer be required to submit budgets. Because all budgets exceeding the MARI would be subject to budget review under this bill versus less than 50 percent under the current system, hospitals not previously subject to board scrutiny in the past because of where they fell within their group may incur additional costs for justifying their need for increases above the MARI. Assuming one-half of the 293 hospitals which filed budgets in fiscal year 1987-88 did not exceed the MARI, there is potential for administrative cost savings of approximately 15 to 25 percent.
HB 1700, the General Appropriations Bill, contains $6.2 million in General Revenue for the second phase of the physician fee increase. Also included is $136,192 for the Medical Education Tuition Reimbursement Program.

III. LONG RANGE CONSEQUENCES:

Indigent Care

The Indigent Care sections of this bill are consistent with the goals of the State Comprehensive Plan to improve access to health care services for indigent persons and should, in conjunction with the changes implemented in chapter 87-92, Laws of Florida, provide a positive long term policy change in the way the state has historically targeted and funded health care programs for its medically indigent population.

Generally, the bill continues to place emphasis on funding primary and preventive care services which were key components of the 1987 law, and which are ultimately more beneficial and cost effective. By continuing and completing the phase-in of the programs implemented in chapter 87-92, Laws of Florida, the state will have moved into the position of having a baseline system of two compatible and integrated health care programs (Primary Care and Medicaid) -- one or both of which will be available to persons with incomes below the federal poverty line. In addition, the state is assisted in the funding of these programs by the federal and county governments, and the hospital industry through the assessment on their gross revenues. The long range impact of the policy decisions made in the indigent care parts of this bill should be beneficial to both the state and the citizens it serves. These benefits should increase over time as indigent persons learn of and begin to utilize basic and preventive health care services in lieu of waiting until health problems are more serious and more costly.

Health Care Cost Containment Board

The reenactment of Chapter 395, Part II, Florida Statutes (proposed Chapter 407, Florida Statutes) is consistent with the State Comprehensive Plan which sets as a goal the need to help assure access to affordable, quality health care and to reduce health care cost as a percentage of the total financial resources available to the state and its citizens. The long range impact of keeping a process in place which requires hospitals to justify any increase in charges over certain established thresholds should provide some assurance that the ratio between costs and charges for hospital care is fair and equitable, and that the public's right to affordable health care is protected. This assurance becomes even more critical at least until the current volatile and rapidly changing health care delivery system begins to settle down and stabilize.

Rural Hospitals

The measures provided for in this bill should provide some measure of relief for rural hospitals; however, they are not sufficient to ensure the continued financial health of rural hospitals. As competition with urban facilities increases and unforeseen changes in the market occur, rural hospitals must diversify in order to be competitive and remain attractive to rural residents. The adoption of non-traditional and sometimes non-medical services should help the rural hospitals to stay viable, particularly if they are able to fill the unmet needs of the rural residents and especially the unmet needs of the elderly.
Clearly the most controversial sections of this bill deal with the Health Care Cost Containment Board, and specifically with the regulatory powers conferred on the Board. The major debate has centered on 4 major issues.

**GROSS VERSUS NET REGULATION** - The first and probably the most important issue is whether to regulate hospitals on "gross revenues" or "net revenues." In hospital "lingo," gross revenue means the amount the hospital charges to patients, regardless of who pays the bill. This number is consistent across all payor groups within the hospital, and it is the number from which all revenue deductions are subtracted. Net revenue means the amount of money a hospital actually collects from all patients. This number is not consistent among payor groups and can vary significantly depending on who is paying or not paying the bill. For example, Medicare pays based on a fixed fee per diagnosis and ignores charges; charity care patients often pay nothing; and PPO and HMO payors usually pay a discounted rate. The shortfalls from these discounted payors are often cost-shifted into the gross revenue charged to private pay and insured patients.

Under the current regulatory system, which is based on gross revenues, the amount a hospital can increase charges and cost-shift the increase to private or full pay patients is limited. This is the case, because the increase in charges is capped equally to all payor groups, regardless of what percentage the patient pays. For example, if a 10 percent increase in gross revenues is allowed, the maximum a private or full pay patient's charges can be increased is 10 percent.

Under a net review system, there is no limit on the amount a hospital can increase gross revenues (charges), and cost-shift the increase to the private pay patient. Net revenue regulation only controls the amount the hospital can collect. Because a hospital collects different revenues from each payor group, and in charity cases no revenues, the effect of a 10 percent increase in allowable collections would permit the hospital to charge the private pay patients whatever the market will bare to make up for the shortfalls in other payor collections. The result is no regulation of charges at all.

**MARI** - The maximum allowable rate of increase or MARI is the threshold established in law which, if exceeded by certain high charge hospitals, would place the hospital in a detailed budget review situation. The bill allows a hospital to increase its charges above the MARI if it can justify to the board that the increase is reasonable and necessary. Current law establishes the MARI at the national hospital input price index (NHIPI) plus 3 points to reflect the higher cost of providing services in Florida. The hospital industry has argued for significant increases in the MARI, which would effectively reduce the number of hospitals exceeding the threshold and therefore not need to justify increases in charges.

**REGULATE ALL VERSUS ONLY SOME HOSPITALS** - Under the current law, hospitals ranked in the lower 50th percentile based on gross revenues per adjusted admission, are not subject to budget review and, another 30% of higher charge hospitals can escape budget review if they stay within the MARI. For non-regulated hospitals falling below the 50th percentile, the mean budgeted rate of increase in charges from 1987 to 1988 was 19.0% compared to an average mean of 8.5% for hospitals subject to regulation. This trend has persisted since the budget regulation authority was imposed on the board. The expectation that competition, rather than regulation, would help to contain increases in charges has apparently not materialized. This is evidenced by rates of increase by non-regulated hospitals equating to twice as high as increases in regulated hospitals. When analyzing the projected rates of increase...
from 1987-1988, it is clear that the 85 hospitals between the 50th and the 80th percentile were constrained by the MARI threshold. When the case mix allowance, which can be added to the MARI under board rule without triggering a budget review, was deducted from the hospitals projected rate of increase, 47 hospitals submitted their budgets directly at the MARI; 9 hospitals submitted their budgets at one percent below the MARI; and, 8 hospitals submitted budgets at three percent below the MARI. In total, after deducting the case mix add-on only 9 out of the 85 hospitals falling within this range submitted budgets with rates of increases above the MARI. By staying within this threshold, all these hospitals were able to escape detailed budget review thus affirming the board's sentinel effect over rates of increase.

COMPOSITION OF BOARD - The fourth major area of controversy focuses on the make-up of the board. The American Association of Retired Persons and the Commissioner of Insurance strongly support an autonomous full-time, non-provider board. Arguments focus on the fact that the current board appears to be provider dominated, and cannot be an effective advocate for the health care consumers. The current 11 member board consists of one member employed by a for-profit hospital chain, one member employed as an administrator of a not-for-profit hospital, one consumer member who was a former hospital administrator, one consumer member who was a former trustee on the board of a hospital, and one purchaser member who was a former finance office for a hospital. In addition, hospitals provide significant representation on various technical advisory panels which make policy recommendations to the board.

V. AMENDMENTS:

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE: Prepared by: Staff Director:
Cathie Herndon Mike Hansen

FINANCE & TAXATION: Prepared by: Staff Director:

APPROPRIATIONS: Prepared by: Staff Director:
Lynn Dixon

STANDARD FORM 3/88
This bill reenacts the Hospital Cost Containment Board with its regulatory powers, continues the indigent care and certificate of need initiatives implemented in Chapter 87-92, Laws of Florida, amends the Health Care Responsibility Act of 1977, establishes a policy for assisting rural hospitals, and provides for several studies relating to health care costs and manpower shortages.

A. PRESENT SITUATION:

Chapter 87-92, Laws of Florida, provided major initiatives to fund and increase access to health care for indigents. Specifically, it enhanced the Medicaid program by: expanding eligibility to pregnant women and children up to age 2 with incomes up to 100 percent of the federal poverty level; phasing in coverage to children up to age 5 by 1991; expanding eligibility to elderly and disabled with incomes up to 90 percent of the poverty level; increasing Medicaid provider fees, requiring DHRS to develop a plan for a phase-in of all physician fees by 1991, and providing special fees for obstetricians and neonatologists. The law also provided for funding for the second phase of the state/county primary care program network and four types of demonstration projects aimed at increasing access for indigents and low income persons to affordable health care; allowed for the creation of independent special taxing districts by counties to fund indigent health care; and, provided for a redistribution of $69.5 million to assist certain hospitals in funding uncompensated care. Chapter 87-92, Laws of Florida, also provided a major rewrite of the certificate of need regulation, including a restructuring and streamlining of the procedures with the intent of providing for more timely and accountable decisions.

Chapter 395, Part II and the Hospital Cost Containment Board are scheduled to Sunset Review pursuant to s. 11.61, F.S., on October 1, 1988, subject to Legislative review and re-enactment. Part II of Chapter 395, F.S., relates to hospital cost containment, and creates the Hospital Cost Containment Board (or board). The stated purpose of the board is to advise the Legislature on health care costs and inflationary trends in health care; to educate consumers and perform other related tasks. Another major function of the board is to review and approve hospital budgets. Each hospital is required to annually submit to the board two detailed financial statements: a projected budget, submitted 90 days prior to the beginning
of each hospital's fiscal year; and a report of actual experience, submitted to the
board within 120 days after the end of each hospital's fiscal year. The board
reviews each hospital's projected budget based on a comparison to the hospital's
previous actual experiences, and a comparison to the performance of other hospitals
of similar type. Hospitals with budgets which exceed certain standards are subjected
to detailed review by the board.

The board was given authority in 1984 as a result of the Health Care Access Act
(Chapter 84-35, Laws of Florida), to approve, to disapprove, or to disapprove in
part, hospital budgets based on an established maximum allowable rate of increase
(MARI) for hospital gross revenue. If a hospital's gross revenue is in the lower 50
percent of its group or, the lower 80 percent of its group and the hospital has a
rate of increase in gross revenues below the MARI, then the hospital's budget is
approved without further action by the board. All other hospitals must have their
budgets approved by the board, based on patient-payor mix or other standards listed
in the law. The law provides penalties for hospitals which exceed the MARI or their
approved budgets. Penalties include a prospective reduction to the hospital's
budget, fines to be paid into the Public Medical Assistance Trust Fund and possible
revocation of a hospital's license. The membership of the board consists of 11
members which are appointed by the Governor and confirmed by the Senate. Four
members of the board are consumers, four members are providers (two of whom must
represent hospitals, one of whom must be a nursing home provider) and 3 members are
purchasers.

Sections 400.341 - 400.346, Florida Statutes, require the Hospital Cost Containment
Board to collect and disseminate information relating to nursing home charges.

Rural hospitals in Florida are responsible for meeting many of the health care needs
of citizens living in the more remote regions of the state. These hospitals have
been undergoing experiences quite different from their urban counterparts in recent
years, which threaten the continued financial viability of the rural hospital. Many
of these problems have been documented by the Department of Health and Rehabilitative
Services (DHRS) on a state-wide level, and by national research organizations and the
federal government on a national level. In Florida, one half of the 30 hospitals
identified by the DHRS as rural, face serious economic difficulties. Inpatient
occupancy rates fell from 54.6% in 1982 to 34.7% in 1986. In three of the four years
between 1982 and 1985, 14 of the 30 rural hospitals reported operating losses. In
1985 alone, 17 out of 30 of the predominate smaller rural hospitals reported
losses. Additionally, the economic instability experienced by these hospitals has
been exacerbated by volatility in ownership: four out of every five of these
facilities have been leased or sold within the past six years. Direct negative
effects on rural hospitals have a similar causal impact on the health of rural
citizens. For example, 7 out of 20 rural hospitals have discontinued obstetrical
services since 1981. These services are now available in only 38% of the state's 34
rural counties, compared to 59% in 1981.

B. EFFECT OF PROPOSED CHANGES:

**Indigent Care**

This bill would complete the expansion of the state/county primary care system to all
67 counties by funding an additional $10 million dollars. It changes the name of the
indigent health care special district to "health care special district;" broadens the
scope of the district by allowing the district to fund county-owned or operated
hospitals; allows the district to fund hospital services for indigents in private or
public facilities and allows the county to fund its share of state or federal
indigent care programs which require financial participation by the county. The bill
also clarifies language requiring voter approval of any tax levy and requires
districts to comply with all reporting and compliance requirements. The bill
prohibits health care districts from issuing bonds of any type. Finally, it provides
an exception to the definition of independent special district to allow certain
county governing bodies to be the governing body of a health care special district.

This bill would further the Medicaid enhancements begun in Chapter 87-92, Laws of
Florida, by providing for the second and subsequent phases of the physician fee
increases up to the Medicare 50th percentile, including reimbursement for pediatric
critical care specialist and pediatric surgeons; increasing Medicaid coverage for
children up to age 5 immediately, instead of phasing-in coverage; providing for a
phase-in of Medicaid coverage for children from age 6 to 8 beginning October 1, 1989;
increasing Medicaid eligibility for elderly and disabled adults with incomes between
90 and 100 percent of poverty; increasing lengths of stay to 90 days for neonates in
Regional Perinatal Intensive Care Centers or, if it is not possible to target this
group only, to increase lengths of stay for all children under 21 participating in
the Medicaid Early Periodic Screening Diagnosis and Treatment Program; adding two
additional primary care health training demonstration projects; and, by extending the
Sunset Review of the Medicaid Medically Needy Program for one year. Finally, the
bill allows for a redistribution of up to $70 million dollars of Public Medical
Assistance Trust Fund surplus dollars to hospitals providing a minimum of 2 percent
of its gross revenues in charity care, and provides the funding for the third and
final phase of the state's primary care system.

Health Care Cost Containment Board

This bill re-enacts Chapter 395, Part II, Florida Statutes relating to the Hospital
Cost Containment Board which was scheduled to be repealed on October 1, 1988 pursuant
to s. 11.61, F.S. The bill accomplishes this by transferring the entire part into a
newly created chapter, (Chapter 407), and rearranging, amending, and renumbering the
sections. In addition, sections 400.314 - 400.246, Florida Statutes relating to
nursing home reporting are also transferred, renumbered and amended into Chapter 407,
F.S. The chapter is titled Health Care Cost Containment, and the name of the
Hospital Cost Containment Board has been changed to the "Health Care Cost Containment
Board."

This bill simplifies and streamlines the methodology by which a hospital would have
to file its annual budget with the board, and be subject to detail budget review or
penalties. Specifically, the bill changes the budget review process in 10 major ways.

1. Subjects all hospitals to budget review if they exceed the maximum allowable
rate of increase (MARI) with the exception of those hospitals exempted under
current law, the Florida Elks Children's Hospital, and certain rural hospitals.

2. Requires only hospitals requesting an increase in charges (gross revenues per
adjusted admission, GR/AA) which exceed the MARI or, are requesting budget
amendments which would cause the hospital to exceed the MARI, to file projected
budgets and be subject to detailed budget review.

3. Hospitals not requesting increases above the MARI only file a "budget letter"
which stipulates what the hospital's projected GR/AA for its next fiscal year
will be, and affirms that the hospital intends to stay within the MARI for its

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4. Allows a hospital, whose actual audited experience at the end of the fiscal year indicates it came in below the MARI, to "bank" up to a cumulative total of 3 percentage points to be used in the future.

5. Changes the definition of maximum allowable rate of increase (MARI), by allowing hospitals to increase charges by the market basket index (currently the National Hospital Input Price Index, NHIPI) plus two points as the base, and then allows for additional points to be added to the base depending on each hospital's specific experience by giving 50% credit for the proportion of Medicare days to total days, 100% credit for uncompensated charity care days to total days, and 100% credit for the proportion of Medicaid days to total days.

6. Allows budget amendments to be retroactive in certain circumstances.

7. Prioritizes review criteria ranking reasonable rate of return as the first priority, and allows the hospitals to use this criteria to justify increased charges.

8. Gives the board some discretion in using review criteria to evaluate penalty situations.

9. Allows a hospital whose increases in net revenue was less than the NHIPI plus 2 percentage points, to bank up to a cumulative maximum of 3 net revenue percentage points to be used to offset any future year penalties for exceeding the MARI.

10. Shortens the timeframe the board has to approve a budget subject to budget review, from 120 to 90 days.

The bill also changes the current law by decreasing the number of members on the board from 11 to 9 members. The new board would consist of three providers, including one representative of the for-profit hospitals, one representative of the not-for-profit hospitals and one representative of the nursing home industry; three members who are major purchasers of health care; and, three members who are consumers, provided, one consumer member must be 60 years of age or older.

The bill provides for a three-phase 18 month study to be conducted by the State's University System, to determine a Florida specific measure of hospital expenses (FHIPI), to make recommendations on a methodology and reporting system to measure the impact of changes in reimbursement levels from all government payers, to make recommendations for a statistical measure or index for severity of illness for acute care hospitals and, to make a separate recommendation for a severity index for psychiatric hospitals.

In addition, the bill directs the Health Care Cost Containment Board to conduct a study of the shortage in the supply of registered nurses and a study on the fiscal impact on hospitals for providing health care services to migrant and rural farmworkers.

Finally, the bill provides for another sunset review of the Health Care Cost Containment Act (Chapter 407) in 1992.
Health Care Responsibility Act

This legislation amends Part IV of Chapter 154, Florida Statutes, relating to the Health Care Responsibility Act. It establishes intent to place the financial obligation for out-of-county hospital care of a qualified indigent on the county in which the indigent resides. The bill defines a "qualified indigent," for purposes of reimbursement under the act, as a person having an average family income for the previous 12 months which is below 100 percent of the federal poverty level, who is not eligible to participate in any other government program which provides hospital care, and who has no insurance. It allows certain hospitals to be reimbursed for out-of-county indigents by the county of residence, provided the hospital has met its "charity care obligation." The bill defines a hospital's charity care obligation to mean the ratio of charity care days to total acute care days which is equal to or greater than 2 percent. The bill requires the Department of Health and Rehabilitative Services, in cooperation with the counties, to adopt rules for statewide eligibility determination and residency certification procedures and criteria to be used in qualifying indigents for reimbursement under this act.

Rural Hospitals

This bill creates the Rural Hospital Act of 1988 which strengthens the ability of rural hospitals to operate at "full strength" in terms of services and staffing, and helps to ensure that the health of our rural residents is provided for. Specifically, it defines a rural hospital as a hospital with 85 beds or less which has certain population, density and distance limits as compared to other hospitals. The bill requires coordination of state primary care programs and state programs for the aged with rural hospitals when feasible; extends Medicaid funding to rural hospital swing bed services; authorizes a study of rural hospital manpower shortages and certification and licensure requirements; and finally, the bill provides for a $100,000 appropriation to the Medical Education Tuition Reimbursement Program to reimburse health care practitioners employed by rural hospitals and rural area health education centers (AHEC's).

Certificate of Need

This bill contains several revisions to the state's certificate of need law, as follows: provides expedited review for a single facility which either combines or divides two or more CON's for services or beds; gives health care facilities which are part of the state university system standing to intervene in an administrative hearing for a CON within the same service area of the facility, upon showing that the facility will be substantially affected by the issuance of a CON to a competing facility; extends the validity period for a CON from the current one to two years for certain nursing home multi-facility projects; and, provides for expedited review for certain nursing homes to increase their beds by 50 percent provided they have been operating in the state for at least 60 years. Finally, the bill allows for Public Medical Assistance Trust Fund Dollars to be used, if necessary, to support the local health councils and the Statewide Health Council if funds received from the certificate of need application fees are insufficient to support the funding amount authorized.

C. SECTION-BY-SECTION ANALYSIS:

Section 1. Title "Affordable Health Care Assurance Act"

Section 2. Amends S. 154.01, F.S., relating to the public health unit delivery system. Allows counties the option of relinquishing ownership of public health
facilities and equipment to the Department of Health and Rehabilitative Services by mutual consent of the parties in the contract.

Section 3. Amends s. 154.011, F.S., relating to primary care services. Clarifies that the Legislature's intent was for a system of primary care programs to be organized in all 67 counties. Requires that each program shall provide a comprehensive mix of preventive, personal and non-institutional acute care services.


Section 5. Amends s. 154.302, F.S., relating to Legislative intent, places the ultimate financial obligation for the hospital care of qualified indigents receiving services at certain out-of-county hospitals, on the county in which the indigent resides.

Section 6. Amends section 154.304, F.S., relating to definitions. Major definition changes include:

Defines "certified resident" to mean a person who has been certified either by the county of residence or by DHRS as being a resident of a certain county.

Defines "charity care obligation" to mean the minimum amount of charity care reported to the Health Care Cost Containment Board, based on the hospital's audited actual experience, before it is eligible to be reimbursed by a county. A hospital's charity care obligation is defined as the ratio of charity care days to total acute care days which is equal to or greater than 2 percent.

Defines "participating hospital" to mean a hospital which is eligible to receive reimbursement because it meets its charity care obligation and, has either a formal signed agreement with a county or counties to treat the county's indigent patients or, it can demonstrate to the Health Care Cost Containment Board that at least 5 percent of its uncompensated charity care was generated by out of county residents.

Defines "qualified indigent" to mean, a person who is without financial resources to pay his hospital bill; whose hospital care is not covered by a state or federally funded program; who has a family income for the 12 months preceding the determination which is below 100 percent of the federal nonfarm poverty level; and, who is without private insurance or has inadequate private insurance.

Defines a "regional referral hospital" to mean a teaching hospital as defined in s. 395.502, F.S., which is eligible to receive reimbursement because it meets its charity care obligation.

Section 7. Amends s. 154.306, F.S., relating to financial responsibility for a certified resident who is a qualified indigent patient. Places ultimate financial responsibility for funding a certified resident who is a qualified indigent patient receiving services in an out-of-county participating hospital or in a regional referral hospital, on the county of which the patient is a resident. Requires each county by January 1, 1989, to provide or arrange for indigent eligibility determination procedures and resident certification procedures. Limits the minimum financial obligation of the county to a maximum of 45 days per year at 80 percent of the hospital's Medicaid per diem rate, up to a maximum cap of $4 per capita. Exempts counties from paying for elective or non emergency admissions or services at out-of-county hospitals when the county provides funding for such services and the services are available at a local hospital; or, if the out-of-county hospital has not
obtained prior written authorization and approval. Requires the county to be liable for payment for all emergency care received at out-of-county hospitals for qualified indigents certified as residents of the county. Exempts counties from paying for out-of-county hospital services if the hospital has not met its charity care obligation.

Section 8. Amends s. 154.308, F.S., relating to determination of a qualified indigent's eligibility. Requires DHRS to establish uniform statewide eligibility criteria to determine whether a person financially qualifies as indigent for the purposes of this act. Allows for determination of indigency to be made by any county or by the DHRS. Requires the determination to be made within 60 days following written notification by the hospital. Requires the hospital to be notified in cases where indigency can not be documented, or in cases where it was determined the patient was not qualified. Allows counties to establish less restrictive thresholds for indigency.

Section 9. Creates s. 154.309, F.S., relating to certifying a qualified indigent's residency. Requires DHRS to establish procedures which provide criteria to be used to determine an indigent's county of residence. Allows for the county thought to be or known to be the county of residence to be given first priority to certify a resident. Provides that DHRS shall certify residency if the county is unable or unwilling to make such determination, and provides that such determination shall be binding on the county.

Section 10. Amends s. 154.31, F.S., relating to the obligation of the participating hospital or regional referring hospital to admit for emergency treatment all Florida residents who meet the eligibility standards, without regard to county of residence. Gives DHRS the authority to impose administrative fines on hospitals which do not meet the requirements of this section, and allows it to suspend eligibility for reimbursement under the provisions of the act.

Section 11. Creates s. 154.3105, F.S., relating to rules to administer this act. Requires DHRS to develop rules based on the recommendations of a work group consisting of equal representation by the department, the hospital industry and the counties. Requires the rules at a minimum to address eligibility determination procedures to determine indigency, and certification determination procedures to determine residency.

Section 12. Amends s. 154.312, F.S., relating to procedures for settlement of disputes. Adds technical language which would allow for the affected counties, DHRS, the Health Care Cost Containment Board, or the hospital to be eligible to utilize chapter 120 remedies for resolving disputes. Provides that the hearing officer's order shall be the final agency action.

Section 13. Amends s. 154.314, F.S. relating to hospital certification of delinquent eligible payments due from a responsible county to the Comptroller of the State of Florida. Provides that if payment not received from a responsible county within 90 days of receipt of a statement; or, if it is not received within 60 days after the date of exhaustion of all legal remedies, the hospital shall certify to Comptroller the amount owed. Gives Comptroller 45 days to remit to hospital from any tax sharing or revenue sharing funds due the county. Requires the Comptroller to report to the Governor and Appropriations and Finance and Tax Committees in the House and Senate a quarterly accounting of the amount certified by the hospitals and the amount paid by the Comptroller.
Section 14. Amends s. 154.316, F.S., relating to admission of indigent patients. Gives the hospital admitting an indigent who may qualify for reimbursement under the act, ten days to notify the county thought to be or known to be the county of residence or it forfeits its right to reimbursement.

Section 15. Amends s. 154.331, F.S., relating to indigent health care districts by changing the name to health care special districts and broadening the powers and functions of the district, subject to voter approval. Specifically, it allows districts to fund county owned or operated hospitals, institutional care for indigents in privately or publicly owned facilities and, the county's share of state or federal indigent health care programs which require financial participation by the county. Clarifies and strengthens the language relating to levying taxes; relating to the requirements placed on the districts to comply with s. 200.065, F.S., (truth in millage); and, relating to all reporting and compliance requirements currently required under Chapter 218, Part III, F.S., or any other statute. Changes the appointment of the board from all members being appointed by the county governing body to the Governor appointing 2 members and the county governing body appointing the remainder. Provides that districts may be dissolved pursuant to current statutory requirements under s. 165.051, F.S., or by the county governing body if approved by the voters. Prohibits tax districts from issuing bonds of any type. Allows for the county governing body, when acting as the governing body of a health care special district, to have the same powers and duties and be subject to the same requirements and limitations as an independent board acting as the governing body of such district.

Section 16. Amends s. 200.001, F.S., relating to millage, and definitions. Provides for an exception to the definition of independent special district to allow certain county governing bodies to be the governing body of a health care special district.

Section 17. Amends s. 381.701, F.S., relating to CON definitions. Defines multi-facility project as a unit of a specified size with nursing home beds, adult congregate living facility (ACLF) beds and independent living units.

Section 18. Amends s. 381.703, F.S., relating to funding local health councils and the Statewide Health Council to allow for monies from the Public Medical Assistance Trust Fund to be used, if necessary, to fund the councils if funds received from certificate of need application fees are insufficient to support the funding amount authorized.

Section 19. Amends s. 381.705, F.S., relating to review criteria for the issuance of a CON. Specifies that the department must approve an application for a CON to consolidate or divide nursing home beds or services, unless the application fails to meet the test for financial feasibility or unless the consolidation would result in the beds being moved by more than 15 miles from their original location.

Section 20. Amends s. 381.706, F.S., relating to projects subject to CON review. Includes in expedited review the following projects: a 50 percent increase in nursing home beds for nursing homes connected to a residential campus which has been operating in the state for more than 60 years; and the combination or division of nursing home beds or services within a service district when authorized by two or more CON's.

Section 21. Amends s. 381.709, F.S., relating to the CON review process. Gives standing in an administrative hearing for a CON to health care facilities located on the campus of a state university, upon showing that the facility would be
substantially affected by the issuance of the CON to a competing facility. Certain additional restrictions apply.

Section 22. Amends s. 381.710, F.S., relating to conditions and monitoring for CON. Extends the validity period for a CON from the current length of one year, to two years for multi-facility projects as defined in s. 381.701, F.S., as amended by this act. Extends the validity period on a CON for consolidation or division of nursing home beds or services as provided for in s. 381.706, F.S., as amended by this act.


Section 24. Amends, transfers and renumbers s. 395.502, F.S., relating to definitions, to s. 407.002, F.S. Changes the definition of "Board" from Hospital Cost Containment Board to Health Care Cost Containment Board. Changes the definition of "maximum allowable rate of increase" (MARI), by establishing a base index to which a hospital specific adjustment can be added, to reach an individual MARI for each hospital. Adds a definition of "rate of return" which may include, but not be limited to four financial indicators which the board would use to determine reasonableness of the financial requirements of a hospital, and adds a definition for "rural hospital."

Section 25. Amends, transfers and renumbers s. 395.5025, F.S., relating to the Legislature's intent, to s. 407.003, F.S. Broadens the intent of the board: to promote improved consumer and purchaser understanding of government funded programs and third party reimbursement; and to recommend to the Legislature appropriate strategies to foster health care cost containment and improve access. Declares that the rising cost of health care, and cost shifting and cross subsidization by hospitals to increase revenues regardless of the cause, is of vital concern to the people of the state.

Section 26. Amends, transfers and renumbers s. 395.503, F.S., relating to the Hospital Cost Containment Board, to s. 407.01, F.S. Changes the name to Health Care Cost Containment Board. Determines board shall be a separate budget entity from the Department of Health and Rehabilitative Services and that the executive director shall be its agency head for all purposes. Decreases membership from 11 to 9 members effective with appointments after January 1, 1989. Changes the board makeup to 3 providers, one of which is a representative of the for-profit hospitals, one of which is a representative of the not-for-profit hospitals, and one of which is a representative of the the nursing home industry; 3 consumers, one of which in 60 years of age or older; and 3 major purchasers.

Section 27. Amends, transfers and renumbers s. 395.504, F.S., dealing with powers and duties of board, to s. 407.02, F.S. Limits board's authority to approve, amend or disapprove budgets to only those hospitals requesting increases above the maximum allowable rate of increase (MARI). Strikes and transfers the language dealing with publishing physician data obtained from the Department of Insurance to s. 407.70, F.S. Empowers the board to investigate consumer complaints regarding problems with hospital billing practices and to issue reports in cases where the board determines the hospital engaged in unreasonable and unfair billing practices.

Section 28. Creates a new section 407.025, F.S., providing immunity to hospitals and other reporting entities for providing patient data to the board.
Section 29. Amends, transfers and renumbers s. 395.505, F.S., relating to rules to s. 407.03, F.S. Makes technical changes to replace the word "part" with the word "chapter".

Section 30. Amends, transfers and renumbers s. 395.5051, F.S., relating to effect of act on existing rules, to s. 407.035, F.S. Provides that nothing contained in the act would change rules promulgated to enact chapter 84-35, Laws of Florida, unless in direct conflict with this act. Provides that all budgets or budget amendments beginning prior to February 1, 1989 shall be filed and reviewed subject to chapter 84-35, Laws of Florida.

Section 31. Amends, transfers and renumbers s. 395.512, F.S., relating to the budget of the board to s. 407.04, F.S. Requires the board to submit its final legislative budget request directly to the Governor by November 1 of each even numbered year.

Section 32. Amends, transfers and renumbers s. 395.507, F.S., relating to uniform system of financial reporting for hospitals, to s. 407.05, F.S. Requires only hospitals requesting approval of a rate of increase in gross revenue per adjusted admission (GR/AA) in excess of the maximum allowable rate of increase (MARI) to file budgets for detailed review. Allows for the establishment of not more than 15 groups for the purpose of comparison in the budget review process.

Section 33. Amends transfers and renumbers s. 395.514, F.S., relating to hospital violation of rules, to s. 407.06, F.S. Makes technical changes by correcting references from violations of "part" to violations of "chapter".

Section 34. Amends, transfers and renumbers s. 395.508, F.S., relating to hospital costs and finances; analysis, studies and reports, to s. 407.07, F.S. Changes section title from "hospital" to "health care". Adds authority for board to study effects of Medicare, Medicaid and other government reimbursement mechanisms. Gives the board authority to conduct analysis and research on impact of uncompensated care on hospital budgets. Gives the board authority to conduct analysis and research on the state's role in funding indigent care.

Section 35. Amends, transfers and renumbers s. 395.513, F.S., relating to program accountability, to s. 407.08, F.S. Expands the requirements of the board's annual report to include an analysis of the reasons for existing levels of cross subsidization. Expands the report to include the extent to which public funding policies may be affecting health care costs. Also expands the report to include the extent to which other factors, such as uncompensated care, skilled employee shortages, changes in technology and shifts from institutional to ambulatory care may be affecting health care costs.

Section 36. Amends, transfers and renumbers s. 395.5085, F.S., relating to collection and dissemination of hospital charge information, to s. 407.09, F.S. Allows board to distribute information utilizing the Consumer Information and Advisory Council created in s. 407.10, F.S., or by any other appropriate means available. Strikes language relating to Consumer Information Network and moves most of the language into s. 407.10, F.S.

Section 37. Creates s. 407.10, F.S., relating to the Consumer Information and Advisory Council, previously known as the Consumer Information Network. In addition to responsibilities previously handled by Consumer Information Network, it allows the council to conduct or sponsor consumer information or education seminars at locations throughout the state. It further gives the Council authority to hold public hearings in order to solicit consumer concerns or complaints relating to health care costs and
as a result of those hearings, make recommendations to the board for study, action or investigation.

Section 38. Amends, transfers and renumbers s. 395.5042, F.S., relating to the Office of Technical Assistance, to s. 407.11, F.S. Expands the responsibilities of the office to include: developing cost containment strategies for providers, employers and consumers; serving as a clearinghouse for information concerning federal and state legislative initiatives affecting health care delivery system and government health care programs; and, developing an outreach program to assist small business to include cost containment initiatives for small business insurance plans.

Section 39. Transfers and renumbers s. 395.511, F.S., relating to quality assurance monitoring to s. 407.12, F.S. Requires hospitals to maintain a quality assurance program and make quality assurance plans available to the board upon request. Allows the board to request information from the Department of Health and Rehabilitative Services, the Department of Professional Regulation, and the Department of Insurance which would enable it to monitor a hospital's quality assurance.

Section 40. Amends, transfers and renumbers s. 395.515, F.S., relating to prospective payment arrangements, to s. 407.13, F.S. Provides for technical changes to name of board.

Section 41. Amends, transfers and renumbers s. 400.341, F.S., relating to legislative intent - nursing home costs, to s. 407.30, F.S. Provides for technical changes.

Section 42. Amends, transfers and renumbers s. 400.343, F.S., relating to uniform system of financial reporting for nursing homes to s. 407.31, F.S. Provides technical changes in statutory cites.

Section 43. Amends, transfers and renumbers s. 400.344, F.S., relating to nursing home revenues and financial analysis, studies and reports, to s. 407.32, F.S. Provides technical changes relating to other statutory cites. Allows the board to prepare and file supplementary studies and reports based on information analyzed relating to nursing home data.

Section 44. Amends, transfers and renumbers s. 400.345, F.S., relating to nursing home assessments to fund the budget of board to conduct nursing home financial disclosure program, to s. 407.33, F.S. Provides technical changes.

Section 45. Amends, transfers and renumbers s. 400.346, F.S., relating to nursing homes violations of law or rules, to s. 407.34, F.S. Provides technical changes to other statutory cites.

Section 46. Substantially amends, transfers and renumbers s. 395.509, F.S., relating to review of hospital budgets, to s. 407.50, F.S. Eliminates hospitals from filing a detailed budget with the board unless the hospital wishes to exceed the maximum allowable rate of increase (MARI). Requires, as an alternative, for hospitals to file a "budget letter" which specifies what the hospitals expected gross revenues per adjusted admission will be for its next fiscal year, and a statement affirming it intends to stay within the MARI. Requires all hospitals which exceed the MARI, either through submission of a budget request or by filing a budget amendment, to be subject to detailed budget review regardless of where they fall in their group. Allows hospitals staying below the MARI to "bank" percentage points to be used in the future, up to a cumulative maximum of 3 points. Changes the "a" through "k" review criteria and prioritizes them. Exempts from budget review the Florida Elks...
Children's Hospital, certain rural hospitals, those hospitals exempted under current law, and any hospital in which at least 90 percent of its admissions are contracted through a prospective payment system.

Section 47. Amends, transfers and renumbers s. 395.5094, F.S., relating to exceeding approved budget and penalties, to s. 407.51, F.S. Retains current law which places a hospital in a potential penalty situation when its actual net revenues per adjusted admission exceeds the previous year's actual by more than the MARI, or exceeds the projected budget as approved by the board. Requires the board to establish a proxy for psychiatric case mix to reduce the amount of excess a psychiatric hospital may be liable for. Allows the board to reduce a hospital's excess in certain unforeseen circumstances which occurred in the last three months of a hospital's fiscal year or, if the imposition of the penalty would have a severe adverse effect which would jeopardize the continued existence of an otherwise economically viable hospital. Allows a hospital whose increase in net revenues was less than the NHPI plus 2 percentage points, to bank up to a cumulative maximum of 3 net revenue percentage points to be used to offset any future year penalties for exceeding the MARI.

Section 48. Transfers and renumbers s. 395.5125, F.S., relating to operating costs; non-deductible items, to s. 407.52, F.S. Leaves the original language intact.

Section 49. Transfers and renumbers s. 395.5135, F.S., relating to burden of proof, to s. 407.53, F.S. Leaves the original language intact.

Section 50. Amends, transfers and renumbers s. 395.5092, F.S., relating to duty of Public Council; to s. 407.54, F.S. Clarifies that Public Council may represent consumers before the board, its advisory panels, in administrative hearings or before any other state and federal agencies or courts in any issue related to budget review.

Section 51. Amends, transfers and renumbers s. 395.52, F.S., relating to information on physician's charges, to s. 407.70, F.S. Moves current language dealing with physician information to this section. Specifically, it exempts physicians from any provisions of this act if the physician bills his services independently of the hospital. Requires board to publish an annual report containing available physician charge comparisons from information obtained by insurers. Requires insurers to submit physician data directly to the Health Care Cost Containment Board instead of being reported to the Department of Insurance.

Section 52. Requires the board to contract with the State University System to conduct a study which would develop and recommend a Florida specific hospital input price index (FHIPI) to measure hospital expenses and, a statistical indicator or index to measure severity of illness for acute care hospitals and psychiatric hospitals.

Section 53. Requires the Health Care Cost Containment Board to conduct a study of the shortage in the supply of registered nurses by February 1, 1990.

Section 54. Requires the Health Care Cost Containment Board to conduct a study by January 31, 1989 on the impact on hospital for providing health care services to migrant and rural farmworkers.

Section 55. Amends section 409.266, F.S., relating to the Medicaid program. Allocates an additional $10 million from Public Medical Assistance Trust for expansion of primary care system for Medicaid and other low income persons. Increases Medicaid eligibility to elderly and disabled persons from 90 to 100 percent of the poverty level. Increases Medicaid coverage for children up to age 5 with
incomes below 100 percent of poverty level immediately, instead of the scheduled phase-in; and, phases-in eligibility for children from age 6 to age 8 beginning October 1, 1989. Requires DHRS to prepare a report by March 1, 1989 on all programs funded through PMATF, with emphasis on the Medically Needy Program. Outlines the next 4 phases of physician fee increases as provided for in chapter 87-92, Laws of Florida. Extends hospital length of stay for Medicaid eligible neonates in Regional Perinatal Intensive Care Centers to 90 days. If HCFA does not allow Florida to single out this subgroup of children, then the department is directed to extend hospital length of stay to 90 days for all Medicaid eligible children under 21, through the Early Periodic Screening Diagnosis and Treatment Program.

Section 56. Amends s. 409.2661, F.S., relating to medically indigent demonstration projects. Allows for the addition of one more rural and one more urban primary care health training project to be added to the two projects which were funded in Chapter 87-92, Laws of Florida. Provides for $2 million dollars to be appropriated from the Public Medical Assistance Trust Fund to be used to fund the additional projects.

Section 57. Amends section 409.2662, F.S., relating to use of monies from the Public Medical Assistance Trust Fund to allow for the Medicaid swing beds, health councils, length of stay extension and the Medical Education Tuition Reimbursement Program to be funded from this revenue source.

Section 58. Amends s. 409.2663, F.S., relating to a redistribution of Public Medical Assistance Trust Fund to hospitals providing a minimum amount of charity care. Distributes $70 million dollars in 4 quarterly installments to hospitals which provided a minimum of 2% of their gross revenues in documented charity care as reported to the Health Care Cost Containment Board for each quarter beginning in April 1988. Places a cap at 80 percent of Medicaid per diem and pays for no longer than 12 days length of stay. No hospital can receive more than 1/3 of each quarterly payment.

Section 59. Amends s. 627.9175, F.S., deletes language relating to reports insurers were required to submit to the Department of Insurance on physician charges, since the information is required in another section of the bill to be reported directly to the Health Care Cost Containment Board.

Section 60. Creates, the "Rural Hospital Act of 1988," which is contained in sections 60 through 68 of the bill.

Section 61. Establishes legislative findings and intent relating to rural hospitals. Provides that sharply declining occupancy rates, increasing dependence on Medicaid and Medicare reimbursements, liability concerns, frequent changes in ownership, high level of bad debt, greater competition on more sophisticated levels with urban hospitals, and physician and personnel staffing problems are threatening the existence of rural hospitals, and therefore it is the intent of the Legislature to ease this burden.

Section 62. Provides definitions for "rural hospital," "rural Area Health Education Center" and "swing-bed". Defines "rural hospital" to mean a hospital which has 85 beds or less, and which meets at least one of the following requirements: It must be the only provider in a county with no greater than 100 persons per square mile; or, it must be the only acute care hospital within 30 minutes of travel time in a county with no greater than 100 persons per square mile; or, it must be a provider served by a tax district encompassing a population of no greater than 100 persons per square mile. Defines "swing-beds," according to federal regulations, as beds which can be used interchangeably for hospital, skilled nursing facility (SNF), or intermediate
care facility (ICF) services. Defines "Rural Area Health Education Centers" (RAHEC's), to mean those centers as authorized by P.L. 94-484, which provide services in counties with population densities of no greater than 100 persons per square mile.

**Section 63.** Requires the Department of Health and Rehabilitative Services to fully utilize and coordinate primary care programs with the outpatient services at rural hospitals.

**Section 64.** Authorizes funds from the Public Medical Assistance Trust Fund to be utilized for the Medical Education Tuition Reimbursement Program (METRP) as created in s. 240.4067, F.S. Limits reimbursement under this program to primary care physicians and nurses employed by or affiliated with rural hospitals or Rural Area Health Education Centers (RAHEC's).

**Section 65.** Extends Medicaid funding to rural hospital swing-beds for 30 day lengths of stay.

**Section 66.** Requires the Department of Health and Rehabilitative services to fully utilize and coordinate the department's Aging and Adult Services Program Office with rural hospitals, when cost effective and feasible.

**Section 67.** Requires the Department of Health and Rehabilitative Services to conduct a manpower shortage study in rural hospitals.

**Section 68.** Authorizes the Department of Health and Rehabilitative Services to adopt rules necessary to implement the provisions of the Rural Hospital Act which allows for swing beds to be utilized by rural hospitals.

**Section 69.** Extends Medically Needy Program repeal date as provided for in section 50, chapter 87-92, Laws of Florida, to October 1, 1989, unless reenacted by the Legislature.

**Section 70.** Repeals section 24, chapter 82-182, Laws of Florida, relating to Sunset Review of chapter 395, Part II, Florida Statutes, and reenacts the Hospital Cost Containment Board as amended and transferred to chapter 407, F.S., but provides that the act shall stand repealed on October 1, 1992, subject to future review pursuant to s. 11.61, F.S.

**Section 71.** Repeals s. 400.342, F.S., relating to definitions for nursing home financial reporting. This definition was incorporated into the definition section of s. 407.002, F.S. Repeals s. 212.055, F.S., relating to a discretionary indigent care sales tax in Hillsborough County, which is now obsolete.

**Section 72.** Establishes appropriation language to fund budget issues which were incorporated into the bill after the Appropriations Bill had passed out of Appropriations Committee.

**Section 73.** Instructs the Division of Statutory Revision and Index of the Joint Legislative Management Committee to change the name of the "Hospital Cost Containment Board" to Health Care Cost Containment Board" whenever it appears in statutes.

**Section 74.** Provides an effective date.
II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT: FY 88-89  FY 89-90  FY 90-91

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring or First Year Start-Up Effects:

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<th>Expenditures</th>
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<td>DHRS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Indigent Relief</td>
<td>$70,000,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manpower Shortage Study</td>
<td>40,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Shortage Study</td>
<td>100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Univ. of FL HFIPI Study</td>
<td>88,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impact Study (Non-Resident Poor)</td>
<td>36,000</td>
<td></td>
<td></td>
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<tr>
<td>TOTAL NONRECURRING EXPENDITURES:</td>
<td>$70,264,000</td>
<td></td>
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</tr>
</tbody>
</table>

2. Recurring or Annualized Continuation Effects:

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>FY 88-89</th>
<th>FY 89-90</th>
<th>FY 90-91</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHRS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Indigent Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Fee</td>
<td>$24,800,000</td>
<td>$55,470,000</td>
<td>$86,150,000</td>
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<tr>
<td>Children Ages 3-5</td>
<td>5,700,000</td>
<td>19,800,000</td>
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<td>Elderly/Disabled 90-100%</td>
<td>9,800,000</td>
<td>36,700,000</td>
<td>41,300,000</td>
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<td>Extend LOS for Children</td>
<td>14,000,000</td>
<td>15,400,000</td>
<td>17,400,000</td>
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<tr>
<td>Children Ages 6-8</td>
<td>0</td>
<td>1,700,000</td>
<td>10,300,000</td>
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<tr>
<td>Primary Care</td>
<td>10,000,000</td>
<td>10,000,000</td>
<td>10,000,000</td>
</tr>
<tr>
<td>Primary Care Demo.</td>
<td>2,000,000</td>
<td>2,000,000</td>
<td>2,000,000</td>
</tr>
<tr>
<td>Admin. Costs</td>
<td>3,000,000</td>
<td>4,700,000</td>
<td>4,800,000</td>
</tr>
<tr>
<td>b. Health Care Cost Containment Board</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and Benefits (3 FTEs)</td>
<td>121,300</td>
<td>121,300</td>
<td>121,300</td>
</tr>
<tr>
<td>c. Rural Hospitals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Education Tuition Program</td>
<td>100,000</td>
<td>100,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Rural Hospital Swing Beds</td>
<td>1,400,000</td>
<td>1,500,000</td>
<td>1,600,000</td>
</tr>
<tr>
<td>TOTAL RECURRING EXPENDITURES:</td>
<td>$70,921,300</td>
<td>$147,491,300</td>
<td>$196,271,300</td>
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</tbody>
</table>

3. Long Run Effects Other Than Normal Growth:

None

4. Appropriations Consequences:

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>FY 88-89</th>
<th>FY 89-90</th>
<th>FY 90-91</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHRS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Medical Assistance Trust Fund</td>
<td>$101,300,000</td>
<td>$57,420,000</td>
<td>$70,840,000</td>
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<tr>
<td>General Revenue Fund</td>
<td>7,540,000</td>
<td>15,860,000</td>
<td>24,220,000</td>
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<tr>
<td>Health Care Cost Containment TF</td>
<td>345,300</td>
<td>121,300</td>
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<tr>
<td>Medical Care Trust Fund</td>
<td>32,000,000</td>
<td>74,090,000</td>
<td>101,090,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$141,185,300</td>
<td>$147,491,300</td>
<td>$196,271,300</td>
</tr>
</tbody>
</table>

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1044  STANDARD FORM 3/88
1. **Non-recurring or First Year Start-Up Effects:**

None

2. **Recurring or Annualized Continuation Effects:**

**PRIMARY CARE** - None

**HEALTH CARE SPECIAL TAX DISTRICTS** - Indeterminate positive impact

**ELDERLY AND DISABLED/ CHILDREN AGES 3-5** - Counties would be required to pay 35% of the cost of hospital inpatient services for these groups with lengths of stays between 12 and 45 days.

**EXTEND LOSS FOR CHILDREN** - None

**HEALTH CARE COST CONTAINMENT BOARD** - Indeterminate

**RURAL HOSPITALS**

<table>
<thead>
<tr>
<th>Maximum Liability</th>
<th>$49,555</th>
<th>$49,555</th>
<th>$49,555</th>
</tr>
</thead>
</table>

3. **Long Run Effects Other Than Normal Growth:**

None

C. **DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:**

1. **Direct Private Sector Costs:**

None

2. **Direct Private Sector Benefits:**

**Benefits to Hospitals:**

- 100% of Redistribution $70,000,000
- 100% of LOS for kids 14,000,000
- 75% of Elderly/Disabled 7,400,000
- 50% of Children Ages 3-5 2,900,000
- 50% of Medically Needy 61,500,000
- 100% of Medicaid Swing Bed 1,400,000

Total $157,200,000

**Benefits to Physicians:**

- 100% of Physician Fees $24,800,000
- 10% of Elderly/Disabled 1,000,000
- 45% of Children Ages 3-5 2,600,000
- 15% of Medically Needy 11,500,000
- 5% of Primary Care 500,000

Total $38,700,000

**Benefits to Pharmacies:**

- 15% of Elderly/Disabled $1,500,000
- 5% of Children Ages 3-5 200,000
- 5% of Medically Needy 3,800,000

Total $5,500,000
3. Effects on Competition, Private Enterprise, and Employment Markets:

None

D. FISCAL COMMENTS:

Hospitals currently submitting budgets within the MARI should realize cost savings because they would no longer be required to submit budgets. Because all budgets exceeding the MARI would be subject to budget review under this bill versus less than 50 percent under the current system, hospitals not previously subject to board scrutiny in the past because of where they fell within their group may incur additional costs for justifying their need for increases above the MARI. Assuming one-half of the 293 hospitals which filed budgets in fiscal year 1987-88 did not exceed the MARI, there is potential for administrative cost savings of approximately 15 to 25 percent.

HB 1700, the General Appropriations Bill, contains $6.2 million in General Revenue for the second phase of the physician fee increase. Also included is $136,192 for the Medical Education Tuition Reimbursement Program.

AGENCY IMPACT

The Department of Health and Rehabilitative Services may need additional staff if requested or needed to determine and certify an indigent as eligible under this act. It is conceivable however, that the present work-force the department employs to perform Medically Needy eligibility and eligibility for other Medicaid optional programs, might be utilized at no additional cost to the state, since many of the patients which fall into the "indigent" category would already be potential caseloads for Medicaid. It is also expected that some additional cost might be incurred by the Comptroller's office to prepare the quarterly reports on the amount certified by hospitals as being owed, and the amount actually reimbursed to hospitals from tax sharing revenues.

LOCAL IMPACT

It is impossible to determine what the actual cost to each county will be as a result of this bill becoming law. However, maximum cost can be determined by taking the most recent population estimates and multiplying that by the $4 per capita cap provided for in the bill. Based on the April 1, 1987 state population estimates as published by the Bureau of Economic and Business Research of the College of Business at the University of Florida the maximum fiscal impact on all counties for 1988-1989 is estimated to be $48,174,432 based on an estimated total population of 12,043,608.

PRIVATE IMPACT

The expected impact on a participating hospital and a regional referral hospital would be positive, due to the splitting of the financial eligibility determination from the residency determination. In addition, the ability to have any county or DHRS determine eligibility for indigency and, the ability to have DHRS certify residency in cases where a county refuses or is unable to make such a determination, should increase a hospital's chances of being reimbursed.

III. LONG RANGE CONSEQUENCES:

Indigent Care
The Indigent Care sections of this bill are consistent with the goals of the State Comprehensive Plan to improve access to health care services for indigent persons and should, in conjunction with the changes implemented in chapter 87-92, Laws of Florida, provide a positive long term policy change in the way the state has historically targeted and funded health care programs for its medically indigent population.

Generally, the bill continues to place emphasis on funding primary and preventive care services which were key components of the 1987 law, and which are ultimately more beneficial and cost effective. By continuing and completing the phase-in of the programs implemented in chapter 87-92, Laws of Florida, the state will have moved into the position of having a baseline system of two compatible and integrated health care programs (Primary Care and Medicaid) -- one or both of which will be available to persons with incomes below the federal poverty line. In addition, the state is assisted in the funding of these programs by the federal and county governments, and the hospital industry through the assessment on their gross revenues. The long range impact of the policy decisions made in the indigent care parts of this bill should be beneficial to both the state and the citizens it serves. These benefits should increase over time as indigent persons learn of and begin to utilize basic and preventive health care services in lieu of waiting until health problems are more serious and more costly.

**Health Care Cost Containment Board**

The reenactment of Chapter 395, Part II, Florida Statutes (proposed Chapter 407, Florida Statutes) is consistent with the State Comprehensive Plan which sets as a goal the need to help assure access to affordable, quality health care and to reduce health care cost as a percentage of the total financial resources available to the state and its citizens. The long range impact of keeping a process in place which requires hospitals to justify any increase in charges over certain established thresholds should provide some assurance that the ratio between costs and charges for hospital care is fair and equitable, and that the public's right to affordable health care is protected. This assurance becomes even more critical at least until the current volatile and rapidly changing health care delivery system begins to settle down and stabilize.

**Rural Hospitals**

The measures provided for in this bill should provide some measure of relief for rural hospitals; however, they are not sufficient to ensure the continued financial health of rural hospitals. As competition with urban facilities increases and unforeseen changes in the market occur, rural hospitals must diversify in order to be competitive and remain attractive to rural residents. The adoption of non-traditional and sometimes non-medical services should help the rural hospitals to stay viable, particularly if they are able to fill the unmet needs of the rural residents and especially the unmet needs of the elderly.

**Health Care Responsibility Act**

To the extent that this bill would improve access to hospital care for indigent persons as well as help to reduce uncompensated charity care for major indigent providers, it is consistent with the long range goals of the state. The issue relating to a county's financial obligation for indigents residing in its county, but receiving medical services out of the county, has been the subject of several disputes between hospitals and counties. A large number of disputed cases are over patients who have not been previously certified by a county as an eligible indigent
and who have been admitted to a regional referral hospital in an emergency situation. Although many of the patients may be financially eligible for services because they are transients, migrant workers or poor people who do not own property, some counties are reluctant to certify the patient and accept financial responsibility for their care. This is due in part to the problems associated with the inability to verify residence due to incomplete, inaccurate or unavailable data. Further, it may be to the county's benefit not to certify patients because of the cost. Since this bill places the responsibility on each county to establish or make available, procedures for determining financial eligibility and procedures for certifying residency, it may resolve some of the problems in determining indigents qualified. However, the bill still does not guarantee payment by the county of residency. Although the patient may be determined to be a "qualified indigent" by any county, and the department would be able to make a residency determination when a county refuses, the issue may still be contested by the county being billed, and therefore be may end up in the administrative hearing process before any compensation was awarded to the hospital from tax sources available through the Comptroller's Office. Certainly, the changes made to the current law by this bill would give the hospital a much better chance of proving its case against a county, particularly if DHRS has made determinations in the hospital's favor.

IV. COMMENTS:

Clearly the most controversial sections of this bill deal with the Health Care Cost Containment Board, and specifically with the regulatory powers conferred on the Board. The major debate has centered on 4 major issues.

GROSS VERSUS NET REGULATION - The first and probably the most important issue is whether to regulate hospitals on "gross revenues" or "net revenues." In hospital "lingo," gross revenue means the amount the hospital charges to patients, regardless of who pays the bill. This number is consistent across all payer groups within the hospital, and it is the number from which all revenue deductions are subtracted. Net revenue means the amount of money a hospital actually collects from all patients. This number is not consistent among payor groups and can vary significantly depending on who is paying or not paying the bill. For example, Medicare pays based on a fixed fee per diagnosis and ignores charges; charity care patients often pay nothing; and PPO and HMO payers usually pay a discounted rate. The shortfalls from these discounted payors are often cost-shifted into the gross revenue charged to private pay and insured patients.

Under the current regulatory system, which is based on gross revenues, the amount a hospital can increase charges and cost-shift the increase to private or full pay patients is limited. This is the case, because the increase in charges is capped equally to all payor groups, regardless of what percentage the patient pays. For example, if a 10 percent increase in gross revenues is allowed, the maximum a private or full pay patient's charges can be increased is 10 percent.

Under a net review system, there is no limit on the amount a hospital can increase gross revenues (charges), and cost-shift the increase to the private pay patient. Net revenue regulation only controls the amount the hospital can collect. Because a hospital collects different revenues from each payor group, and in charity cases no revenues, the effect of a 10 percent increase in allowable collections would permit the hospital to charge the private pay patients whatever the market will bear to make up for the shortfalls in other payor collections. The practical result is no regulation of charges at all.
MARI - The maximum allowable rate of increase or MARI is the threshold established in law which, if exceeded by certain high charge hospitals, would place the hospital in a detailed budget review situation. The bill allows a hospital to increase its charges above the MARI if it can justify to the board that the increase is reasonable and necessary. Current law establishes the MARI at the national hospital input price index (NHIPI) plus 3 points to reflect the higher cost of providing services in Florida. The hospital industry has argued for significant increases in the MARI, which would effectively reduce the number of hospitals exceeding the threshold and therefore not required to justify increases in charges. The bill provides for a base MARI, which is set at the NHIPI (the national inflation index for hospital's cost) plus 2 additional points. Added to this, the bill allows for additional points to be added, on a hospital specific basis, which would give a hospital credit for 100 percent of the Medicaid and charity care days it provides, and 50 percent credit for the number of Medicare days it provides. The practical effect of computing the MARI in this manner is that it allows those hospitals providing charity care, Medicaid and Medicare to increase charges at a higher rate, to cover the cost of providing those services, but does not allow a hospital to cost shift to the private pay patients the losses from its bad debts, contractual discounts to HMO's and PPO's, courtesy discounts, or 50 percent of its Medicaid days. The average MARI computed by the board on this model, based on 1986 actual audited data, was 9.8 percent. This compares to an average of approximately 13.7 percent for the same fiscal year for all hospitals (regulated and unregulated), under the current MARI.

REGULATE ALL VERSUS ONLY SOME HOSPITALS - Under the current law, hospitals ranked in the lower 50th percentile based on gross revenues per adjusted admission, are not subject to budget review and, another 30% of higher charge hospitals can escape budget review if they stay within the MARI. For non-regulated hospitals falling below the 50th percentile, the mean budgeted rate of increase in charges from 1987 to 1988 was 19.0% compared to an average mean of 8.5% for hospitals subject to regulation. This trend has persisted since the budget regulation authority was imposed on the board. The expectation that competition, rather than regulation, would help to contain increases in charges has apparently not materialized. This is evidenced by rates of increase by non-regulated hospitals equating to twice as high as increases in regulated hospitals. When analyzing the projected rates of increase from 1987-1988, it is clear that the 85 hospitals between the 50th and the 80th percentile were constrained by the MARI threshold. When the case mix allowance, (which can be added to the MARI under board rule without triggering a budget review), was deducted from the hospitals projected rate of increase, 47 hospitals submitted their budgets directly at the MARI; 9 hospitals submitted their budgets at one percent below the MARI; and, 8 hospitals submitted budgets at three percent below the MARI. In total, after deducting the case mix add-on only 9 out of the 85 hospitals falling within this range submitted budgets with rates of increases above the MARI. By staying within this threshold, all these hospitals were able to escape detailed budget review thus affirming the board's sentinel effect over rates of increase.

COMPOSITION OF BOARD - The fourth major area of controversy focuses on the make-up of the board. The American Association of Retired Persons and the Commissioner of Insurance strongly support an autonomous full-time, non-provider board. Arguments focus on the fact that the current board appears to be provider dominated, and cannot be an effective advocate for the health care consumers. The current 11 member board consists of one member employed by a for-profit hospital chain, one member employed as an administrator of a not-for-profit hospital, one consumer member who was a former hospital administrator, one consumer member who was a former
trustee on the board of a hospital, and one purchaser member who was a former finance office for a hospital. In addition, hospitals provide significant representation on various technical advisory panels which make policy recommendations to the board.

V. AMENDMENTS:

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by:
Cathie Herndon

FINANCE & TAXATION:
Prepared by:

APPROPRIATIONS:
Prepared by:
Lynn Dixon

Staff Director:
Mike Hansen

Staff Director:

Staff Director:
Dr. James A. Zingale
The committee substitute:


--Retains current law providing for an 11 member board, but revises composition of board to include three providers, three purchasers, four consumers, and the Deputy Assistant Secretary for Regulation and Health Facilities of HRS.

--Changes the definition of maximum allowable rate of increase (MARI) by allowing hospitals to increase charges by the market basket index, (National Hospital Input Price Index "NHIP") plus two points as the base; and then allows for a hospital specific index addressing the hospital's shortfalls. Gives 50 percent credit for Medicare, 100 percent credit for charity care and 100 percent credit for Medicaid.

--Subjects all hospitals (except DHRS and DOC hospitals, Shriner's Hospital, comprehensive rehabilitation hospitals, rural hospitals with less than 85 beds, and hospitals where, for the previous 2 years payments for 85 percent or more of the hospital's patient days have been determined in advance) to budget review, but only if the hospital wishes to exceed the MARI.

--Requires only hospitals wishing to exceed the MARI need file detailed budgets.

--Requires all hospitals requesting increases below the MARI submit a "budget letter" which indicates what the hospital's expected GR/AA will be for its next fiscal year, and a statement affirming it intends to stay within the MARI.

--Allows hospitals to accumulate percentage points up to a cumulative maximum of three points to be used in future years.

--Gives hospitals the option, when a penalty is assessed, to have its current budget prospectively reduced or have the next year's budget reduced.

--Allows hospitals to accumulate up to 3 net revenue percentage points to offset penalties in future years.

--Allows board to waive a penalty when extraordinary circumstances exist.

--Provides for a HCCB study to include, among other things, development of a Florida Hospital Input Price Index (FHIPI), severity of illness, and government shortfall impact.

--Provides for a mandated legislative review of hospital industry and board performance on or before October 1, 1993.

--Creates ch. 389, F.S., the "Health Planning Act of 1988."

--Designates DHRS as the state health planning agency.
Requires DHRS to furnish a biennial state health plan, a biennial indigent health care plan, and an annual health care cost containment plan.

Transfers the Office of Technical Assistance currently within the HCCB to DHRS.

Requires DHRS to establish a State Center for Health Statistics.

Establishes within DHRS a State Comprehensive Health Information System Advisory Council consisting of 15 members.

Transfers the responsibility for collection and dissemination of information relating to nursing home charges from HCCB to DHRS.

Provides for renumbering of local health councils and Statewide Health Council to ch. 389, F.S.

Provides for a DHRS study of health care coverage for the uninsured.

Provides for DHRS to prepare a plan for the implementation of a selective contracting program for the contracting of hospital inpatient and outpatient services provided to Medicaid recipients.

In addition, the committee substitute makes technical and clarifying changes.

Committee on Commerce

[Signature]
Staff Director

(FILE THREE COPIES WITH THE SECRETARY OF THE SENATE)
This bill reenacts the Hospital Cost Containment Board with its regulatory powers, establishes a funding source for the Statewide Health Council and the local health councils, and creates a State Center for Health Statistics within the Department of Health and Rehabilitative Services. In addition, the bill provides for three studies: A study to develop the components for a Florida-specific hospital input price index, and a severity of illness index; a study to evaluate and make recommendations on the shortage in the supply of registered nurses; and, a study to look at the fiscal impact on hospitals in Florida providing health care services to migrant and rural farmworkers.

A. PRESENT SITUATION:

Chapter 395, Part II and the Hospital Cost Containment Board are scheduled to Sunset Review pursuant to s. 11.61, F.S., on October 1, 1988, subject to Legislative review and re-enactment. Part II of Chapter 395, F.S., relates to hospital cost containment, and creates the Hospital Cost Containment Board (or board). The stated purpose of the board is to advise the Legislature on health care costs and inflationary trends in health care; to educate consumers and perform other related tasks. Another major function of the board is to review and approve hospital budgets. Each hospital is required to annually submit to the board two detailed financial statements: a projected budget, submitted 90 days prior to the beginning of each hospital's fiscal year; and a report of actual experience, submitted to the board within 120 days after the end of each hospital's fiscal year. The board reviews each hospital's projected budget based on a comparison to the hospital's previous actual experiences, and a comparison to the
performance of other hospitals of similar type. Hospitals with budgets which exceed certain standards are subjected to detailed review by the board.

The board was given authority in 1984 as a result of the Health Care Access Act (Chapter 84-35, Laws of Florida), to approve, to disapprove, or to disapprove in part, hospital budgets based on an established maximum allowable rate of increase (MARI) for hospital gross revenue. If a hospital's gross revenue per adjusted admission (average charge per admission) is in the lower 50 percent of its group or, the lower 80 percent of its group and the hospital has a rate of increase in gross revenues below the MARI, then the hospital's budget is approved without further action by the board. All other hospitals must have their budgets approved by the board, based on patient-payer mix or other standards listed in the law. The law provides penalties for hospitals which exceed the MARI or their approved budgets. Penalties include a prospective reduction to the hospital's budget, fines to be paid into the Public Medical Assistance Trust Fund and possible revocation of a hospital's license.

The membership of the board consists of 11 members which are appointed by the Governor and confirmed by the Senate. Four members of the board are consumers, four members are providers (two of whom must represent hospitals, one of whom must be a nursing home provider) and 3 members are purchasers.

Sections 400.341 - 400.346, Florida Statutes, require the Hospital Cost Containment Board to collect and disseminate information relating to nursing home charges.

The Statewide Health Council and the local health councils are currently funded from a State Trust Fund accrued through fees charged to Certificate-of-Need (CON) applicants. The cost to continue these councils is approximately $2.3 million per year. The recent relaxation of CON requirements has cut the number of applications, and therefore, the fees from those applications resulting in a projected $1.2 million shortfall for fiscal year 1988-89.

Except for the Hospital Cost Containment Board's financial data bank on hospital's and nursing home charges, a comprehensive, accessible and centralized health care information system is unavailable.

B. EFFECT OF PROPOSED CHANGES:

This bill re-enacts Chapter 395, Part II, Florida Statutes relating to the Hospital Cost Containment Board which was scheduled to be repealed on October 1, 1988 pursuant s. 11.61, F.S. The bill accomplishes this by transferring the entire part into a newly created chapter, (Chapter 407), and rearranging, amending, and renumbering the sections. In addition, sections 400.314 - 400.246, Florida Statutes relating to nursing home reporting are also transferred, renumbered and amended into Chapter 407, F.S. The chapter is titled Health Care Cost Containment, and the name of the Hospital Cost Containment Board has been changed to the "Health Care Cost Containment Board."
This bill simplifies and streamlines the methodology by which a hospital would have to file its annual budget with the board, and be subject to detail budget review or penalties. Specifically, the bill changes the budget review process in 10 major ways.

1. Subjects all hospitals to budget review if they exceed the maximum allowable rate of increase (MARI) with the exception of those hospitals exempted under current law, the Florida Elks Children's Hospital, and certain rural hospitals.

2. Requires only hospitals requesting an increase in charges (gross revenues per adjusted admission, GR/AA) which exceed the MARI or, are requesting budget amendments which would cause the hospital to exceed the MARI, to file projected budgets and be subject to detailed budget review.

3. Hospitals not requesting increases above the MARI only file a "budget letter" which stipulates what the hospital's projected GR/AA for its next fiscal year will be, and affirms that the hospital intends to stay within the MARI for its group.

4. Allows a hospital, whose actual audited experience at the end of the fiscal year indicates it came in below the MARI, to "bank" up to a cumulative total of 3 percentage points to be used in the future.

5. Changes the definition of maximum allowable rate of increase (MARI), by allowing hospitals to increase charges by the market basket index (currently the National Hospital Input Price Index, NHIPI) plus two points as the base, and then allows for additional points to be added to the base depending on each hospital's specific experience by giving 50% credit for the proportion of Medicare days to total days, 100% credit for uncompensated charity care days to total days, and 100% credit for the proportion of Medicaid days to total days.

6. Allows budget amendments to be retroactive in certain circumstances.

7. Prioritizes review criteria ranking reasonable rate of return as the first priority, and allows the hospitals to use this criteria to justify increased charges.

8. Gives the board some discretion in using review criteria to evaluate penalty situations.

9. Allows a hospital which had increases in net revenue below the NHIPI plus 2 percentage points to bank up to a cumulative maximum of 3 net revenue percentage points to be used to offset any future year penalties for exceeding the MARI.

10. Shortens the timeframe the board has to approve a budget subject to budget review, from 120 to 90 days.

The bill also changes the current law by decreasing the number of members on the board from 11 to 9 members. The new board will consist...
of three providers, including one representative of the for-profit hospitals, one representative of the not-for-profit hospitals and one representative of the nursing home industry; three members who are major purchasers of health care; and, three members who are consumers, provided, one consumer member must be 60 years of age or older. Finally, the bill provides for another Sunset Review of the Health Care Cost Containment Act (Chapter 407, F.S.) in 1992.

The bill provides for a three-part 18 month study to be conducted by the State's University System, to determine a Florida specific measure of hospital expenses (Florida Hospital Input Price Index or FHIPI). The study would also provide recommendations on a methodology and reporting system to measure the impact of changes in reimbursement levels from all government payers, to make recommendations for a statistical measure or index for severity of illness for acute care hospitals and, to make a separate recommendation for a severity index for psychiatric hospitals.

In addition, the bill directs the Health Care Cost Containment Board to conduct a study of the shortage in the supply of registered nurses and a study on the fiscal impact on hospitals for providing health care services to migrant and rural farmworkers.

A funding source for the Statewide Health Council and the local health councils is also established within the bill to supplement the declining certificate-of-need application fees. The bill provides for assessments on all health care facilities subject to licensure and is estimated to generate approximately $1,193,350. Hospitals, nursing homes and Medicare certified home health agencies are assessed an annual fee of $500.00, and all other health care facilities are assessed $150.00. The department is directed to establish rules to implement this provision.

Finally, the bill creates a State Center for Health Care Statistics with responsibilities to develop a comprehensive information system which may be utilized by the Legislature, other state agencies, and private and public entities. A 13 member advisory council is established to assist the department in reviewing and making recommendations concerning the information system.

C. SECTION-BY-SECTION ANALYSIS:


Section 2. Amends, transfers and renumbers s. 395.502, F.S., relating to definitions, to s. 407.002, F.S. Changes the definition of "Board" from Hospital Cost Containment Board to Health Care Cost Containment Board. Changes the definition of "maximum allowable rate of increase" (MARI), by establishing a base index to which a hospital specific adjustment can be added, to reach an individual MARI for each hospital. Adds a definition of "rate of return" which may include, but not be limited to four financial indicators which the board would use to determine reasonableness of the financial requirements of a hospital, and adds a definition for "rural hospital."
Section 3. Amends, transfers and renumbers s. 395.5025, F.S., relating to the Legislature's intent, to s. 407.003, F.S. Broadens the intent of the board: to promote improved consumer and purchaser understanding of government funded programs and third party reimbursement; and to recommend to the Legislature appropriate strategies to foster health care cost containment and improve access. Declares that the rising cost of health care, and cost shifting and cross subsidization by hospitals to increase revenues regardless of the cause, is of vital concern to the people of the state.

Section 4. Amends, transfers and renumbers s. 395.503, F.S., relating to the Hospital Cost Containment Board, to s. 407.01, F.S. Changes the name to Health Care Cost Containment Board. Determines board shall be a separate budget entity from the Department of Health and Rehabilitative Services and that the executive director shall be its agency head for all purposes, except for matters involving chapter 120, F.S. In such cases, the board shall act as the agency head. Decreases membership from 11 to 9 members effective with appointments after January 1, 1989. Changes the board makeup to 3 providers, one of which is a representative of the for-profit hospitals, one of which is a representative of the not-for-profit hospitals, and one of which is a representative of the nursing home industry; 3 consumers, one of which is 60 years of age or older; and 3 major purchasers.

Section 5. Amends, transfers and renumbers s. 395.504, F.S., dealing with powers and duties of board, to s. 407.02, F.S. Limits board's authority to approve, amend or disapprove budgets to only those hospitals requesting increases above the maximum allowable rate of increase (MARI). Strikes and transfers the language dealing with publishing physician data obtained from the Department of Insurance to s. 407.70, F.S. Empowers the board to investigate consumer complaints regarding problems with hospital billing practices and to issue reports in cases where the board determines the hospital engaged in unreasonable and unfair billing practices.

Section 6. Creates a new section 407.025, F.S., providing immunity to hospitals and other reporting entities for providing patient data to the board.

Section 7. Amends, transfers and renumbers s. 395.505, F.S., relating to rules to s. 407.03, F.S. Makes technical changes to replace the word "part" with the word "chapter".

Section 8. Amends, transfers and renumbers s. 395.5051, F.S., relating to effect of act on existing rules, to s. 407.035, F.S. Provides that nothing contained in the act would change rules promulgated to enact chapter 84-35, Laws of Florida, unless in direct conflict with this act. Provides that all budgets or budget amendments beginning prior to February 1, 1989 shall be filed and reviewed subject to chapter 84-35, Laws of Florida.

Section 9. Amends, transfers and renumbers s. 395.512, F.S., relating to the budget of the board to s. 407.04, F.S. Requires the board to submit its final legislative budget request directly to the Governor by November 1 of each even numbered year.
Section 10. Amends, transfers and renumbers s. 395.507, F.S., relating to uniform system of financial reporting for hospitals, to s. 407.05, F.S. Requires only hospitals requesting approval of a rate of increase in gross revenue per adjusted admission (GR/AA) in excess of the maximum allowable rate of increase (MARI) to file budgets for detailed review. Allows for the establishment of not more than 15 groups for the purpose of comparison in the budget review process.

Section 11. Amends transfers and renumbers s. 395.514, F.S., relating to hospital violation of rules, to s. 407.06, F.S. Makes technical changes by correcting references from violations of "part" to violations of "chapter".

Section 12. Amends, transfers and renumbers s. 395.508, F.S., relating to hospital costs and finances; analysis, studies and reports, to s. 407.07, F.S. Changes section title from "hospital" to "health care". Adds authority for board to study effects of Medicare, Medicaid and other government reimbursement mechanisms. Gives the board authority to conduct analysis and research on impact of uncompensated care on hospital budgets. Gives the board authority to conduct analysis and research on the state's role in funding indigent care.

Section 13. Amends, transfers and renumbers s. 395.513, F.S., relating to program accountability, to s. 407.08, F.S. Expands the requirements of the board's annual report to include an analysis of the reasons for existing levels of cost subsidization. Expands the report to include the extent to which public funding policies may be affecting health care costs. Also expands the report to include the extent to which other factors, such as uncompensated care, skilled employee shortages, changes in technology and shifts from institutional to ambulatory care may be affecting health care costs.

Section 14. Amends, transfers and renumbers s. 395.5085, F.S., relating to collection and dissemination of hospital charge information, to s. 407.09, F.S. Allows board to distribute information utilizing the Consumer Information and Advisory Council created in s. 407.10, F.S., or by any other appropriate means available. Strikes language relating to Consumer Information Network and moves most of the language into s. 407.10, F.S.

Section 15. Creates s. 407.10, F.S., relating to the Consumer Information and Advisory Council, previously known as the Consumer Information Network. In addition to responsibilities previously handled by Consumer Information Network, it allows the council to conduct or sponsor consumer information or education seminars at locations throughout the state. It further gives the Council authority to hold public hearings in order to solicit consumer concerns or complaints relating to health care costs and as a result of those hearings, make recommendations to the board for study, action or investigation.

Section 16. Amends, transfers and renumbers s. 395.5042, F.S., relating to the Office of Technical Assistance, to s. 407.11, F.S. Expands the responsibilities of the office to include: developing cost containment strategies for providers, employers and consumers;
serving as a clearinghouse for information concerning federal and state legislative initiatives affecting health care delivery system and government health care programs; and, developing an outreach program to assist small business to include cost containment initiatives for small business insurance plans.

Section 17. Transfers and renumbers s. 395.511, F.S., relating to quality assurance monitoring to s. 407.12, F.S. Requires hospitals to maintain a quality assurance program and make quality assurance plans available to the board upon request. Allows the board to request information from the Department of Health and Rehabilitative Services, the Department of Professional Regulation, and the Department of Insurance which would enable it to monitor a hospital's quality assurance.

Section 18. Amends, transfers and renumbers s. 395.515., F.S., relating to prospective payment arrangements, to s. 407.13, F.S. Provides for technical changes to name of board.

Section 19. Amends, transfers and renumbers s. 400.341, F.S., relating to legislative intent - nursing home costs, to s. 407.30, F.S. Provides for technical changes.

Section 20. Amends, transfers and renumbers s. 400.343, F.S., relating to uniform system of financial reporting for nursing homes to s. 407.31, F.S. Provides technical changes in statutory cites.

Section 21. Amends, transfers and renumbers s. 400.344, F.S., relating to nursing home revenues and financial analysis, studies and reports, to s. 407.32., F.S. Provides technical changes relating to other statutory cites. Allows the board to prepare and file supplementary studies and reports based on information analyzed relating to nursing home data.

Section 22. Amends, transfers and renumbers s. 400.345, F.S., relating to nursing home assessments to fund the budget of board to conduct nursing home financial disclosure program, to s. 407.33., F.S. Provides for technical changes.

Section 23. Amends, transfers and renumbers s. 400.346, F.S., relating to nursing homes violations of law or rules, to s. 407.34, F.S. Provides technical changes to other statutory cites.

Section 24. Substantially amends, transfers and renumbers s. 395.509, F.S., relating to review of hospital budgets, to s. 407.50, F.S. Eliminates hospitals from filing a detailed budget with the board unless the hospital wishes to exceed the maximum allowable rate of increase (MARI). Requires, as an alternative, for hospitals to file a "budget letter" which specifies what the hospitals expected gross revenues per adjusted admission will be for its next fiscal year, and a statement affirming it intends to stay within the MARI. Requires all hospitals which exceed the MARI, either through submission of a budget request or by filing a budget amendment, to be subject to detailed budget review regardless of where they fall in their group. Allows hospitals staying below the MARI to "bank" percentage points to be used in the future, up to a cumulative maximum of 3 points.

STANDARD FORM 5/88
Changes the "a" through "k" review criteria and prioritizes them. Exempts from budget review the Florida Elks Children's Hospital, certain rural hospitals, those hospitals exempted under current law, and any hospital in which at least 90 percent of its admissions are contracted through a prospective payment system.

**Section 25.** Amends, transfers and renumbers s. 395.5094, F.S., relating to exceeding approved budget and penalties, to s. 407.51, F.S. Retains current law which places a hospital in a potential penalty situation when its actual net revenues per adjusted admission exceed the previous year's actual by more than the MARI, or exceed the projected budget as approved by the board. Requires the board to establish a proxy for psychiatric case mix to reduce the amount of excess a psychiatric hospital may be liable for. Allows the board to reduce a hospital's excess in certain unforeseen circumstances which occurred in the last three months of a hospital's fiscal year or, if the imposition of the penalty would have a severe adverse effect which would jeopardize the continued existence of an otherwise economically viable hospital. Allows a hospital whose increase in net revenues was less than the NHPI plus 2 percentage points, to bank up to a cumulative maximum of 3 net revenue percentage points to be used to offset any future year penalties for exceeding the MARI.

**Section 26.** Transfers and renumbers s. 395.5125, F.S., relating to operating costs; non-deductible items, to s. 407.52, F.S. Leaves the original language intact.

**Section 27.** Transfers and renumbers s. 395.5135, F.S., relating to burden of proof, to s. 407.53, F.S. Leaves the original language intact.

**Section 28.** Amends, transfers and renumbers s. 395.5092, F.S., relating to duty of Public Council; to s. 407.54, F.S. Clarifies that Public Council may represent consumers before the board, its advisory panels, in administrative hearings or before any other state and federal agencies or courts in any issue related to budget review.

**Section 29.** Amends, transfers and renumbers s. 395.52, F.S., relating to information on physician's charges, to s. 407.70, F.S. Moves current language dealing with physician information to this section. Specifically, it exempts physicians from any provisions of this act if the physician bills his services independently of the hospital. Requires board to publish an annual report containing available physician charge comparisons from information obtained by insurers. Requires insurers to submit physician data directly to the Health Care Cost Containment Board instead of being reported to the Department of Insurance.

**Section 30.** Requires the board to contract with the State University System to conduct a study which would develop and recommend a Florida specific hospital input price index (FHIPI) to measure hospital expenses and, a statistical indicator or index to measure severity of illness for acute care hospitals and psychiatric hospitals.
Section 31. Requires the Health Care Cost Containment Board to conduct a study of the shortage in the supply of registered nurses by February 1, 1990.

Section 32. Requires the Health Care Cost Containment Board to conduct a study by January 31, 1989 on the impact on hospital for providing health care services to migrant and rural farmworkers.

Section 33. Repeals section 24, chapter 82-182, Laws of Florida, relating to Sunset Review of chapter 395, Part II, Florida Statutes, and reenacts the Hospital Cost Containment Board as amended and transferred to chapter 407, F.S.

Section 34. Provides that Chapter 407 shall stand repealed on October 1, 1992, subject to future review of the Legislature pursuant to s. 11.61, F.S.

Section 35. Amends s. 381.703, F.S., relating to funding the Statewide and local health councils. Provides for assessments on all health care facilities subject to licensure to help fund the councils. Assesses hospitals, nursing homes and Medicare certified home health agencies an annual fee of $500.00, and all other facilities $150.00. Directs the department to establish rules to implement this provision.

Section 36. Repeals s. 400.342, F.S., relating to definitions for nursing home financial reporting. Incorporates it into the definition section of s. 407.002, F.S. Repeals s. 627.9175(3), F.S., relating to the requirement insurers provide data on physician charges to Department of Insurance. Reports will now be made directly to the Health Care Cost Containment Board.

Section 37. Establishes appropriation language to fund budget issues which were incorporated into the bill after the Appropriations Bill had passed out of Appropriations Committee.

Section 38. Establishes legislative intent for the Center for Health Statistics. Provides that information compiled by the comprehensive health information system be made available to interested persons to improve decision-making processes, and to require providers and other health care related entities to provide information necessary to operate the comprehensive health information system.

Section 39. Establishes the Center for Health Statistics within the Department of Health and Rehabilitative Services to collect and disseminate data on health care status, resources, costs, trends and other areas relating to funding and providing health care services to residents of the state. Provides that the department create a comprehensive health information system to coordinate the data collection efforts of other state local and federal agencies. Provides that funding to operate the center shall come from fees, grants and appropriations from the General Revenue Fund to be deposited into the Comprehensive Health Information System Trust Fund. Creates a 13 member state comprehensive health information system advisory council to assist the center in reviewing the comprehensive health information system and to recommend improvements for such system. Provides qualifying language which precludes the center from
restricting, affecting, or controlling the collection, analysis, release or publication of data pursuant to the Health Care Cost Containment Act as passed in this bill, or by any other state agency pursuant to its statutory authority, duties or responsibilities.

Section 40. Instructs the Division of Statutory Revision and Index of the Joint Legislative Management Committee to prepare a reviser's bill for submission to the 1989 regular session to conform cross-references, to renumber sections, and to replace the name of the "Hospital Cost Containment Board" to Health Care Cost Containment Board whereever it appears in statutes.

Section 41. Provides that October 1, 1988 is the effective date unless otherwise provided within the bill.

II. FINAL FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:
(Prepared by Committee on Health Care)

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

Non-recurring or First Year
Start-Up Effects:

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>FY 88-89</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCCB</td>
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</tr>
<tr>
<td>Nursing Shortage Study</td>
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<tr>
<td>Univ. of FL FHIPI Study</td>
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<tr>
<td>Impact Migrant Study</td>
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<tr>
<td>TOTAL NONRECURRING EXPENDITURES:</td>
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Recurring or Annualized
Continuation Effects:

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<tr>
<td>DHRSC</td>
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</tr>
<tr>
<td>Center for Health Statistics</td>
<td>no funding allocated</td>
</tr>
<tr>
<td>HCCB</td>
<td></td>
</tr>
<tr>
<td>Salaries and Benefits (3 FTEs)</td>
<td>$121,300</td>
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<td>(new positions)</td>
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<tr>
<td>TOTAL RECURRING EXPENDITURES:</td>
<td>$121,300</td>
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Appropriations Consequences:

<table>
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<tr>
<th>Expenditures</th>
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</thead>
<tbody>
<tr>
<td>Health Care Cost Containment TF</td>
<td>$309,300</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>$309,300</td>
</tr>
</tbody>
</table>
B. FISCAL COMMENTS:
(Prepared by Committee on Health Care)

Hospitals currently submitting budgets within the MARI should realize cost savings because they would no longer be required to submit budgets. Because all budgets exceeding the MARI would be subject to budget review under this bill versus less than 50 percent under the current system, hospitals not previously subject to board scrutiny in the past because of where they fell within their group may incur additional costs for justifying their need for increases above the MARI. Assuming one-half of the 293 hospitals which filed budgets in fiscal year 1987-88 did not exceed the MARI, there is potential for administrative cost savings of approximately 15 to 25 percent.

No monies were appropriated in this bill or in the Appropriations Bill which were specifically allocated to fund the State Center for Health Statistics. It is assumed that the Department of Health and Rehabilitative Services would need to create the Center within its currently available resources, which would include any fees, grants or donations it is authorized by the bill to accept. The department estimates that 20 positions and $700,000 would be required to fully fund the center. This figure does not include resources for the computer and software requirements which will undoubtedly be necessary to implement the comprehensive health information system called for in the legislation.

III. LONG RANGE CONSEQUENCES:

The reenactment of Chapter 395, Part II, Florida Statutes (proposed Chapter 407, Florida Statutes) is consistent with the State Comprehensive Plan which sets as a goal the need to help assure access to affordable, quality health care and to reduce health care cost as a percentage of the total financial resources available to the state and its citizens. The long range impact of keeping a process in place which requires hospitals to justify any increase in charges over certain established thresholds should provide some assurance that the ratio between costs and charges for hospital care is fair and equitable, and that the public's right to affordable health care is protected. This assurance becomes even more critical at least until the current volatile and rapidly changing health care delivery system begins to settle down and stabilize. The Center for Health Statistics has the potential for providing data which will assist planners and economists over the long term to better manage the health care resources available to the state and the private sector.

IV. COMMENTS:

Clearly the most controversial sections of this bill deal with the Health Care Cost Containment Board, and specifically with the regulatory powers conferred on the Board. The major debate has centered on 4 major issues.

GROSS VERSUS NET REGULATION - The first and probably the most important issue is whether to regulate hospitals on "gross revenues" or "net revenues." In hospital "lingo," gross revenue means the
amount the hospital charges to patients, regardless of who pays the bill. This number is consistent across all payor groups within the hospital, and it is the number from which all revenue deductions are subtracted. Net revenue means the amount of money a hospital actually collects from all patients. This number is not consistent among payor groups and can vary significantly depending on who is paying or not paying the bill. For example, Medicare pays based on a fixed fee per diagnosis and ignores charges; charity care patients often pay nothing; and PPO and HMO payors usually pay a discounted rate. The shortfalls from these discounted payors are often cost-shifted into the gross revenue charged to private pay and insured patients.

Under the current regulatory system, which is based on gross revenues, the amount a hospital can increase charges and cost-shift the increase to private or full pay patients is limited. This is the case, because the increase in charges is capped equally to all payor groups, regardless of what percentage the patient pays. For example, if a 10 percent increase in gross revenues is allowed, the maximum a private or full pay patient's charges can be increased is 10 percent.

Under a net review system, there is no limit on the amount a hospital can increase gross revenues (charges), and cost-shift the increase to the private pay patient. Net revenue regulation only controls the amount the hospital can collect. Because a hospital collects different revenues from each payor group, and in charity cases no revenues, the effect of a 10 percent increase in allowable collections would permit the hospital to charge the private pay patients whatever the market will bare to make up for the shortfalls in other payor collections. The practical result is no regulation of charges at all. This bill retains regulation on gross revenue.

MARI - The maximum allowable rate of increase or MARI is the threshold established in law which, if exceeded by certain high charge hospitals, would place the hospital in a detailed budget review situation. The bill allows a hospital to increase its charges above the MARI if it can justify to the board that the increase is reasonable and necessary. Current law establishes the MARI at the national hospital input price index (NHIPI) plus 3 points to reflect the higher cost of providing services in Florida. The hospital industry has argued for significant increases in the MARI, which would effectively reduce the number of hospitals exceeding the threshold. These hospitals, therefore, would not be required to justify increases in charges. The bill provides for a base MARI, which is set at the NHIPI (the national inflation index for hospital's cost) plus 2 additional points. Added to this, the bill allows for additional points to be added, on a hospital specific basis, which would give a hospital credit for 100 percent of the Medicaid and charity care days it provides, and 50 percent credit for the number of Medicare days it provides. The practical effect of computing the MARI in this manner is that it allows those hospitals providing charity care, Medicaid and Medicare to increase charges at a higher rate to cover the cost of providing those services, but does not allow a hospital to cost shift to the private pay patients the losses from its bad debts, contractual discounts to HMO's and PPO's, courtesy discounts, or 50 percent of its Medicare days. The average
MARI computed by the board on this model, based on 1986 actual audited data, was 9.8 percent. This compares to an average rate of increase of approximately 13.7 percent for the same fiscal year for all hospitals (regulated and unregulated), under the current MARI for the same time period.

**REGULATE ALL VERSUS ONLY SOME HOSPITALS** - Under the current law, hospitals ranked in the lower 50th percentile based on gross revenues per adjusted admission, are not subject to budget review and, another 30% of higher charge hospitals can escape budget review if they stay within the MARI. For non-regulated hospitals falling below the 50th percentile, the mean budgeted rate of increase in charges from 1987 to 1988 was 19.0% compared to an average mean of 8.5% for hospitals subject to regulation. This trend has persisted since the budget regulation authority was imposed on the board. The expectation that competition, rather than regulation, would help to contain increases in charges has apparently not materialized. This is evidenced by rates of increase by non-regulated hospitals equating to twice as high as increases in regulated hospitals. When analyzing the projected rates of increase from 1987-1988, it is clear that the 85 hospitals between the 50th and the 80th percentile were constrained by the MARI threshold. When the case mix allowance, (which can be added to the MARI under board rule without triggering a budget review), was deducted from the hospitals projected rate of increase, 47 hospitals submitted their budgets directly at the MARI; 9 hospitals submitted their budgets at one percent below the MARI; and, 8 hospitals submitted budgets at three percent below the MARI. In total, after deducting the case mix add-on only 9 out of the 85 hospitals falling within this range submitted budgets with rates of increases above the MARI. By staying within this threshold, all these hospitals were able to escape detailed budget review thus affirming the board's sentinel effect over rates of increase. This bill would exempt only hospitals not subject to review under current law, certain rural hospitals, the Elks Children's Hospital and hospitals with prospective payment arrangements affecting 90 percent of their patients.

**COMPOSITION OF BOARD** - The fourth major area of controversy focuses on the make-up of the board. The American Association of Retired Persons and the Commissioner of Insurance strongly support an autonomous full-time, non-provider board. Arguments focus on the fact that the current board appears to be provider dominated, and cannot be an effective advocate for the health care consumers. The current 11 member board consists of one member employed by a for-profit hospital chain, one member employed as an administrator of a not-for-profit hospital, one consumer member who was a former hospital administrator, one consumer member who was a former trustee on the board of a hospital, and one purchaser member who was a former finance office for a hospital. In addition, hospitals provide significant representation on various technical advisory panels which make policy recommendations to the board. The bill provides for a nine member part-time board consisting of 3 providers.
V. BILL HISTORY:

4/6/88 Passed out of Health Financing Subcommittee as HC PCB 88-08 with 10 amendments. Amendments included provisions which would make the board a 3 member full-time board, and defined MARI as the NHIPI with no additional percentage points.

5/3/88 Passed out of Health Care Full Committee with 13 amendments. Amendments reverted back to a part-time nine member board, set MARI at what was passed in final version of bill, and added the "Rural Hospital Act" (HC PCB 88-09).

5/11/88 Introduced as HB 1673 and referred to Appropriations Committee

5/17/88 Amended and passed out of Appropriations as a Committee Substitute. Amendments included the addition of HB 1561 (Nurse Shortage Study).

5/24/88 Passed House (111 yeas, 3 nays), placed in Senate messages.

5/30/88 Amended and substituted for SB 904, and passed Senate as amended (37 yeas, 0 nays). Removed the indigent care components of the bill (see CS/CS/SB 534), and added the Center for Health Statistics and funding for the Statewide and local health councils.

5/31/88 Amended and passed the House (115 yeas, 0 nays).

6/2/88 Amended and passed the Senate (36 yeas, 0 nays).

6/3/88 House concurred in Senate Amendments (113 yeas, 0 nays) Ordered engrossed and then enrolled.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:

Prepared by: Cathie Herndon

Staff Director: Michael P. Hansen

FINANCE & TAXATION:

Prepared by: Lynn Dixon

Staff Director: James A. Zingale

STANDARD FORM 5/88
A REVIEW OF
CHAPTER 395, PART II, FLORIDA STATUTES
HEALTH CARE COST CONTAINMENT

By the Staff of
The Florida Senate Committee on Commerce
March 1988
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I. INTRODUCTION

The Regulatory Sunset Act, chapter 81-318, Laws of Florida, provides for a systematic repeal of those statutes which regulate initial entry and practice of certain professions and occupations. Each year, several statutes are scheduled for review and subsequent repeal. Based on the findings of the statutory review, the Legislature may choose to reenact the regulation or to repeal it. This review concerns chapter 395, part II, Florida Statutes, entitled the "Health Care Cost Containment Act of 1979" which will be repealed on October 1, 1988, unless it is reenacted by the Legislature.

The Regulatory Sunset Act sets forth specific criteria for the review of statutes scheduled for repeal. Essentially, these criteria mandate a determination as to whether the law is a legitimate exercise of the state's police power. Stated another way, the primary question considered in this review is:

Does ch. 395, part II, F.S., protect the public from serious potential harm, to the extent that if the act were repealed there would be a threat
to the public's health, safety, or welfare?

If the answer is negative, then the statute must fall. However, if the answer is positive, then the statute must be evaluated to determine if it addresses the potential for serious public harm at the least public cost. This review begins with an examination of the statute, its origin, and operation. An effort was made to avoid lengthy quotations from the chapter, as the entire chapter is set forth in the appendix. The administrative rules are addressed next, followed by a discussion of the law and the various administering agencies. Finally, the costs and benefits of the law are evaluated from the perspective of the regulating entity, the health care industry, and the public. These findings are followed by conclusions and recommendations.

This review is a product of staff research, meetings with interested parties, and information received from industry, consumer, and board representatives.
II. SUMMARY

This review examines, pursuant to the Sunset Act, the statutory provisions, operating procedures, costs of and benefits derived from, the Hospital Cost Containment Board. It assesses the potential impact of abolition of the board and makes a recommendation as to whether the Legislature should reenact chapter 395, part II, F.S., which creates the board and provides for its composition, organization, powers, and responsibilities.

Chapter 395, part II, "The Health Care Cost Containment Act of 1979" which created the board, was enacted in 1979. In 1984 the board was given regulatory authority pursuant to the Health Care Access Act. The board is made up of 11 members appointed by the Governor and confirmed by the Senate. Members serve 3 year staggered terms and represent various groups including major purchasers of health care, providers of health care, consumers and nursing homes.

The board has the responsibility of promoting competition among health care providers and providing a "safety net" of regulation in an effort to control increases in health care costs. These responsibilities are carried out by gathering and disseminating health care information.
to consumers, providing technical assistance to various health care groups and coalitions, advising the Legislature of trends and concerns in the health care area and by reviewing all hospital budgets and reducing only the few (pursuant to statute) exhibiting the highest charges and greatest rates of increase. This budget review function provides for a very limited regulatory role and is intended by the Legislature to serve as a "safety net" to "catch" the few hospitals exhibiting the highest average charges and rates of increase. Therefore, by statute, the majority of Florida hospitals are unregulated.

During its existence, the board has served to gather data valuable to both private and public decision makers and has implemented a budget review process which is working in a manner consistent with statutory provisions and intent. The board has served as a valuable information source for the health care industry, consumers, and the state government. The board's budget review functions are operating as required by statutes and appears to be providing the "safety net" intended by the Legislature even though the overall effect of the limited regulation on health care costs is not large. In addition, the information gathered during the budget review process is a valuable information source to policy makers and major purchasers of hospital services.
Therefore, on the basis of this review, and a favorable report by the Office of the Auditor General, it is recommended that the Legislature reenact chapter 395, part II, F.S.
III. FINDINGS

A. THE LAW

Chapter 395, part II, F.S., "Health Care Cost Containment" was designed to help control inflationary trends in health care costs. To obtain this goal the Hospital Cost Containment Board (hereafter the board), ch. 79-106, L.O.F., was created. The board, and related statutory provisions, are the subject of this review as required by the Sunset Act, s. 11.61, F.S. The board is located administratively within the Department of Health and Rehabilitative Services. A copy of the "Health Care Cost Containment Act of 1979" is attached as Appendix A.

1. Intent

Section 395.5025, F.S., states that it is the intent of the Legislature to assure that adequate health care is affordable and accessible to the citizens of the state of Florida. To accomplish this goal, the board was created to perform the following functions:

1) To advise the Legislature regarding health care costs, the inflationary trends in health care costs, the impact of health care costs on the state budget, the impact of hospital charges and third party reimbursement mechanisms on health care costs, and the education of consumers and
providers of health care services in order to encourage price competition in the health care marketplace.

2) To contain health care costs through improved competition between hospitals and improved competition between insurers, through financial incentives which foster efficiency instead of inefficiency, and through sincere initiatives on behalf of providers, insurers and consumers to contain costs.

3) To establish a program of prospective budget review and approval as a "safety net" in the event competition oriented methods do not adequately contain costs and the access of Florida's citizens to adequate hospital care becomes jeopardized because of unaffordable costs.


The provisions of ch. 395, part II provide for board composition, organization, powers, and responsibilities.

a) Board Composition

The board, created by s. 395.503, F.S., currently consists of 11 members appointed by the Governor and confirmed by the Senate. Board members serve 3 year staggered terms and include three major purchasers of health care, three providers of health care, four consumers of health care, and a nursing home representative. A list of all current board members is attached as Appendix B.
b) **Board Organization**

The board is statutorily required to biennially elect a chairperson and vice-chairperson from its membership. The board is also required to appoint an executive director. The executive director hires the board's staff and the board may contract with outside persons for necessary services. The board is authorized to receive and accept grants, gifts, and other payments, and may create committees and ad hoc advisory committees. An organizational chart detailing the board's staff structure is attached as Appendix C.

c) **Powers and Responsibilities**

The powers and duties of the board are set out in s. 395.504, F.S. The board's primary responsibilities can be divided into two general areas; promotion of competition through information gathering and dissemination, and regulation through budget review. The board's specific statutory powers and duties are set out below:

1) **Shall require the submission by hospitals of such case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups as the board deems necessary in order to have available the statistical information necessary to properly conduct budget review and approval and to carry out its public information**
and education functions. Such data may include, but is not limited to: leases, contracts, itemized patient bills, medical record abstracts, and related diagnostic information necessary to evaluate the case-mix of a hospital and to identify actual charges and lengths of stay associated with specific diagnostic groups; necessary operating expenses; appropriate expenses incurred for rendering services to patients who cannot or do not pay; all properly incurred interest charges; and reasonable depreciation expenses based on the expected useful life of the property and equipment involved.

2) Shall approve, approve as amended by the board, or disapprove the budget of each hospital, including its projected expenditures and projected revenues.

3) May contract with local health councils to disseminate information to the public on health care costs.

4) Shall cooperate with the comprehensive Health Planning Office of the Department of Health and Rehabilitative Services in the development of a biennial work plan defining the roles and responsibilities of the board and the comprehensive Health Planning Office in the establishment of an integrated health care data base and shall consult with and make recommendations to the board and the Secretary of Health and Rehabilitative Services with respect to analyses and studies of health care costs, capital expenditures by hospitals and their relationship to health care costs, and related matters which may be undertaken by the board.

5) May inspect and audit hospital books and records, including records of individual or corporate ownership, for compliance with part II, ch. 395.
6) Shall publish and make available to the public a toll-free telephone number for the purpose of handling consumer complaints and shall serve as a liaison between consumer entities and other private entities and governmental entities for the disposition of problems identified by consumers of hospital care.

7) Shall monitor the effects of preferred provider organizations and changes in reimbursement methodologies for Medicare on cost shifting.

8) Shall designate executive staff members to issue preliminary findings pursuant to s. 395.509(8).

9)(a) Shall publish, based on information provided by the Department of Insurance under s. 627.9175(1), an annual report containing premium and benefit comparisons, or the equivalent thereof, for policies of individual health insurance and shall disseminate the report in the manner provided in s. 395.5085. The report shall also indicate, as applicable, the extent to which the premiums charged by a given entity have increased over the prior premium year.

(b) Shall publish, based on information provided by the Department of Insurance under s. 627.9175(3), an annual report containing available physician charge comparisons, profiles, and related information.

Therefore, the board has the responsibility to make the health care marketplace more competitive (and thereby slow the increase in health care costs) by providing health care consumers with information needed to make prudent purchases. This duty is to be accomplished through several means; for example, the board is required to
distribute various informative publications to health care consumers to aid them in health care purchases. In addition, certain information gathered by the board is required to be transmitted to the Governor and the Legislature to enable them to make well-informed public policy choices. Finally, the board is required to aid health care coalitions and other groups through its Office of Technical Assistance (created by s. 395.5042, F.S.). This office was created by the Legislature to serve as a focal point for governmental efforts and activities to promote health care cost containment by providing technical assistance to persons, business and purchaser coalitions.

To the extent these competition promotion initiatives do not adequately contain health care costs, the board is authorized to review hospital budgets and reduce the budgets of certain hospitals which contain rates of increase deemed excessive by the board (using statutorily set criteria). Consistent with the "safety net" intent of the statute, only a small percentage of hospitals are ever subject to this budget reduction power.

3. History

While the board has been affected by legislation in almost every year of its existence, there are two chapters in the Laws of Florida which have been of primary importance. The first is ch. 79-106, L.O.F., which created
the board and provided for its information gathering functions to promote competition. The second is ch. 84-35, L.O.F., which gave the board its regulatory authority over hospital budgets. In addition, the following enactments (listed in chronological order) have had a significant impact on board functions.

Chapter 80-187, L.O.F., exempted hospitals operated by the Department of Health and Rehabilitative Services and the Department of Corrections from assessments used to finance the activities of the board.

Chapter 82-182, L.O.F., created s. 395.5025, providing for legislative intent, and amended existing sections to provide for a staggering of terms, modified membership, appointment, organization, and staffing procedures. Certain duties of the board regarding budget services and studies were deleted from the statute while provisions requiring the adoption of rules with respect to submissions by hospitals of financial and accounting data were added. Review procedures were also amended, providing new criteria and limitations, and provisions relating to the bienniel assessments levied against hospitals to help fund the board were also clarified. In addition, the board was scheduled for review and repeal on October 1, 1988, pursuant to Sunset.
Chapter 83-269, L.O.F., provided an exemption from the public records act of ch. 119, F.S., for certain patient records obtained by the board. Chapter 83-269, L.O.F., further increased the membership of the board from 9 to 11 members (with the addition of two representatives of major non-health and non-insurance employers) and provided for collection of case mix data. Case mix data reflects the relative severity of a patient's condition in a hospital. Chapter 83-269 also amended the board's authority to impose a penalty in s. 395.514, F.S., to penalize a hospital which files a false or incomplete report.

Chapter 84-35, L.O.F., as well as providing the above mentioned regulatory authority, also provided for the transfer of the positions, property, personnel, and unexpended balances of appropriations, allocations, and other funds of the board from the Department of Insurance to the Executive Office of the Governor by a type four transfer, as defined in s. 20.06(4), effective December 31, 1985. Board membership was also reduced from 11 to 9 members by the elimination of the positions added by ch. 83-269, L.O.F.

Chapter 87-92, L.O.F., increased membership on the board from 9 to 11 members (current board composition is discussed in part 2.a) and required the board to certify to the Department of Health and Rehabilitative Services, the
amount of money certain hospitals will receive for indigent care in a redistribution of funds from the Public Medical Assistance Trust Fund. The board was transferred from the Office of the Governor to the Office of the Secretary of the Department of Health and Rehabilitative Services effective October 1, 1987.

Chapter 87-295, L.O.F., provided an exemption from the penalty in s. 395.5094, F.S., for certain hospitals receiving funds from the Florida Department of Corrections.

Not relating to ch. 395, part II, F.S., but affecting the board, was ch. 85-298, L.O.F., which requires the board to collect certain data from Florida nursing homes, but provides for no budget regulation of nursing homes by the board.

B. RULES

Implementation of the Health Care Access Act (which gave the board its regulatory authority) has resulted in extensive rule-making activity by the board. These rules provide definitions, establish a uniform reporting system for hospitals, provide procedures for budget hearing reviews as well as providing guidelines and procedures for other board functions. A copy of the rules is attached as Appendix D.
C. THE HOSPITAL COST CONTAINMENT BOARD - OFFICE OF THE GOVERNOR

1) Relationship to the Executive Agency

The board was originally located for administrative and budgetary purposes within the Department of Insurance. Effective December 31, 1985, the board, pursuant to ch. 84-35, L.O.F., was transferred from the Department of Insurance to the Executive Office of the Governor by means of a type four transfer as defined in s. 20.06 (4), F.S. The board remained located within the Office of the Governor until October 1, 1987, when it was transferred to the Office of the Secretary of the Department of Health and Rehabilitative Services pursuant to ch. 87-295, L.O.F.

During the board's tenure with the Office of the Governor, the agency provided staff support to the board. This support encompassed personnel, purchasing and budgetary oversight for the board which was performed as part of the agency's staff responsibilities to all of the divisions of the Governor's office. The board was assessed $71,407.81 for this support during fiscal year 1986-87.
2) **Revenues and Expenditures**

The board's primary source of revenue comes from a statutorily mandated assessment on all licensed Florida hospitals. This assessment is limited to .04 per cent of the gross operating costs of each hospital. Assessments are collected on a quarterly basis and hospitals are notified annually of the amount due. The board's revenue and expenditures since its inception in 1979 are set out in detail in Appendix E.

The gathering of information on nursing home costs and charges is statutorily required to be financed separately by means of assessments levied exclusively against nursing homes. Funds gathered for the purpose are part of the Hospital Cost Containment Board Trust Fund but are required to be maintained in a separate account.

The Hospital Cost Containment Board Trust Fund contains the revenues gathered for operation of the board. When the balance of the trust fund exceeds the projected needs of the board, the board will vote on whether to forego collection of a quarterly assessment. Collections of assessments will begin again as the balance of the trust fund becomes depleted.
3) **Goals and Accomplishments**

The board's efforts to control increases in health care costs can be divided into four general areas:

1) Regulation through hospital budget review
2) Public information
3) Office of Technical Assistance
4) Research and data collection

Using data and information provided by the board and drawn from a recent report by the Auditor General, the accomplishments of the board will be discussed in the following sections.

a. **Regulation through hospital budget review**

The board was legislatively granted authority to review hospital budgets in 1984. This review authority was first applied to 1986 budgets and the board is currently completing the review of fiscal 1987 budgets. Therefore, any conclusions as to the relative effectiveness or ineffectiveness of the board must be tempered by the fact that only two budget cycles have been subject to regulation and review.

It should also be noted that the board is only now completing an extensive rule development period necessary to efficiently administer the budget review.
process. In addition, the board is increasing the automation of the budget review process to further increase efficiency.

The following excerpt from the October 1987 Auditor General's Performance Audit of the board provides an excellent description of the operation of the budget review process:

"Under the budget review process authorized by chapter 395, part II, Florida Statutes, the Hospital Cost Containment Board reviews all hospital budgets, but is only authorized to modify or reduce budgets that fail to meet certain criteria. During the budget review process (see Appendix F for a graphical illustration), the board first groups together hospitals with similar characteristics. The board then ranks hospitals in each group according to their most recently submitted or approved gross revenue per adjusted admission (GR/AA) and establishes values of the GR/AA at the 50th and 80th percentiles.

It also establishes the Maximum Allowable Rate of Increase (MARI) for the review period. The MARI is composed of two parts, a market basket index and plus points.

Currently, the board uses the National Hospital Input Price Index (NHIPI) as the market basket index.

Plus points are defined as additional percentage points added to the market basket index to adjust for the Florida specific experience and are set by statute at 5 percent for 1985, 4 percent for 1986, and 3 percent for each year thereafter. The board uses the GR/AA values and MARI to screen
the new budgets proposed by hospitals to determine which will be automatically approved and which will be subject to detailed review to determine the reasonableness of the increase. Under this screening process, hospitals fall into one of five categories:

1. Hospital budgets that have a GR/AA below the 50th percentile for their group are automatically approved regardless of the rate of increase.

2. Hospital budgets that have a GR/AA equaling or exceeding the 50th percentile but less than the 80th percentile for their group and a rate of increase less than or equal to the MARI are also automatically approved.

3. Hospital budgets that have a GR/AA equaling or exceeding the 50th percentile but less than the 80th percentile for their group and a rate of increase exceeding the MARI are subject to detailed review.

4. Hospital budgets that have a GR/AA equaling or exceeding the 80th percentile for their group and a rate of increase less than or equal to the MARI are subject to detailed review, but the rate of increase cannot be reduced below the NHIPI plus two percentage points.

5. Hospital budgets that have a GR/AA equaling or exceeding the 80th percentile for their group and a rate of increase exceeding the MARI are subject to detailed review.
After this screening process, board staff examine each of the budget's subject to detailed review to determine if the budgeted rate of increase is just, reasonable, and not excessive."

While board findings and the Auditor General's conclusion differ as to the exact impact of the budget review process on hospital budget increases, both agree that the impact has been only marginal. Since there are many factors which affect hospital charges, it is difficult to isolate the impact of budget review, but it should be noted that budget review was only intended by the Legislature to serve as a "safety net." This "safety net" function is served by the board, even though its overall affect on hospital costs is minimal, because hospitals with the highest average charges are required to justify their budget increases. In addition, the information gathered through the budget review process is valuable to policy makers and consumers of hospital care.

In summary, the regulatory function of the board is not preventing or having a great effect in controlling hospital rate increases in the state of Florida. However, the board was never intended to be a rate-setting entity like the Public Service Commission. Instead, the board was intended to restrain rate increases through competition promotion and to regulate budgets only in limited circumstances.
b. **Public Information**

The board serves to promote competition between hospitals by providing information to health care consumers. By providing the public with information as to the average charge for specified hospital services, health consumers can make informed health care purchases.

To meet consumers' needs for information relating to charges, each year the board produces several publications designed to provide data from which an individual can make informed decisions about health care purchases. Pursuant to statute, the board bi-annually publishes a patient's guide to average hospital charges by illness categories. The guide compares regional hospital charges for specified services to enable consumers within a region to compare the costs of various health care services provided in their area. The board distributes this publication via a toll-free hotline, health councils, Department of Health and Rehabilitative Services district offices, insurance field offices and other sources.

The board also annually publishes a brochure comparing physician charges for various medical and surgical procedures. The charges are drawn from claims that are submitted to the Department of Insurance by health insurance companies doing business in Florida. This publication allows consumers to compare the average charge
for basic medical and surgical procedures in their region to the fees they are currently paying.

In addition, the board produces an outpatient surgery brochure. This publication provides information on common procedures that have often been performed on an outpatient basis. It also helps raise issues for discussion between the patient and doctor prior to the surgery being performed.

The board is currently planning a publication which will provide information on Florida nursing home charges and services offered.

The board also serves as a source of information for the media. In 1986, the board received over 400 telephone calls from the media seeking information relating to health care concerns. Within the board, the Public Information Office is assigned the responsibility of mailing monthly press releases as well as the publication of consumer education brochures. This office also maintains a toll-free telephone line to receive consumer complaints concerning hospital bills.
c. Office of Technical Assistance

In addition to direct consumer assistance, the board also provides assistance to organized groups interested in cost containment. This is accomplished through the Office of Technical Assistance (O.T.A.) which was legislatively created in 1984. The statutory responsibilities of the O.T.A. can be grouped into 5 areas:

1) To assist employers in the formation of health care coalitions around the state.

2) To develop model health care benefit packages for use by employers and providers . . . [to] promote the cost-effective delivery of adequate care.

3) To serve as a clearinghouse for information concerning innovations in the delivery of health care services and the enhancement of competition in the health care marketplace.

4) To coordinate the study . . . [of the State of Florida Employees Health Plan] and pursue the implementation of mechanisms through which state government will lead by example in the prudent purchase of adequate health services.

5) To work with existing health coalitions and local health councils in carrying out their respective goals in an efficient and effective manner.

The O.T.A. serves as a liaison between board activity and the coalition and councils. Technical
assistance and data gathered by the board through its other activities is shared with the coalition and local health councils.

The O.T.A. also serves as an information source for individuals seeking health care information. Staff are regularly contacted for information arising out of studies and surveys conducted by the O.T.A. In addition, the office is contacted for referral to other information sources and for assistance in compiling publications directed at health care consumers.

d. Research, Data Collection and Legislative Advisory Duties

The board began collecting hospital financial and statistical data in 1979. In 1984, the board's data base was expanded to include aggregate hospital patient data. This extensive data gathering creates a resource which is intended to benefit both public and private decision-makers. Private decision-makers enjoy an information resource which allows them to make prudent health care purchases and thereby encourage competition. Public decision makers also benefit from this resource when the Legislature draws on this information when developing health care policy.

This data base has recently served as a resource for the Legislature. During the 1987 regular
legislative session this data provided the basis for the analysis of the uncompensated care provided by Florida hospitals and the proposed redistribution of the Public Medical Assistance Trust Fund. This data now provides the basis for the distribution of those funds.

The board has also performed or is performing a number of special studies at the direction of the Legislature. The Health Care Access Act directed the board to coordinate a study of the state employees health benefit plan. During its 1985 session, the Legislature directed the board to perform a study of hospital neonatal intensive care units and their impact on the state's regional perinatal intensive care center program. The 1987 session resulted in legislation which directed the board to study subacute care and trauma care. These studies are currently underway and are due to be completed by February 1988 and December 1988, respectively.
IV. CONCLUSIONS AND RECOMMENDATIONS

Section 11.61(6), F.S. provides the criteria to be used by the Legislature in determining whether or not to reestablish a regulatory program. These criteria are as follows:

1) Would the absence of regulation significantly harm or endanger the public health, safety, or welfare?

2) Is there a reasonable relationship between the exercise of the police power of the state and the protection of the public health, safety, or welfare?

3) Is there a less restrictive method of regulation available which would adequately protect the public?

4) Does the regulation have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?

5) Is the increase in cost more harmful to the public than the harm which could result from the absence of regulation?

6) Are any facets of the regulatory process designed for the purpose of benefitting, and do they have as their primary effect the benefit of, the regulated entity?

The board’s regulatory function not only protects the public by providing a regulatory "safety net," but also by providing the public with valuable information gathered during budget review activities. Currently, there are no other entities which would provide this service to the
public if the board was abolished. The public would be deprived of the only entity currently working to restrain the increases in health care costs. Without the competition promotion, advisory functions and regulation the board currently provides, the public would be adversely affected by the likely increases in the costs of health care. Therefore, the absence of regulation provided by the board would adversely affect the public welfare.

The relationship between the states' exercise of police power (through board activities) and the protection of the public's health, safety, or welfare is reasonable given the importance of affordable health care to the citizen's of Florida. Rapidly rising costs can make health care unaffordable for those on limited or fixed incomes, therefore, state action to aid that portion of the states' population are reasonable.

There is not a less restrictive method of regulation as the current system is already designed to be limited in its operation. Therefore, any less restrictive form of regulation would not adequately protect the public because it would mean the elimination of the limited benefit the public currently enjoys.

With regard to costs, the board is primarily financed through assessments levied against hospitals. These assessments are only .04 percent of the gross operating
costs of each hospital and are reasonable given the many benefits the board has provided for the public.

Finally, the board's regulatory role does provide a benefit for the hospitals through its information gathering functions. General data gathered by the board as well as specific studies are valuable not only to the consumer but also to the health care provider. Through information gathered by the board, health care providers can study trends in the health care marketplace. In addition, to the extent that the board improves competition, the most efficient health care providers are rewarded through increased consumer patronage.

The board was created to help control inflationary trends in health care costs by promoting competition between health care providers and by establishing a regulatory "safety net" to control budget increases by hospitals with the highest average charges. In response to this directive, the board has implemented a process to review and approve hospital budgets which is operating in accordance with statutory requirements. In addition, the board has performed information gathering and dissemination functions which have been of benefit to both private and public decision makers. To quote the program audit performed by the Auditor General:
The budget review component was intended to provide a safety net in the event competitive forces do not prevent unreasonable increases in hospital costs. We concluded that the program is meeting its statutory intent, even though most hospitals are either able to meet the statutory criteria for automatic approval of their budgets or to justify their budget increases. Moreover, the data collected and maintained by the board is valuable both to policymakers and major health care purchasers. Until clear indications exist that competition is exerting sufficient pressure to contain hospital costs, we recommend that the budget review process be continued.

The primary criticism of board activities outlined in the report of the Auditor General was that the board's emphasis on budget review resulted in its other, non-regulatory, activities being insufficiently implemented. The Auditor General recommended that steps be taken to reduce time spent on budget review in order for more staff efforts to be directed to information gathering, dissemination, and technical assistance functions.

In response to these recommendations, the board is currently implementing methods to streamline the budget review process. These actions being taken by the board should be sufficient to alleviate the concerns raised by the Auditor General.

It is therefore recommended that the state continue to exercise its efforts to curb the spiraling costs of
health care by fostering competition within the industry through the dissemination of valuable consumer information and review of certain hospital cost data, and that the Legislature reenact part II, chapter 395, F.S.
V. APPENDICES

A. Chapter 395, Part II, Florida Statutes
B. Hospital Cost Containment Board Members
C. Hospital Cost Containment Board Organizational Chart
D. Rules of the Department of Health and Rehabilitative Services Hospital Cost Containment Board
E. Revenue and Expenditure Charts
F. Budget Review Chart
G. Sunset Questionnaire
Appendix A

Chapter 395, Part II, Florida Statutes
relative costliness of the mix of cases of that hospital compared to a state or national mix of cases

(6) "Commissioner" means the insurance Commissioner.

(7) Comprehensive rehabilitative hospital" means a hospital licensed by the Department of Health and Rehabilitative Services as a specialty hospital, as that term is defined in s. 395.002(14), provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the hospital are classified as "comprehensive rehabilitative beds" pursuant to s. 395.003(4), and are not classified as "general beds.

(8) "Consumer" means any person other than a person who administers health activities, provides health services, has a fiduciary interest in a health facility or other health agency, or has a material financial interest in the rendering of health services.

(9) "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing such service as to offset some of the costs of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.

(10) "Department" means the Department of Insurance.

(11) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue. Gross revenues do not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors.

(12) "Hospital" means a health care institution as defined in s. 395.002(6).

(13) "Local health council" means the agency defined in s. 381.493(3)(p).

(14) "Major health care purchaser" means 1 of the 10 largest private employers in the state, a commercial health insurer, or a health care services plan certified under chapter 641.

(15) "Maximum allowable rate of increase" or "MARI" means the maximum rate at which a hospital is expected to increase its average gross revenues per adjusted admission for a given period. The maximum allowable rate of increase is composed of two parts, the market basket index and plus points, which are defined as follows:

(a) "Market basket index" means the revised market basket index used to measure the inflation in hospital input prices as employed on January 1, 1984, by the Secretary of the United States Department of Health and Human Services for purposes of Medicare reimbursement.
(b) "Plus points" means additional percentage points added to the market basket index to adjust for the Florida specific experience. The plus points to be added to the market basket index shall be 5 percent for calendar year 1985, 4 percent for calendar year 1986, and 3 percent for each year thereafter.

(16) "Medically indigent" means a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources required to meet his basic needs for shelter, food, and clothing.

(17) "Net revenue" means gross revenue minus deductions from revenue.

(18) "Operating expenses" or "operating expenditures" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses, and other operating expenses, excluding income taxes.

(19) "Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.

(20) "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the board in meeting its responsibilities pursuant to this part.

(21) "State health planning agency" means the agency designated by the Governor to perform the health planning and development functions prescribed by s. 1523, Pub. L. No. 93-641, the National Health Planning and Resources Development Act of 1974.

(22) "Teaching hospital" means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

(23) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts, contractual adjustments, uncompensated care, administrative, courtesy, and policy discounts and adjustments, and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

Note.--s. 1, ch. 79-106; s. 2, ch. 81-318; s. 4, ch. 82-182; s. 776, ch. 82-243; s. 14, ch. 84-35.

Note.--October 1, 1985, pursuant to s. 24, ch. 82-182, and is scheduled for review pursuant to s. 11, ch. 81-318, in advance of that date.

Note.--Section 381.492 was repealed by s. 43, ch. 87-92. Section 20, ch. 87-92, defines "local health councils" in newly created s. 381.702.

1395.5025 Legislative intent to assure affordable health care.--It is the intent of the Legislature to assure that adequate health care is affordable and accessible to all the citizens of this state. To further the accomplishment of this goal, the Hospital Cost Containment Board is created to advise the Legislature regarding health care costs, inflationary trends in health care costs, the impact of health care costs on the state budget, the impact of hospital charges and third-party reimbursement mechanisms on health care costs, and the education of consumers and providers of health care services in order to encourage price competition in the health care marketplace. The Legislature finds and declares that rising hospital costs and cost shifting are of vital concern to the people of this state because of the danger that...
PART II

HEALTH CARE COST CONTAINMENT

395.501 Short title.—This part shall be known and may be cited as the "Health Care Cost Containment Act of 1979." 

395.502 Definitions. — As used in this act, the term

1. "Adjusted admission" means the sum of acute admissions and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

2. "Audited actual data" or "audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards.

3. "Board" means the Hospital Cost Containment Board created by s 395.503.

4. "Budget" means the projections by the hospital, for a specified future time period, of expenditures and revenues, with support of statistical indicators.

5. "Case mix" means a calculated index for each hospital, based on financial accounting and case-mix data collection as set forth in s 395.504, reflecting the
rules are not required for the submission of data for a special study or when information is being requested for a single hospital. Such data may include, but is not limited to leases, contracts, itemized patient bills, medical record abstracts, and related diagnostic information necessary to evaluate the case mix of a hospital and to identify actual charges and lengths of stay associated with specific diagnostic groups, necessary operating expenses, appropriate expenses incurred for rendering services to patients who cannot or do not pay, all properly incurred interest charges, and reasonable depreciation expenses based on the expected useful life of the property and equipment involved.

(2) Shall approve, approve as amended by the board, or disapprove the budget of each hospital, including its projected expenditures and projected revenues.

(3) May contract with local health councils to disseminate information to the public on health care costs.

(4) Shall cooperate with the comprehensive Health Planning Office of the Department of Health and Rehabilitative Services in the development of a biennial work plan defining the roles and responsibilities of the board and the comprehensive Health Planning Office in the establishment of an integrated health care data base and shall consult with and make recommendations to the board and the Secretary of Health and Rehabilitative Services with respect to analyses and studies of health care costs, capital expenditures by hospitals and their relationship to health care costs, and related matters which may be undertaken by the board.

(5) May inspect and audit hospital books and records, including records of individual or corporate ownership, for compliance with this part. Upon presentation of a written request for inspection to a hospital by the board or its staff, the hospital shall make available to the board or its staff for inspection, copying, and review all books and records relevant to the determination of whether the hospital has complied with this part.

(6) Shall publish and make available to the public a toll-free telephone number for the purpose of handling consumer complaints and shall serve as a liaison between consumer entities and other private entities and governmental entities for the disposition of problems identified by consumers of hospital care.

(7) Shall monitor the effects of preferred provider organizations and changes in reimbursement methodologies for Medicare on cost shifting.

(8) Shall designate executive staff members to issue preliminary findings pursuant to s. 395.505(3).

9(a) Shall publish, based on information provided by the Department of Insurance under s. 627.9175(1), an annual report containing premium and benefit comparisons, or the equivalent thereof, for policies of individual health insurance and shall disseminate the report in the manner provided in s. 395.505.

History.—s. 1, ch. 79-106, s. 2, ch. 81-318, s. 10, ch. 73-24, ch. 82-182, s. 5, ch. 83-295, s. 17, ch. 84-35.

9(b) Shall publish, based on information provided by the Department of Insurance under s. 627.9175(3), an annual report containing available physician charge comparisons, profiles, and related information and shall disseminate the report in the manner provided in s. 395.505.

History.—s. 1, ch. 79-106, s. 1, ch. 81-318, s. 10, ch. 73-24, ch. 82-182, s. 5, ch. 83-295, s. 17, ch. 84-35.

395.5042 Office of Technical Assistance within board.—It is the intent of the Legislature to create a single entity to serve as a focal point for governmental efforts and activities to promote health care cost containment by providing technical assistance to persons, businesses, and purchaser coalitions interested in containing the costs of health care. Therefore, there is created within the Hospital Cost Containment Board the Office of Technical Assistance, which shall include such professional, technical, and clerical staff as may be necessary to enable it to carry out its duties. The Office of Technical Assistance shall:

1. Assist employers in the formation of health care coalitions around the state.

2. Develop model health care benefit packages for use by employers and providers in implementing health benefit plans which promote the cost-effective delivery of adequate care.

3. Serve as a clearinghouse for information concerning innovations in the delivery of health care services and the enhancement of competition in the health care marketplace.

4. Pursue the implementation of mechanisms through which state government will lead by example in the prudent purchase of adequate health services.

5. Work with existing health coalitions and local health councils in carrying out their respective goals in an efficient and effective manner.

History.—s. 1, ch. 84-35; s. 3, ch. 86-7.

395.505 Rules; public hearings; investigations; subpoena power.—In addition to the powers granted to the board elsewhere in this part, the board is authorized to:

1. Adopt, amend, and repeal rules respecting the exercise of the powers conferred by this part which are applicable to the promulgation of rules.

2. Hold public hearings, conduct investigations, and subpoena witnesses, papers, records, and documents in connection therewith. The board may administer oaths or affirmations in any hearing or investigation.

3. Exercise, subject to the limitations and restrictions herein imposed, all other powers which are reasonably necessary or essential to carry out the expressed objects and purposes of this part.

History.—s. 1, ch. 79-106, s. 2, ch. 81-318, s. 10, ch. 73-24, ch. 82-182.

395.5051 Effect of ch. 84-35, Laws of Florida, on existing rules.—Nothing contained in chapter 84-35, Laws of Florida, is intended to repeal or modify any of the existing rules of the Hospital Cost Containment Board, as created in s. 395.503, unless such rule or part thereof is in direct conflict with the provisions of chapter 84-35.

History.—s. 3, ch. 84-35.
hospital services are becoming unaffordable and thus inaccessible to residents of the state. It is further declared that hospital costs should be contained through improved competition between hospitals and improved competition between insurers, through financial incentives which foster efficiency instead of inefficiency, and through sincere initiatives on behalf of providers, insurers, and consumers to contain costs. As a safety net, it is the intent of the Legislature to establish a program of prospective budget review and approval in the event that competition-oriented methods do not adequately contain costs and the access of Floridians to adequate hospital care becomes jeopardized because of unaffordable costs.

1995.503 Hospital Cost Containment Board.—

(1) There is created the Hospital Cost Containment Board. The board shall be administratively located within the office of the secretary of the Department of Health and Rehabilitative Services and shall be composed of eleven members appointed by the Governor and confirmed by the Senate. Four members must be providers of health care, including two representatives of the hospital industry and one representative of the nursing home industry, three members must be major purchasers of health care, and four members must be consumers with no direct involvement in health care. All members of the board must be permanent residents of the state, and at least one member of the board must be 60 years of age or older.

(b) Each appointment to the board shall be for a 3-year term, except that the initial appointment of the provider member added by chapter 87-92, Laws of Florida, shall be for a term ending December 31, 1989, and the initial appointment of the consumer member added by chapter 87-92, Laws of Florida, shall be for a term ending December 31, 1988. No member is eligible for appointment for more than two consecutive terms, regardless of the length of any term. A vacancy on the board shall be filled within 60 days from the date on which the vacancy occurs, which appointment shall be made for the remainder of the unexpired term.

(c) The Governor may remove from office any member who would no longer be eligible to serve on the board by virtue of the requirement that he be a provider, purchaser, consumer, or resident of the state, who becomes disqualified for neglect of any duty required by law, or who misses more than four meetings in any one year.

(2) The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall meet from time to time to fulfill its responsibilities. Meetings may be called by the chairperson or any five members and, except in the event of an emergency, shall be called by written notice. Meetings shall be called in advance and be open to the public. Five voting members of the board constitute a quorum.

(b) Board members shall be remunerated at the rate of $50 per diem while on official board business and shall be reimbursed for their expenses while on official business for the board in accordance with the provisions of s 112.061.

(3) The board shall appoint an executive director who shall serve at the pleasure of the board and who shall have had experience in the organization, financing, or delivery of health care. The executive director shall perform the duties delegated to him by the board. The executive director, with the concurrence of the board, shall appoint, and may terminate, a general counsel, a chief financial analyst with at least 5 years' experience in hospital financial management, a director of public information, and a director of research and may appoint, with the consent of the board, such other staff and staff attorneys as the board deems necessary. The board may contract with persons outside the board for services necessary to carry out its activities when this will promote efficiency, avoid duplication of effort, and make the best use of available expertise.

(b) The board may apply for and receive and accept grants, gifts, and other payments, including property and service from any governmental or other public or private entity or person, and make arrangements as to the use of same, including the undertaking of special studies and other projects relating to health care costs.

(4) The board may create committees from its membership and may create such ad hoc advisory committees to advise the board and its staff in specialized fields related to the functions of hospitals as it deems necessary. The members of any ad hoc advisory committee shall be entitled to reimbursement for expenses incurred, including travel expenses.

1995.504 Powers and duties of board.—To properly carry out its authority, the board shall require the submission of hospitals of such case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups as the board deems necessary in order to have available the statistical information necessary to properly conduct budget review and approval and to carry out its public information and education functions as contained in s 395.5085. Such requirement shall be promulgated by rule if the submission of case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups is being required of all hospitals or of any group thereof, however,
ed pursuant to s 395 504(1), shall establish a reliable, timely, and consistent information system

(2) Semiannually, the board shall identify, by hospital, average charges and lengths of stay associated with established diagnostic groups. Charge information shall be cited for at least the following payer classifications: insurance, not-for-profit insurance, Medicaid, and Medicare. Combined average charges for all payer classifications reported shall be published by the board semiannually for dissemination to the media and the public at large. The publication shall identify charges associated with at least the 10 most frequently occurring diagnostic groups and such other information as the board deems appropriate, published by county or region.

(3) The board shall coordinate the distribution of summary actual charge data by diagnostic groups and special publications through a Consumer Information Network. The membership of this network may include the members of the Senate and the House of Representatives, consumer service offices located within the Department of Insurance, insurance companies licensed to transact business in this state, Florida business coalitions on health care, local health councils and the designated state health planning agency, the Board of Medical Examiners, and hospitals. The Board of Medical Examiners may include any hospital that, at least 60 days prior to the next fiscal year of the hospital, as established under s 395 507(2), provides the most recent information concerning the number of hospital care days for inpatients and the total cost of hospital care for inpatients for the most recently approved or submitted budgets for the hospitals in each group, including any hospital that is contesting its grouping assignment under the procedures set forth in the budget of the hospital for the previous fiscal year. Hospitals shall be classified under the procedures set forth in the budget of the hospital for the previous fiscal year. Hospitals shall be classified under the procedures set forth in the budget of the hospital for the previous fiscal year.

(4) The board shall, through the Consumer Information Network, conduct consumer information seminars at locations throughout the state.

395.509 Review of hospital budgets.—

(1) Each hospital shall file its budget with the board for approval. A hospital shall not exceed the projected expenditures or revenues in the budget as approved by the board. The projected budget filed under s 395 507 shall be deemed approved unless it is disapproved by the board within 120 days after filing. Upon agreement by the board and the hospital, the 120-day period may be waived or extended. During the review by the board, the board may amend the projected budget and approve the budget as amended. Until the projected budget is approved, the level of expenditures and revenues set forth in the budget of the hospital for the previous fiscal year will remain in effect.

(2) The projected budget filed by the hospital under s 395 507(6) shall be approved by the board unless the board determines that

(a) The gross revenue of the hospital per adjusted admission equals or exceeds the upper 20th-percentile value for gross revenue per adjusted admission as established 150 days prior to the next fiscal year of the hospital for its group as established under s 395 507(2), or

(b) The rate of increase in the gross revenue per adjusted admission between the budget projection, as required in s 395 507(6), and the most recent board-approved budget, which, for the first year shall be the base year inflated for 1985 by the maximum allowable rate of increase as set forth in subsection (11), exceeds the maximum allowable rate of increase, and the gross revenue of the hospital per adjusted admission equals or exceeds the 50th-percentile value for gross revenue per adjusted admission as established 150 days prior to the next fiscal year of the hospital for its group as established under s 395 507(2).

If the budget cannot be approved without further action by the board, the board may approve, or approve as amended, a budget with a rate of increase greater or lesser than the maximum allowable rate of increase pursuant to subsection (5). However, for any hospital with a budget which is not approved without further action by the board due to the application of paragraph (a) and which does not exceed the maximum allowable rate of increase in paragraph (b), the board shall not reduce the budget for gross revenues per adjusted admission below either of the following, whichever is greater: the market basket index, plus 2 percent, or the median absolute dollar value increase in gross revenues per adjusted admission for all other hospitals in its group, as established under s 395 507(2). Percentile values for gross operating revenue per adjusted admission shall be determined monthly by the board for each group established pursuant to s 395 507(2) by ranking projected gross operating revenues per adjusted admission contained in the most recently approved or submitted budgets for the hospitals in each group, including any hospital that is contesting its grouping assignment in determining the applicability of paragraph (a) or paragraph (b), the board shall consider the basis of the projections by the hospital, including consideration of the following factors: any increase in patient admissions caused by the creation of preferred provider organizations or health maintenance organizations, population increases, changes in the hospital case mix or in services offered, changes in technology, or other similar factors. If the provisions of paragraph (a) or paragraph (b) cannot apply to a hospital because of a pending administrative hearing or judicial review of the grouping assignment of a hospital, then the budget of that hospital will be subject to review under subsections (5) and (6) in the event that this subsection or any paragraph hereof is held to be unconstitutional, then it is the intent of the Legislature that all budgets be reviewed pursuant to the provisions of subsections (5) and (6).

(3) After a hospital budget is approved, approved as amended, or disapproved for a given fiscal year, no amendment to such budget shall be made, except in accordance with the following procedures:

(a) A request by a hospital to amend its budget must be in writing with supporting documents. The budget amendment will be deemed approved unless it is disapproved or approved as amended by the board within 120 days after such filing. Upon agreement by the board and the hospital, the 120-day period may be waived or extended.

(b) After a hospital requests a budget amendment, but before the final decision by the board on the amendment, the board may extend provisional approval to any
1395.507 Uniform system of financial reporting.—
(1) The board shall, by rule, after consulting with appropriate professional and governmental advisory bodies and holding public hearings, and considering existing and proposed systems of accounting and reporting utilized by hospitals, specify a uniform system of financial reporting based on a uniform chart of accounts developed after considering the American Hospital Association Chart of Accounts, the American Institute of Certified Public Accountants Hospital Audit Guide, and generally accepted accounting principles. However, this provision shall not be construed to authorize the board to require hospitals to adopt a uniform accounting system. As a part of such uniform system of financial reporting, the board may require the filing of any information relating to the cost, to both the provider and the consumer, of any service provided in such hospital except the cost of a physician’s services which is billed independently of the hospital.

(2) For the purposes of this part, and in order to allow meaningful comparisons, the board shall, by rule, group hospitals according to characteristics, including, but not limited to, a measure of the nature and range of services provided, teaching hospital status, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, average daily census, geographical differences, and, when available, case mix. The rule shall provide for the establishment of 10 general groups and for the establishment of additional specialty groups as needed, however, no group shall contain fewer than five hospitals.

(3) In establishing such uniform reporting procedures, the board shall, among other issues, take into consideration the need for financial data which reflects the average bill per day and the average bill per stay billed by the hospital and the degree of cross-subsidization by cost center.

(4) When appropriate, the reporting system shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred in connection with educational research and other non-patient-related activities, including, but not limited to, charitable activities of such hospitals.

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

(6) At least 90 days prior to the commencement of its next fiscal year, each hospital shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting:

(a) Its budget for the next fiscal year, including projected expenditures, projected revenues, and statistical measures necessary for the board to evaluate these projections. Any hospital the final budget of which requires public review and approval may submit its budget prior to public review and approval and shall subsequently file any amendments adopted during the public review process at least 45 days prior to the beginning of the fiscal year of the hospital.

(b) Its actual experience for the first 6 months of its current fiscal year, including actual expenditures, actual revenues, and statistical measures necessary for the board to evaluate the actual experience.

(c) Its estimated experience for the last 6 months of its current fiscal year, including estimated expenditures, estimated revenues, and statistical measures necessary for the board to evaluate these estimates.

(d) Information necessary for the board to evaluate the effectiveness of current services and the justification of the hospital for increased costs to continue current services, improve existing services, and provide new services.

(e) Its schedule of projected rates which will be implemented to generate projected revenues.

(7) Within 120 days after its fiscal year ends, each hospital shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting, its actual audited experience for that fiscal year, including expenditures, revenues, and statistical measures.

(8) The board may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of this part.

(9) The Shriners Hospital for Crippled Children, located in Tampa, is exempt from the financial reporting requirements of this part until such time as it first receives revenues from or on behalf of any individual patient.


1395.508 Hospital costs and finances; analyses, studies, and reports.—
(1) The board shall from time to time undertake analyses and studies relating to health care costs, making maximum use of local health councils and the designated state health planning agency whenever possible, and relating to the financial status of any hospital or hospitals subject to the provisions of this part. The board and the department shall jointly develop criteria to analyze and study the effect upon health care costs of third-party reimbursement mechanisms. The board shall incorporate into its reports the findings of the department relating to the effect upon health care costs of third-party reimbursement mechanisms, including health insurance as defined in s 624.03 and 627.652, health care service plans as defined in s 641.01, and health maintenance organizations as defined in s 641.19(6).

(a) The board may publish and disseminate such information as it deems desirable in the public interest.

(2) The board shall also prepare and file such summaries and compilations or other supplementary reports based on the information analyzed by the board hereunder as will advance the purposes of this part.


1395.5085 Collection and dissemination of hospital charges and other hospital-specific information; Consumer Information Network.—
(1) The board, relying on summary actual charge data by diagnostic groups and other information collect-
the receipt of the preliminary findings of the staff constitutes a waiver of the right of the hospital to contest the final decision of the board, and the board is authorized to enter a final order consistent with the staff's preliminary findings without further proceedings.

(e) During the pendency of any hearing or an appeal of a final order of the board, the levels of expenditures and revenues set forth in the budget for the previous year of the hospital shall remain in effect.

(9) The board may publish its findings in connection with any review conducted under this section in the newspaper of the largest circulation in the county in which the hospital is located.

(10) Notwithstanding any other provisions of this part, any hospital operated by the Department of Health and Rehabilitative Services or the Department of Corrections, or any comprehensive rehabilitative hospital, is exempt from budget review and approval, but is required to submit to the board a projected budget, as required by s 395.507(6)(a), and an audited actual experience, as required by s 395.507(7).

(11) The review and approval of hospital budgets pursuant to this act shall begin for hospitals with fiscal years which begin on or after February 1, 1985. The base-year projected budget and actual experience for each hospital shall be the 1984 audited actual experience for that hospital, as required by s 395.507(7), and shall be inflated for 1985 by the maximum allowable rate of increase. However, if the 1984 audited actual experience of a hospital for net revenues per adjusted admission exceeds its 1984 projected budget for such revenues filed with the board by a greater than 10 percent, then the projected budget of that hospital for such revenues for fiscal year 1986 shall be reduced by the amount of such excess which is over 10 percent, except that the base-year reduction shall not apply to hospitals opened since May 18, 1982.

(12) A physician who provides services within a hospital is exempt from the provisions of this part if he bills his services independently of the hospital.

The determination of the amount of any such excess shall be determined by the board, and a penalty shall be levied against the hospital, to be deposited in the Public Medical Assistance Trust Fund, as created in s 409.2662.

(a) For the first occurrence within a 5-year period, the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 5 percent, and, if such excess is greater than 5 percent over the maximum allowable rate of increase, any amount in excess of 5 percent shall be levied by the board as a fine against such hospital, to be deposited in the Public Medical Assistance Trust Fund.

(b) For the second occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 2 percent, and, if such excess is greater than 2 percent over the maximum allowable rate of increase, any amount in excess of 2 percent shall be levied by the board as a fine against such hospital, to be deposited in the Public Medical Assistance Trust Fund.

(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall

1. Levy a fine against the hospital in the total amount of the excess, to be deposited in the Public Medical Assistance Trust Fund.
2. Notify the Department of Health and Rehabilitative Services of the violation, whereupon, the department shall accept any application for a certificate of need pursuant to ss 381.701-381.715 from or on behalf of such hospital until such time as the hospital has demonstrated, to the satisfaction of the board, that, following the date the penalty was imposed under subparagraph 1, the hospital has stayed within its projected budget for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.
3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the Department of Health and Rehabilitative Services, whereupon the department shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.

The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital pursuant to s 409.2667 or s 409.2663. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s 395.101 minus the amount of revenues received by the hospital through the operation of s 409.2667 or s 409.2663. It is the re-
part of the amendment. This provisional approval will be superseded by the final decision of the board.

(4) For purposes of budget review and comparison and to assist in making determinations pursuant to subsection (5), the board shall

(a) Establish groupings of hospitals according to characteristics including, but not limited to, a measure of the nature and range of services provided, teaching hospital status, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, average daily census, geographical differences, and, when available, case mix. The rule shall provide for the establishment of 10 general groups and for the establishment of additional specialty groups as needed; however, no group shall contain fewer than five hospitals.

(b) Establish statistical indicators per adjusted admission to serve as measures of comparison. The statistical indicators shall include, but not be limited to, gross operating revenue, net operating revenue, nonoperating revenue, total revenue, and operating expenditures.

(c) Identify hospitals that have statistical indicators in the upper 20 percent of those indicators for all hospitals in their group.

(5) If the budget of a hospital is not subject to automatic approval because of the provisions of paragraph (2)(a) or paragraph (2)(b), the board shall review the budget to determine whether the rate of increase contained in the budget is just, reasonable, and not excessive. The board shall disapprove any budget, or part thereof, as excessive that contains a rate of increase which is not necessary to maintain the existing level of services of the hospital or, if the hospital increases its existing level of services, any amount not necessary to accomplish that increase in making such determination and in considering any budget amendment filed by a hospital pursuant to subsection (3), the board shall consider the following criteria:

(a) The efficiency, sufficiency, and adequacy of the services and facilities provided by the hospital.

(b) The cost of providing services and the value of the services to the public.

(c) The ability of the hospital to provide services and its ability to improve services.

(d) The ability of the hospital to reduce the cost of services.

(e) The ability of the hospital to earn a reasonable rate of return.

(f) The accuracy of previous budget submissions by the hospital compared to the actual experience of the hospital.

(g) The number of patient days reimbursed by Medicare or Medicaid.

(h) The number of patient days attributable to the medically indigent.

(i) The research and educational services provided by the hospital if it is a teaching hospital.

(j) The projected expenditures or revenues for or from construction of facilities or new services which are subject to regulation under ss. 381.701-381.715 may not be included in the budget of a hospital until the construction or services are approved or authorized by the state health planning agency.

(k) The cost of opening a new hospital, for the first 3 years.

The involvement of the hospital in price-competitive activities, such as preferred provider organizations, health maintenance organizations, and other price-negotiated arrangements, shall not be construed or considered, in any way, as a factor or indication that the budget of the hospital or amendments thereto is unjust, unreasonable, or excessive.

(6) The board shall disapprove in its entirety, or disapprove in part, any budget, or any budget as amended by a hospital pursuant to subsection (3), that contains a rate of increase which the board finds, pursuant to subsection (5), to be unjust, unreasonable, or excessive in disapproving or amending any portion of a budget, the board shall amend the budget and establish a rate of increase which is just, reasonable, and not excessive.

(7) It is the intent of the Legislature that the board, in carrying out its duties and responsibilities of review and approval of hospital budgets pursuant to this part, adjust a hospital budget for changes in the case mix of the hospital. However, the Legislature realizes that comprehensive case-mix data will not be available to the board by the effective date of this act. Further, the Legislature intends that the implementation of this act not be delayed by the absence of case-mix data, but that case-mix data be utilized by the board as soon as it becomes available.

(8)(a) Upon receipt of a budget or an amendment to a budget, the staff of the board shall review the budget, and executive staff members designated by the board shall make preliminary findings and recommendations in writing as to whether the budget should be approved, disapproved, disapproved in part, or amended. The staff shall send the preliminary findings by certified mail to the hospital. The hospital shall have 14 days from the receipt of the preliminary findings and recommendations to file written objections and a request for a hearing with the board, if a hearing is desired, or to file written objections if a hearing is not requested by the hospital.

(b) If a hearing is requested, it shall be conducted by the board or, at the election of the board, by a Division of Administrative Hearings hearing officer, pursuant to the provisions of s. 120.57. The Division of Administrative Hearings of the Department of Administration shall assign at least two full-time hearing officers exclusively to hear matters pertaining to this part. Hearings shall be held within 30 days of filing the request, unless waived by the board and the hospital. All hearings shall be held in Tallahassee, unless the board determines otherwise.

(c) Recommended orders shall be issued within 30 days from the close of the hearing, unless waived by the board and the hospital. The board shall enter a final order within 120 days from the date of filing of the budget.

(d) Any waiver of the time limits within which to conduct a hearing or to issue a recommended order also constitutes a waiver of the time limit to issue the final order and tolls the 120-day automatic approval provision of subsection (1). The provision will be tolled beginning from the date the waiver is entered and will remain tolled 10 days after the recommended order is submitted to the board. The failure to request a hearing within 14 days of
(2) The extent to which third-party reimbursement mechanisms affect health care costs

HISTORY—s 1 ch 19-106 s 2 ch 81-318 es 16 23 24 ch 82-182 s 21 ch 84-35

(2) The extent to which third-party reimbursement mechanisms affect health care costs.

HISTORY—s 1 ch 19-106 s 2 ch 81-318 es 16 23 24 ch 82-182 s 21 ch 84-35

'396.5135 Burden of proof with respect to factual determinations by the board.—Notwithstanding any other provisions of this part, when a hospital alleges that a factual determination made by the board is incorrect, the burden of proof shall be on the hospital to demonstrate that such determination is, in light of the total record, not supported by a preponderance of the evidence. The burden of proof remains with the hospital in all cases involving administrative agency action.

HISTORY.—s 22 30 ch 84-35

'396.514 Violation of part or rule; penalties.—Any hospital which refuses to file, fails to timely file, or files false or incomplete reports or other information required to be filed under the provisions of this part, or which violates any other provision of this part or rule adopted under this part, shall be punished by a fine not exceeding $1,000 a day for each day in violation, to be fixed, imposed, and collected by the board. Each day in violation shall be considered a separate offense. The violation of any provision of this part or of a rule adopted under this part, or the knowing and willful falsification of a report required under this part, is a ground for the imposition of an administrative fine not to exceed $20,000, to be fixed, imposed, and collected by the Department of Health and Rehabilitative Services.

HISTORY.—s 78-106 s 248 ch 81-258 s 2 ch 81-318 es 23 24 ch 82-182 s 21 ch 84-35

'396.515 Prospective payment arrangements.—

(1) The Legislature finds that the traditional retrospective reimbursement practices of health insurers provide hospitals with disincentives to contain costs and are a major contributing factor to the rapidly escalating costs of hospital care. The Legislature further finds that prospective payment arrangements designed to provide hospitals with financial incentives to contain costs will contribute to the deceleration of hospital cost increases while enhancing the adequacy of and access to care so highly valued by consumers. Furthermore, prospective payment arrangements that provide fixed payment amounts which are prospectively set through private-sector negotiation will provide insurers with a greater degree of investment stability. Therefore, the Legislature finds that it is the business of insurance, as well as in the best interests of the citizens of this state, that insurers, on behalf of their insureds, should negotiate with hospitals to establish prospective payment arrangements that provide financial incentives for the containment of hospital costs.

(2) For the purposes of this section, the term “prospective payment arrangement” means a financial agreement, negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payer, which contains, at a minimum, the elements provided for in subsection (4).

(3) Hospitals, as defined in s. 395.002, and health insurers, regulated pursuant to parts VI and VII of chapter 627, shall establish by no later than March 1, 1987, prospective payment arrangements that provide hospitals with financial incentives to contain costs. Each hospital shall negotiate with each health insurer which represents 10 percent or more of the private-pay patients of the hospital to establish a prospective payment arrangement beginning October 1, 1985, and annually thereafter, hospitals and health insurers regulated pursuant to this section shall report the results of each specific prospective payment arrangement adopted by each hospital and health insurer to the Hospital Cost Containment Board, hereinafter referred to as the “board” in the event that a hospital or a health insurer has not complied by March 1, 1987, with the requirements of this section, such hospital or health insurer shall have 60 days in which to justify the reasons for its failure to comply to the board. The board shall take into account the failure of the hospital to comply in its approval or disapproval of the budget of the hospital. In addition, the board shall report a health insurer’s failure to comply to the Department of Insurance, which shall take into account the failure by the health insurer to comply in conjunction with its approval authority under s. 627.410. The board shall adopt any rules necessary to carry out its responsibilities required by this section.

(4) The prospective payment system established pursuant to this section shall include, at a minimum, the following elements:

(a) A maximum allowable payment amount established for individual hospital products, services, patient diagnoses, patient day, patient admission, or per insured, or any combination thereof, which is preset at the beginning of the budget year of the hospital and fixed for the entirety of that budget year, except when extenuating and unusual circumstances acceptable to the board warrant renegotiation.

(b) Timely payment to the hospital by the insurer or the insured, or both, of the maximum allowable payment amount, as so negotiated by the insurer or group of insurers.

(c) Acceptance by the hospital of the maximum payment amount as payment in full, which shall include any deductible or coinsurance provided for in the insurer’s benefit plan.

(d) Utilization reviews for appropriateness of treatment, and

(e) Preadmission screening of nonemergency surgery.

(5) Nothing contained in this section prohibits the inclusion of deductibles, coinsurance, or other cost containment provisions in any health insurance policy.

HISTORY.—s 30 ch 84-35

385.52 Information relating to physician’s charges.

—The ‘Health Care Cost Containment Board may, in its discretion, require the submission by hospitals of information relating to charges made by a physician with respect to hospital services.

HISTORY.—s 11 ch 83-260

Notes.—As amended the reference to the “Health Care Cost Containment Board” a nonexistent board appears to be erroneous from an examination of ch. 83-260 as a whole, a reference to the ‘Hospital Cost Containment Board’ established under s. 385.520 seems intended.
sponsibility of the hospital to demonstrate, to the satisfaction of the board, its entitlement to such reduction. It is the intent of the Legislature that the Hospital Cost Containment Board, in levying any penalty imposed against a hospital for exceeding its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, any change in its case mix.

(2) If the board finds that any hospital chief executive officer, or any person who is in charge of hospital administration or operations, has knowingly and willfully allowed or authorized actual operating revenues or expenditures that are in excess of projected operating revenues or expenditures in the hospital budget as approved by the board, the board shall order such officer or person to pay an administrative fine not to exceed $5,000.

(3) The board may not reduce the budget of or levy a fine upon any hospital based on the hospital's audited actual experience for fiscal year 1986 if the hospital treated inmates from the Department of Corrections and if the hospital exceeded its previous year's audited actual experience by more than the maximum allowable rate of increase or exceeded its projected budget as approved by the board for fiscal year 1986 solely as a result of revenue paid to such hospital by the Department of Corrections for treatment of inmates.

Historical notes:
- (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z)

*1395.512 Budget; expenses; assessments; hospital cost containment program account.—*

(1) The board shall biennially prepare a budget which shall include an estimate of income and expenditures for administration and operation of the hospital cost containment program for the biennium, to be submitted to the Governor for transmittal to the Legislature for approval. Subject to the approval of the Legislature, expenses of the program shall be financed by assessments against hospitals in an amount to be determined biennially by the board but not to exceed 0.04 percent of the gross operating costs of each hospital for the provision of hospital services for its last fiscal year. Every new hospital shall pay its initial assessment upon being licensed by the state and shall base its assessment payment during the first year of operation upon its projections for gross operating costs for that year. Each hospital under new ownership shall pay its initial assessment for the first year of operation under new ownership based on its gross operating costs for the last fiscal year under previous ownership. The assessments shall be levied and collected quarterly. All moneys collected are to be deposited by the Treasurer into the Hospital Cost Containment Trust Fund in the general fund, which account is hereby created. The Hospital Cost Containment Trust Fund shall be subject to the service charge imposed pursuant to chapter 215.

(2) Any amounts raised by the collection of assessments from hospitals provided for in this section which are not required to meet appropriations in the budget act for the current fiscal year shall be available to the board in succeeding years.

(3) Hospitals operated by the Department of Health and Rehabilitative Services or the Department of Corrections are exempt from the assessments required under this section.

Historical notes:
- (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z)

*1395.5125 Operating costs; nondeductible items.—*

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

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

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

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

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

Historical notes:
- (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (A) (B) (C) (D) (E) (F) (G) (H) (I) (J) (K) (L) (M) (N) (O) (P) (Q) (R) (S) (T) (U) (V) (W) (X) (Y) (Z)

*1395.513 Program accountability.—* On or before March 1 of each year, the board shall prepare and transmit to the Governor and the Legislature a report of hospital cost containment program operations and activities for the preceding year. This report shall include copies of summaries, compilations, and supplementary reports required by this part, together with such facts, suggestions, and policy recommendations as the board deems necessary. The board shall specifically state its findings and recommendations on the following issues:

(1) The extent to which cross-subsidization affects the rates and charges for different types of hospital services.
Appendix B

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APPENDIX B
Appendix C

Hospital Cost Containment Board
Organizational Chart
Appendix D

Rules of the Department of Health and Rehabilitative Services
Hospital Cost Containment Board
1ON-1.001 Purpose.

The purpose of this chapter is to implement the provisions of Part II, Chapter 395, Florida Statutes, regarding the submission, compilation and review of relevant actual and budgeted financial and statistical data provided by hospitals in the State of Florida and approval of the budgets of these hospitals.

Specific Authority 395.505 FS. Law Implemented 395.504, 395.508, 395.509 FS. History - New 6-30-80. Previously Numbered 4D-1.01, 27J-1.001 Amended 11-5-84.

1ON-1.002 Definitions.

As used in this Chapter, and in the Hospital Uniform Reporting System Manual, unless the context requires otherwise:

(1) "Board" means the Hospital Cost Containment Board created by Section 395.503, Florida Statutes.

(2) "Commissioner" means the Insurance Commissioner.

(3) "Consumer" means any person other than a person who administers health activities, provides health services, has a fiduciary interest in a health facility or other health agency, or has a material financial interest in the rendering of health services.

(4) "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing the service as to offset some of the costs of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.

(5) "Department" means the Department of Health and Rehabilitative Services.

(6) "Hospital" means a health-care institution as defined in Section 395.002(6), Florida Statutes.

(7) "Local health council" means the agency defined in Section 381.489(3)(p), Florida Statutes.

(8) "Major health care purchaser" means 1 of the 10 largest private employers in the state, a commercial health insurer, or a health care services plan certificated under chapter 641.
(9) "State health planning agency" means the agency designated by the Governor to perform the health planning and development functions prescribed by Section 1523, P.L. No.93-641, the National Health Planning and Resources Development Act of 1974.

(10) "Maximum allowable rate of increase" or "MARI" means the maximum rate at which a hospital is expected to increase its average gross revenues per adjusted admission for a given period. The MARI is composed of two parts, the market basket index and plus points, which are defined as follows:

(a) "Market basket index" means the revised market basket index used to measure the inflation in hospital input prices as employed on January 1, 1984, by the Secretary of the U.S. Department of Health and Human Services for Medicare reimbursement. If the measure ceases to be calculated in this manner, the inflation index shall be the index approved by rule promulgated by the board. The methodology used in determining the index approved by rule shall be substantially the same as the methodology employed on January 1, 1984, for determining the inflation in hospital input prices by the Secretary of the U.S. Department of Health and Human Services for purposes of Medicare reimbursement.

(b) "Plus points" means additional percentage points added to the market basket index to adjust for the Florida specific experience. The plus points to be added to the market basket index shall be 5 percent for calendar year 1985; 4 percent for calendar year 1986; and 3 percent for each year thereafter.

(11) "Budget" means the projections by the hospital, for a specified future time period, of expenditures and revenues, with supporting statistical indicators.

(12) "Case mix" means a calculated index for each hospital, based on financial accounting and case-mix data collection as set forth in Section 395.504, Florida Statutes, reflecting the relative costliness of that hospital's mix of cases compared to a state or national mix of cases.

(13) "Gross revenue" or "gross operating revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue. Gross revenues do not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors.

(14) "Adjusted admission" means the sum of acute admissions and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.
(15) "Operating expenses" or "operating expenditures" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses, and other operating expenses, excluding income taxes.

(16) "Medically indigent" means a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources required to meet his basic needs for shelter, food and clothing.

(17) "Net revenue" or "net operating revenue" means gross revenue minus deductions from revenue.

(18) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. These reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; other such revenue deductions, but also including the offset of restricted donations and grants for indigent care.

(19) "Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.

(20) "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the board in meeting its responsibilities pursuant to this part.

(21) "Comprehensive rehabilitative hospital" means a hospital licensed by the Department of Health and Rehabilitative Services as a specialty hospital, as that term is defined in Section 395.002(14), Florida Statutes; provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the hospital are classified as comprehensive rehabilitative beds pursuant to Section 395.003(4), Florida Statutes, and not as general beds.

(22) "Teaching hospital" means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

(23) "Nonoperating Revenue" means revenues received from sources not directly related to hospital operations such as patient care, related patient services, or the sale of related goods.
(24) "Total Revenue" means the sum of gross revenue, other operating revenue and nonoperating revenue.

(25) "Chart of Accounts" means the list of accounts, code numbers, definitions, standard units of measure and principles and concepts included in the Board's publication entitled Hospital Uniform Reporting System Manual.

(26) The "Florida Hospital Uniform Report" and "report" shall mean collectively, unless otherwise indicated, the prior year audited actual data report, interim report and the budget report to be submitted by each hospital as required by Rule 10N-1.004. Each report may be individually referred to throughout these rules.

(27) "Executive Staff Members" shall mean the Executive Director, or in his absence, the Assistant Executive Director or, in his absence, the Chief Financial Analyst.

(28) "Generally accepted auditing standards" shall be deemed and construed to mean the ten generally accepted auditing standards adopted by the American Institute of Certified Public Accountants, together with interpretations thereof, as set forth in Statements on Auditing Standards as published by the American Institute of Certified Public Accountants in effect as of August 20, 1984 and as may be amended by Rule 21A-20.08, Department of Professional Regulation, Board of Accountancy.

(29) "Generally accepted accounting principles" shall be deemed and construed to mean accounting principles or standards generally accepted in the United States, including, but not limited to, Accounting Principles Board Opinions Nos. 1 to 31 as published by the American Institute of Certified Public Accountants, Statements of Financial Accounting Standards and interpretations thereof as published by the Financial Accounting Standards Board in effect as of August 20, 1984 and as may be amended by Rule 21A-20.07, Department of Professional Regulation, Board of Accountancy.

(30) "Financial statements" shall be deemed and construed to mean a presentation of financial data, including accompanying notes, derived from accounting records and intended to communicate a hospital's economic resources or obligations at a point in time, or the changes therein for a period of time, in accordance with generally accepted accounting principles.

(31) "Change in hospital ownership" shall be deemed to occur when a majority of the ownership or the controlling
interest of the hospital is transferred or assigned. A change in ownership includes, but is not limited to, the acquisition of the hospital by any person by any means; the leasing of the hospital when the lessee agrees to undertake or provide services at the hospital to the extent that legal liability for operation of the hospital rests with the lessee; conversion of the hospital's type or kind of business organization; the sale, acquisition, assignment or other voluntary or involuntary transfer of a majority of the ownership or the controlling interest of the hospital; merger of the hospital corporation into a new corporation; and consolidation of the hospital corporation with one or more corporation resulting in the creating of a new corporation.


10N-1.003 Adoption and Establishment of Uniform Reporting System.

The Board, pursuant to Section 395.505, Florida Statutes, hereby adopts and establishes a uniform system for hospitals to file the prior year audited actual data report, the interim report, and the budget report of financial and statistical information. This system is described and the forms, instructions and definitions therefor are contained in the Board's publication entitled Hospital Uniform Reporting System Manual. The Chart of Accounts adopted pursuant to Section 395.507(1), Florida Statutes, and this Chapter 10N-1, and as hereafter modified, shall be utilized by each hospital for submitting the prior year audited actual data report, the interim report and the budget report.

Specific Authority 395.505 FS. Law Implemented 395.507 FS. History - New 6-30-80, Previously Numbered 4D-1.03, 27J-1.003, Amended 11-5-84, 12-17-84.

10N-1.004 Form and Manner for Submitting Reports.

(1) Each hospital shall submit to the Board at least ninety (90) days prior to the beginning of its fiscal year a budget report as the Board shall require concerning the total financial needs of the hospital and the resources available or expected to become available to meet those needs, including the effect of decisions made by the state health planning agency. The budget report shall contain projected expenditures, projected revenues, and statistical measures necessary to evaluate the budget. When a hospital changes its ownership, the new owner must file a new budget report within sixty (60) days, except that a report need not be filed for a fiscal period of less than ninety (90) days.
(2) Each hospital, except hospitals operated by the Department of Health and Rehabilitative Services or the Department of Corrections or comprehensive rehabilitative hospitals, shall submit to the Board an interim report at the time the hospital budget is submitted.

(3) (a) Each hospital shall submit to the Board not more than one hundred twenty (120) days subsequent to the end of its fiscal year, its audited financial statements and its prior year audited actual data report for the fiscal year then ended.

(b) Such financial statements shall be prepared in accordance with generally accepted accounting principles, and shall be examined by an independent, Florida licensed, certified public accountant, in accordance with generally accepted auditing standards, with an auditor's report issued thereon.

(c) The prior year audited actual data report shall be prepared for each hospital from financial statements referred in paragraph (b) above. When this report is not in agreement with the financial statements, each hospital is to provide reconciliation of amounts presented in its financial statements to amounts reported in its prior year audited actual data report.

(d) In the event a hospital's actual audited data is examined by an agency of federal, state or local government (such as Medicare intermediary or the Internal Revenue Service) and that examination requires adjustments, in accordance with generally accepted auditing standards, to previously reported audited financial statements and adjustments to previously reported prior year audited actual data report then the hospital will report the adjustments to the Board within thirty (30) days of acceptance of the adjustments by hospital management.

(e) When a hospital either changes the date of the end of its fiscal year end or changes ownership, that hospital shall file its audited financial statements and prior year audited actual data report for the period then ended or the last date of ownership within ninety (90) days of such change. A hospital changing ownership shall submit written notification of such change to the Board within thirty (30) days of the change. The notification shall include identification of the new owner; change of address of the new owner, if any, status of hospital license; status of Medicaid and Medicare provider numbers and such other information as may be necessary to identify the new owner. The new owner, or prevailing entity, shall submit written notification which includes name of acquired entity, name and address of new entity, status of
(f) Until a hospital changes ownership as specified in Rule 10N-1.002(31), F.A.C., it is the responsibility of the then current owner to comply with Chapter 395, Florida Statutes, Part II, and these rules and, in particular it is the responsibility of the then-current owner to not exceed projected expenditures or revenues in the approved budget and to prepare and submit timely reports as required to the Board. After the change in ownership, the hospital's existing fiscal year and budget will automatically apply to the new owner unless or until changed or amended and approved by the Board or a new budget is approved by the Board.

(g) When the application for a hospital license required by Section 395.003, Florida Statutes, is filed for a new hospital or due to a change in ownership of an existing hospital, the proposed new owner is to advise the Board in writing of the filing of that application.

(4) If a hospital wishes to file an amendment to its approved budget, a request to amend shall be filed in writing with supporting documents. The materials to be submitted shall be those as specified in subsection (1) of this rule. These supporting documents should clearly indicate the changes requested from the approved budget and why the changes are necessary.

(5) Each report required in this rule shall contain the information specified in the Board's publication entitled Hospital Uniform Reporting System Manual and shall be submitted to the Board in a form and manner consistent with that manual. Where more than one hospital is operated by the reporting organization, the information required by this section shall be reported for each hospital separately.

(6) Any hospital the final budget of which requires public review and approval may submit its budget prior to the public review and approval and shall subsequently file amendments adopted during the public review process at least 45 days prior to the beginning of the hospital's fiscal year.
Hospitals filing the reports specified below with the Board shall also simultaneously file one additional copy of that report with the Board. The specified reports are as follows:

(a) Budget year report and amendments.
(b) Prior year report and amendments.
(c) Audited financial statements.
(d) Interim six month actual and six month estimated report.
(e) Objection file submissions and responses.
(f) Original pleadings.
(g) All changes, amendments or revisions made to budgets prior to Board action.
(h) Objections of hospitals to staff's findings and recommendations.


1ON-1.005 Amendments to the Hospital Uniform Reporting System.

The Board, after due consideration, in its discretion, may prepare and publish modifications of the uniform reporting system adopted and established under Rule 1ON-1.003, for such period and under such conditions as the Board shall determine. The content of such modifications shall be prepared in the format of, and shall be adopted by the Board as a rule or an amendment thereto in accordance with the provisions of Section 120.54, Florida Statutes. If the Board adopts any amendment to the Hospital Uniform Reporting System Manual, a copy of that amendment shall be mailed to each hospital in the State.

Specific Authority 395.505 FS. Law Implemented 395.505 FS. History - New 6-30-80, Previously Numbered 4D-1.05, 27J-1.005, Amended 11-5-84.
10N-1.006 Waivers.

The Board may grant any written request for a waiver from any or all portions of Rule 10N-1.003, Rule 10N-1.004, Rule 10N-1.010, and Rule 10N-1.014, which require a submission to the Board of the prior year audited actual data report, audited financial statements, interim report, budget report or any special information required from each hospital in the State of Florida, which information is not available at that time nor can be reasonably developed by the hospital, provided the request for a waiver is made at least ten (10) days prior to the due date of the report or information except in exceptional circumstances.

Specific Authority 395.505 FS. Law Implemented 395.505(1), 395.505(3) FS. History - New 6-30-80, Previously Numbered 4D-1.06, 27J-1.006, Amended 12-29-83, 11-5-84.

10N-1.007 Interpretive Rulings and Modifications.

(1) The Executive Director of the Board is authorized to make uniformly applicable interpretive rulings with respect to matters contained in the Board's publication entitled Hospital Uniform Reporting System Manual adopted under Rule 10N-1.003. The Executive Director of the Board is also authorized to correct typographical and coding errors as well as make other minor organizational modifications when those corrections and modifications appear to be necessary to facilitate fair, accurate, and efficient reporting of hospital financial information or other data to the Board. The Board shall be notified in advance of the Executive Director's proposed actions pursuant to this authorization and shall approve or disapprove the proposed action at its next regularly scheduled board meeting.

(2) Any interpretive ruling, correction, or modification shall be in writing and distributed as an attachment to a consecutively numbered transmittal letter. The letter shall describe in detail the changes made by the attached material and shall include instructions regarding the placement of the material in the Manual. Each hospital shall be sent a copy of any transmittal letter together with all attachments.

Specific Authority 395.505 FS. Law Implemented 395.505(1), 395.505(3) FS. History - New 6-30-80, Previously Numbered 4D-1.07, 27J-1.007, Amended 11-5-84.
1ON-1.0075 Redistribution of Public Medical Assistance Trust Fund Surplus.

(1) The Board shall determine, based on fiscal year 1986 data for each hospital, the redistribution amounts for each hospital meeting all the criteria of paragraph (a) of subsection (3) of section 12 of Chapter 87-92, Laws of Florida, in accordance with the following procedures:

(a) Determine the dollar value of total uncompensated care by adding the dollar value of bad debts plus the dollar value of charity/uncompensated care as defined in Chapter III, Section 5960 of the Florida Hospital Uniform Reporting System, (FHURS) manual.

(b) Determine the net uncompensated care dollar amount by computing the total restricted and unrestricted revenues provided to the hospital by local governments or tax districts, and subtracting fifty percent of such restricted and unrestricted revenues from the amount of total uncompensated care determined pursuant to paragraph (a) above.

(c) Determine the dollar amount of eligible uncompensated care by subtracting five percent of the hospital's gross operating revenue from the amount of net uncompensated care determined pursuant to paragraph (b) above.

(d) Convert the total amount of eligible uncompensated care determined pursuant to paragraph (c) above to total uncompensated care days by dividing the total dollar amount of such eligible uncompensated care by the hospital's gross revenue per adjusted patient day.

(e) Determine the number of eligible uncompensated care days by adjusting the number of total uncompensated days determined pursuant to paragraph (d) above by multiplying the total number of such uncompensated care days by a factor of .7054, as specified in paragraph (e) of subsection (3) of section 12 of Chapter 87-92, Laws of Florida.

(f) Determine the preliminary hospital redistribution amount by multiplying the number of eligible uncompensated days determined pursuant to paragraph (e) above by eighty percent of the Medicaid per diem rate effective on July 1, 1987. For hospitals not eligible for Medicaid reimbursement, but otherwise eligible for this indigent care redistribution, the multiplication factor for determining the preliminary hospital redistribution amount shall be ninety percent of cost per adjusted patient day, rather than eighty percent of the Medicaid per diem applicable to other hospitals.
(g) Determine the adjusted hospital redistribution amount by reducing each hospital's share, by multiplying the preliminary hospital redistribution amount determined pursuant to paragraph (f) above by the ratio of the $69.5 million cap specified in Chapter 87-92, Laws of Florida, to the state-wide total of the preliminary hospital redistribution amounts determined pursuant to paragraph (f) above. However, the adjusted hospital redistribution amount may not exceed $20.85 million for any one individual hospital.

(2) A hospital may correct its 1986 fiscal year data for purposes of the redistribution of the Public Medical Assistance Trust Fund surplus, if such correction is verified by the hospital's independent certified auditors. Such corrections shall not be considered if received at the Board office after September 29, 1987. All such corrections shall comply with the following criteria, to the Board's satisfaction:

(a) The independent auditor shall submit a letter setting forth the data originally reported and the methodology used in reporting the data;

(b) The independent auditor's letter shall contain the proposed revisions or corrections and the methodology employed to produce such revisions or corrections;

(c) The independent auditor's letter shall explain how the corrected or revised data and accompanying methodology more accurately conform to the definitions in subsection (2) of Section 12 of Chapter 87-92, Laws of Florida, and more fairly represent the true financial picture of the hospital for the time covered in the report;

(d) If the revised data does not agree with the data contained in the original audited financial report, a revised audited financial report shall also be submitted by the independent auditor.

(3) Based on the revised or corrected data described in paragraph (2) above, the Board shall recalculate the redistribution due no later than October 15, 1987 following the procedures set forth in subsection (1) above. The Board shall certify to the Department of Health and Rehabilitative Services a revised formula by October 27, 1987.

(4) To allow the Board to implement the requirements of Specific Appropriation 948A of the 1987-88 General Appropriations Act, each hospital receiving funds in the redistribution of the Public Medical Assistance Trust Fund
surplus pursuant to Chapter 87-92, Laws of Florida, shall report to the Board the aggregate amount of restricted and unrestricted funds received from county and other local government sources from July 1, 1986, through June 30, 1987, no later than December 31, 1987. Each such hospital shall also submit to the Board such information for the period July 1, 1987, through June 30, 1988, no later than September 30, 1988.

Specific Authority 395.505 FS.
Law Implemented Section 12, Chapter 87-92, Laws of Florida.
History - New 02-01-88, Previously Numbered 27J-1.0075.
PART II UNIFORM HOSPITAL REPORT REVIEW PROCESS

ION-1.008 Receipt of Report.

(1) Every report provided the Board pursuant to Section 395.507, Florida Statutes, and Rules 10N-1.003 and 10N-1.004, shall be stamped by the agency clerk or other designated employee as to the date received by the Board.

(2) The dated receipt of a report shall be acknowledged by written notice to the hospital.

Specific Authority 395.505 FS. Law Implemented 395.503(3), 395.504, 395.509 FS. History - New 6-30-80, Previously Numbered 4D-1.08, 27J-1.008, Amended 11-5-84.


Within forty (40) days after receipt of any report, the staff shall determine and notify the hospital whether it is complete and conforms to applicable statutory, rule, and Hospital Uniform Reporting System Manual requirements; and verify the data contained therein.

Specific Authority 395.505 FS. Law Implemented 395.504, 395.505(3), 395.509 FS. History - New 6-30-80, Previously Numbered 4D-1.09, 27J-1.009, Amended 11-5-84.

ION-1.010 Notice of Deficiencies.

(1) Written notice shall be provided by certified mail or telegram to a hospital in the event the staff determines a report is incomplete; fails to conform to applicable statutory, rule, or Hospital Uniform Reporting System Manual requirements; or contains data that cannot be verified. The notice shall clearly indicate the deficiencies found, the corrections or modifications that must be made to make it complete or conforming or its data verifiable, as well as the time by which a corrected or modified report must be received in the Board's office.

(2) A hospital shall have no fewer than ten (10) working days following receipt of notice, to return to the Board's office the requested corrected or modified report.

(3) A hospital not notified as provided in Rule 10N-1.009, above shall be deemed to have submitted a report that is complete, conforming and verified.
10N-1.011 Response to Notice. If the corrected or modified report is not returned to the Board within the specified time period, the entire report shall be deemed delinquent from the original due date, unless a waiver is obtained as prescribed in Rule 10N-1.006.

10N-1.012 Budget Report Review.

(1) The staff shall review the budget report based upon the hospital's ranking for gross revenue per adjusted admission within its group and upon its rate of change in gross revenue per adjusted admission in the proposed budget as required in Section 395.507(6), Florida Statutes, and the most recently Board approved budget.

(2)(a) As part of the budget report review process, groupings of hospitals shall be established according to the characteristics and methodology as outlined in Chapter V, Section B, Hospital Uniform Reporting System Manual and as outlined in Section 395.507(2), Florida Statutes. Percentile values for gross revenue per adjusted admission shall be determined monthly for each group by ranking projected gross revenue per adjusted admission contained in the most recently approved or submitted budgets for the hospitals in each group, including any hospital that is contesting its grouping assignment.

(2)(b) Before hospitals are ranked monthly, the gross revenue per adjusted admission for each hospital in the group shall be adjusted for the number of months until the fiscal year end of the hospital of interest by the pro rata rate of change in the most current index value, as described in paragraph 2(a) above, between the calendar quarters which contain the last month of the hospital's most recently Board approved budget and the last month of the hospital's next budget to be submitted. Such adjustment shall be made as follows:

1. The 1986 or most recently submitted or approved subsequent budgets shall be used. This shall produce a set of budgets which requires adjustment for differing fiscal year ends.
2. Based upon the fiscal year end for the hospital of interest, the rate of change in the hospital market basket index described in paragraph (3)(a) of Section 10N-1.012, F.A.C., shall be calculated between the ends of the calendar quarters which contain the end month of the current fiscal year for the hospital of interest and the ending month for that hospital's next fiscal year.

3. The gross revenue per adjusted admission of the most recent Board-approved budget for the hospital of interest shall be adjusted by the rate of change calculated in subparagraph 2 above.

4. If the time period between a hospital's current and next fiscal year end is other than 12 months, an annualized percentage change shall be calculated using the methodology described in subparagraph 2 above.

5. For all hospitals in the group, except for the hospital of interest, the gross revenue per adjusted admission shall be adjusted by the rate of change obtained by multiplying the annual growth rate as determined in subparagraph 2 or the annualized growth rate determined in subparagraph 4 above by the proportion of the number of months remaining between each hospital's fiscal year and the end of the next fiscal year for the hospital of interest.

(3)(a) For purposes of the budget report review process, the rate of inflation (or deflation) in the hospital market basket index shall be based upon projections provided by a nationally recognized source. The projections shall be available on at least a quarterly basis and shall also be updated at least quarterly. Projections employed for establishing the maximum allowable increase for any hospital shall be those available at least six (6) months prior to the beginning of the fiscal year for the hospital.

(b) The source employed for projections shall be generally available to anyone desiring access to such projections and the specific source of any projection employed shall be noted in material provided to the hospital prior to the submission of its budget. If a published source is generally available, projections shall be obtained from the same projection service as employed by the U.S. Department of Health and Human Services for Medicare reimbursement. If the projection service employed by the U.S. Department of Health and Human Services does not meet the requirements of the Board in terms of general availability and frequency of revision, the projection service employed by the Board shall employ methodologies substantially the same as those utilized to obtain required projections for Medicare reimbursement.
(c) In calculating the rate of inflation (or deflation) for any hospital the rate of increase (or decrease) shall be the percent change in the moving average index for fiscal years during that quarter over the moving average index value for the fiscal years ending in the same quarter for the previous year. The same quarterly index values shall be applied to all fiscal years ending during a given quarter except for hospitals that have changed their fiscal year end. When a hospital has changed its fiscal year end and files a new budget, the rate of increase (or decrease) in the hospital market basket index applicable to the full year ending on the hospital's new fiscal year end will be adjusted using a moving average based on the average index level for the new fiscal year over the average index level for the old fiscal year. Plus points for a hospital which changes its fiscal year shall be pro rated for months not overlapping the previous fiscal year.

(4) As part of the budget report review process, the staff shall consider the basis of the hospital's projections, including, but not limited to, the effect of the following factors:

(a) Increases in patient admissions caused by the creation of preferred provider organizations or health maintenance organizations.

(b) Population changes.

(c) Changes in technology.

(5) As part of the original budget report review process or as part of the budget amendment review process, staff will adjust a hospital budget for changes in the case mix of the hospital as follows:

(a) For purposes of this part, the case mix of a hospital is measured by the case mix score. The method of calculating the case mix score shall be the stated in Chapter V, Section B, Hospital Uniform Reporting System Manual.

(b) The case mix threshold through the fiscal year 1988 budget review cycle shall be 1.4 percentage points. The threshold shall be reviewed annually thereafter.

(c) In determining the adjustment to the budget, staff will evaluate the hospital's case mix supplement to budget year report submitted pursuant to Chapter V, Section F, Hospital Uniform Reporting System Manual. Hospitals may submit data regarding services, physician mix and other supporting evidence in
addition to the required information. Staff will, at a minimum, evaluate the data by addressing the following items.

1. Did the hospital provide case mix information using consistent Diagnosis Related Groups (DRGs) and DRG weights?

2. Does the case mix data include the total inpatient population?

3. Is the projected increase in case mix index above the case mix threshold specified in paragraph (b) above?

4. Is the projected increase in case mix associated with the addition of physician specialties?

5. Is the projected increase in case mix associated with the addition of a new/expanded service?

6. Is the projected increase in case mix associated with a projected increase in length of stay?

7. Is the projected increase in case mix associated with a projected increase in proportion of Medicare patients?

8. Is the projected increase in case mix associated with a projected increase in operating expense per adjusted admission?

9. Is the projected increase in case mix limited to changes in certain DRGs or Major Diagnostic Categories (MDCs)?

10. How reasonable are the projected changes in DRGs?

11. Does the most recent actual data show trends consistent with projected changes?

12. Is the projected increase in case mix associated with an increase in average charger per DRG?

13. Does the hospital have a history of accurate case mix projections?

14. If a budget amendment, did the hospital budget a case mix increase?

15. If a budget amendment, how reasonable are the explanations of unanticipated case mix increases?
(d) If an increase in operating expense per adjusted admission is less than an increase in net case mix as calculated pursuant to paragraph (e) below, an increase in gross revenue per adjusted admission attributable to an increase in case mix shall not exceed the amount of increase in operating expense per adjusted admission. However, when the increase in net case mix as determined pursuant to paragraph (e) below is higher than the increase in operating expense per adjusted admission and the hospital submits evidence of increased efficiency in the operation of the hospital, the increase in gross revenue per adjusted admission shall be the increase in operating expense per adjusted admission plus 40% of the percentage difference between the increase in operating expense per adjusted admission and the increase in net case mix as calculated pursuant to paragraph (e) below.

(e) Upon acceptance by staff of the validity of the budgeted case mix, staff will determine the net case mix change where the net case mix change is the amount of case mix score change from interim to budget, less the threshold adjustment determined under paragraph (b), or for a budget amendment, the net case mix change is the amount of case mix score change from previous year to budget amendment less the case mix threshold adjustment determined under paragraph (b).

(f) For an original budget, or for a budget amendment if no case mix adjustment was applied to the original budget, staff will apply the net case mix change in paragraph (e) to the previously approved gross revenue per adjusted admission attributable to case mix.

(g) For a budget amendment, if a case mix adjustment was applied to the original budget, staff will, upon acceptance by staff of the validity of the budgeted case mix, apply the case mix score change between the original and amended budget to the previously approved gross revenue per adjusted admission to determine the change in gross revenue per adjusted admission attributable to case mix.
(h) If the net case mix as calculated in paragraph (e) above increases, the amount calculated pursuant to paragraphs (f) and (g) above shall be used to increase the amount of the gross revenue per adjusted admission that a hospital would otherwise be entitled to under Section 395.509, Florida Statutes, with this amount being added on after such entitlement has been calculated. The addition of this case mix increase shall not be used in the determination of whether a hospital is subject to detailed budget review under Section 395.509(2), Florida Statutes.

(i) For budgets in detailed budget review, the case mix change applied in paragraphs (f) and (g) above shall increase the gross revenue per adjusted admission for an increase in case mix and decrease the gross revenue per adjusted admission for a decrease in case mix, but the threshold described in paragraph (b) above shall not apply to decreases in case mix.


1ON-1.0125 Analysis of Rate of Increase in Budget Report Review.

(1) In the review of a budget not subject to automatic approval because of the provisions of paragraph (2)(a) or (b) of Section 395.509, Florida Statutes, the Board shall utilize the following criteria from Section 395.509(5)(a)-(k), Florida Statutes, to determine if the requested rate of increase is necessary to maintain the hospital's existing level of services:

(a) Evaluate the information submitted by the hospital on worksheet x-6 and other information submitted by the hospital to determine the efficiency, sufficiency, and the adequacy of the services and facilities provided by the hospital.

(b) Evaluate the cost of providing services and the value of these services to the public based on information submitted by the hospital on worksheet x-6 and other information submitted by the hospital. The amount necessary to continue current services shall be the market basket index, unless it is determined by the Board that the information contained in
the budget report shows that the market basket index is not necessary or that some amount greater than the market basket index is needed. Evidence of the rate of inflation unique to Florida above the market basket index may be presented on a case by case basis.

(c) Evaluate the ability of the hospital to improve existing services and facilities as shown on worksheet X-6 and other information submitted by the hospital.

(d) Evaluate the ability of the hospital to reduce the cost of services as shown on schedule C-2, worksheet X-6, and other information submitted by the hospital.

(e) Reserved

(f) Evaluate the accuracy of previous budget submissions by the hospital for gross revenue per adjusted admission and expense per adjusted admission as compared to the actual experience of the hospital in those indicators. If the hospital's actual experience in either of these indicators varies from the budget by more than ten (10) percent for each of the three most recent years for which actual data is available, or if the hospital's actual experience in the same of either one of these indicators varies from the budget by more than ten (10) percent for the two most recent years for which actual data is available, this creates a rebuttable presumption of inaccurate budgeting, for which the Board may limit the rate of increase in the budget under review by reducing the hospital's budgeted gross revenue per adjusted admission. The total adjustment in a budget year may not exceed the higher of the adjustment determined herein, or the pro-rata amount of the penalty imposed pursuant to Rule 10N-1.062, Florida Administrative Code, applicable to the budget year to which the adjustment herein is to apply.

(g) Reserved

(h) Reserved

(i) Evaluate the rate of change in the revenues and expenses of Research and Education services reported on worksheet X-3 and other information submitted by the hospital for hospitals assigned to Group 10 (Teaching). The effects of external funding and grant subsidies shall be considered as an integral part of the evaluation.

(j) For projects subject to CON, expenditure (cost) or revenue increases not accounted for in prior approved budgets shall be an acceptable justification for a budget increase, but shall not be included in the budget until verification is
made that the CON has been approved. Projects not subject to
CON shall continue to receive consideration of costs and
revenues associated with the project, to the extent that cost
and revenue increases have not been accounted for in previous
budgets.

(k) Evaluate the start-up costs which could not be
classified as normal operating costs related to opening a new
facility for the first three years. These costs will be an
acceptable justification for a budget increase during that
period.

(2) In the determination of the amount necessary to
accomplish an increase in the hospital's level of services,
the hospital shall demonstrate its need for any amount above
the rate of increase determined pursuant to subsection (1)
above based on the review criteria as outlined in Section
395.509 (a-k), Florida Statutes.

Specific Authority: 395.505 FS. Law Implemented 395.509(5) FS.
Previously Numbered 27J-1.0125, History - New 02-01-88

10N-1.013 Criteria for Report Review.

(1) A report shall be deemed:

(a) "Complete" when it contains all data required by the
Board pursuant to Rule 10N-1.003 although the Board may
request special information pursuant to Rule 10N-1.014; and

(b) "Conforming" when it has been prepared in the form
and manner specified by the Board and otherwise conforms to
applicable statutory, rule, or Hospital Uniform Reporting
System Manual requirements regarding reports in effect at the
time such report was submitted to the Board.

(c) "Verified" when the mathematical accuracy and general
reasonableness of the data contained in the report have been
substantiated through review, examination and recomputation,
to the extent considered necessary, and a review of supporting
reconciliation, as may be required.

(2) If a hospital's fiscal year is different from a
calendar year, the plus points shall be calculated by
multiplying the percentage of the fiscal year falling within
each calendar year times the plus points for that calendar
year. The sum of the products shall be the hospital specific
plus points.
(3) The statistical indicators per adjusted admission used as measures of comparison shall include gross revenue, net revenue, nonoperating revenue, total revenue, and operating expenditures.

(4) The staff shall follow the same review process for an amendment to a budget as for a budget report.


10N-1.014 Special Information Requests.

In the event the Board requires additional budget, financial or statistical information or related interpretation, to fully understand information provided by a hospital, a written request detailing the additional information, together with a time period for response, to be provided will be mailed to the hospital.


10N-1.015 Staff Findings and Recommendations.

Upon completion of the staff review of a budget report, the staff shall prepare a written statement of its findings and recommendations to the Board and shall promptly forward a copy to the hospital by certified mail. The statement shall be signed by an Executive Staff Member as designated in Rule 10N-1.002(27) and shall be clearly marked as preliminary findings. This statement shall include:

(a) An analysis of the basis for and accuracy and completeness of the budget report as corrected or modified by the hospital in response to Rule 10N-1.010(1) notice or as supplemented pursuant to Rule 10N-1.014;

(b) A summary description of the findings noted in the review process used by the staff in analyzing increases or decreases in revenues, costs, rates, volume, patient admissions and days, together with any explanation provided by the hospital;

(c) Any other related matters as the Board deems appropriate and may lawfully require, including a specific recommendation regarding approval, disapproval or amendment of the budget.
Effective Date of Projected Budget Approved After the Beginning of a Hospital's Fiscal Year

1ON-1.0155 Effective Date of Projected Budget Approved After the Beginning of a Hospital's Fiscal Year

(1) A projected budget approved by the Board after the beginning of a hospital's fiscal year shall be effective from the date of Board approval.

(2) Until the projected budget is approved, the level of expenditures and revenues set forth in such hospital's budget for the previous fiscal year shall remain in effect.

(3) The level of expenditures and revenues approved for the fiscal year shall be the level resulting from a weighted average of the number of days in the fiscal year during which the hospital operated at the level of the budget for the previous fiscal year and the number of days in the fiscal year during which the hospital will operate at the level of the prospective budget. This subsection shall not apply to a hospital whose budget is timely filed subject to automatic approval pursuant to section 395.509(2)(a) or (b), Florida Statutes, or whose budget is in the upper 20th percentile but whose rate of increase does not exceed the higher of the market basket index plus 2 percent, or the median absolute dollar value increase in gross revenues per adjusted admission for all other hospitals in its group. This subsection shall not apply to a hospital which requests an administrative hearing pursuant to Section 120.57, Florida Statutes, and whose budget is approved by the Board at the revenue levels originally requested by the hospital in the budget subject to the administrative hearing.

1ON-1.016 Hospital's Response to Staff Findings and Recommendations

1ON-1.0165 Corrected Budget Reports.

(1) In the review of budget reports and amended budget reports, when the Board approves a gross revenue per adjusted admission or a net revenue per adjusted admission
which is less than the amount of gross revenue per adjusted admission or net revenue per adjusted admission originally requested by the hospital in the budget report or amended budget report, the hospital shall submit a corrected budget report which conforms to the revenue levels approved by the Board, within 60 days from the date of Board approval, except that for amended budget reports approved within the last 120 days of the hospital's fiscal year, the hospital shall submit a corrected budget report which conforms to the revenue levels approved by the Board, within 18 days from the date of Board approval.

(2) The corrected budget report shall incorporate the revenues as approved by the Board, and shall include a cover letter which indicates the changes from the budget report or amended budget report originally submitted, the schedule of projected rates, and information sufficient to justify the manner by which the budget report or amended budget report is corrected.

(3) If a corrected budget report contains a gross revenue per adjusted admission or net revenue per adjusted admission which is less than the amount approved by the Board, the corrected budget report becomes an amended budget under the provisions of Rule 10N-1.0205(2)(b) and is approved upon filing without further action by the Board.

(4) If a corrected budget report contains a gross revenue per adjusted admission or a net revenue per adjusted admission which is greater than the amount approved by the Board, the hospital shall be subject to penalties pursuant to Rule 10N-1.060.


10N-1.017 Hearing Procedures

ION-1.018 Incorporation of Publications by Reference.

(1) The Hospital Uniform Reporting System Manual, including the forms contained therein, is incorporated by reference in each rule within this rule chapter in which reference is made to the publication. In each instance, the publication becomes a part of the rule, in the entirety of the publication, or in part thereof, as the context of the rule may require. The Board's grouping methodology and geographic price level index are also specified in the Manual.

(2) The public may obtain a copy of the Hospital Uniform Reporting System manual, upon payment of the cost of reproduction, by writing the Board; Attention: Executive Director, 325 John Knox Road, L-101, Tallahassee, Florida 32303.

Specific Authority 395.505 FS. Law Implemented 395.507 FS. History - New 6-30-80, Previously Numbered 4D-1.18, 27J-1.018, Amended 4-9-81, 10-16-81, 2-1-82, 1-10-83, 12-29-83, 5-17-84, 11-5-84, 9-29-85, 2-11-86, 2-27-86, 7-20-87, 8-13-87, 12-15-87, 3-20-88.

PART III BUDGET REVIEW HEARING PROCEDURE

ION-1.019 Definitions.


ION-1.0195 Revisions to Projected Budget.

(1) Projected Budget Defined. A projected budget is the hospital's projected budget, as defined in subsection (4) of Section 395.502, Florida Statutes, which has been filed with the Board for review and approval but has not been acted upon by the Board. Upon filing, a projected budget becomes the "previously-filed projected budget" mentioned in this rule.

(2) (a) Major Revisions. Major revisions to a hospital's projected budget are defined as follows: A change in gross revenue per adjusted admission which places a projected budget in detailed review pursuant to Section 395.509, Florida Statutes, or any change in gross revenue per adjusted admission or net revenue per adjusted admission of greater than 1 percent.
(b) Minor Revisions. Minor revisions to a hospital's projected budget are defined as all other changes, corrections or revisions not defined in paragraph (2)(a) of this rule.

(c) Upon filing, the revised projected budget becomes the hospital's projected budget, which, unless amended by the Board during review or further revised by the hospital, constitutes the hospital's projected budget for purposes of Board action.

(3) Projected Budgets May be Revised. A projected budget may be revised, and revisions may be revised, by a hospital during the Board's review. A revision should contain all of the revisions then proposed by the hospital. There is no limit to the number of revisions contained in a revision.

(4) Filed When Received. A revision is considered filed when received by the Board at its headquarters in Tallahassee.

(5) Effect of Major Revision. A major revision supersedes and replaces the previously-filed projected budget, as if withdrawn. Unless otherwise agreed, major revisions shall toll the 120 day period from receipt of written notice from the hospital that the hospital intends to revise its budget or upon receipt from the hospital of a revised budget, whichever first occurs, until up to ten (10) working days after receipt from the hospital of its data confirmation report. No major revision subject to detailed review may be filed more than 30 days into the 120 day period unless the hospital provides the Board a written waiver to extend the 120 day period until the next regularly scheduled Board meeting following expiration of the statutory time required for hearing by the Division of Administrative Hearings, issuance of a recommended order and filing of exceptions thereto. When the major revision is submitted solely as the result of circumstances unforeseen or reasonably unforeseeable by the hospital, which are beyond the control of the hospital, such as a change in Medicare reimbursement or Medicare reimbursement methodology or substantial malpractice insurance premium increases, which occurred subsequent to the filing of the original budget, the weighted average specified in Rule 10N-1.0155 shall not apply to the revenue levels approved in the major revision. Staff shall transmit revised budgets to data processing within five (5) working days of receipt.

(6) Filing Requirements. A hospital may revise a projected budget by filing the revision in accordance with the following procedures:

(a). A projected budget is revised by filing an original and one copy of the entire projected budget as then proposed by the hospital.
(b). Each page of the revision shall be labelled at the top and the bottom as to whether it is the first, second, third, or a successive revision. For example, the first revision to a projected budget would be labelled "First Revised Projected Budget" at the top and bottom of each page. Labelling may be typed or done by hand so long as it is legible.

(c). Each revision shall be dated and executed in the same manner and in compliance with the requirements for executing the previously-filed projected budget.

(d). Each revision shall be accompanied by a written narrative providing an explanation, justification and information supporting the revision. Every separate revision must be specifically described in writing, to include each worksheet being revised, each account number being revised and a specific description of each revision. (For example, to revise salary column (b) for account number 8610 on Worksheet C-6, "On worksheet C-6, account number 8610 is revised for salary column (b) to read $862,000").

(7) Processing and Review of Revisions.

(a) Revisions will be processed in compliance with the procedures set forth in Part II of these Rules for processing uniform hospital reports (Rules 10N-1.008, F.A.C., through 10N-1.018, F.A.C.).

(b) Rule Chapter 10N-3, F.A.C., is made fully applicable to revisions.

Specific Authority: 395.504, 395.505(1), 395.507, 395.509(4) and 395.515(3) FS. Law Implemented 395.507(6), 395.509(1) and 395.509(3) FS. History - New 2-11-86, Revised 10-07-87, Previously Numbered 27J-1.0195.
10N-1.020 Purpose.

Specific Authority 395.504, 395.505, 120.53 FS. Law Implemented 395.509(3), 395.509(4), 120.53(1)(b) FS. History - New 6-30-82, Previously Numbered 4D-1.20, 27J-1.020, Repealed 1-5-84.

10N-1.0205 Amendment of a Budget After Board Action.

(1) Board Action Defined. Board action means approval, approval as amended, or disapproval of a projected budget by the Board and includes approval of a projected budget by operation of law.

(2) Limitation on Requests to Amend a Budget.

(a) After Board action on a projected budget, no amendment to that budget shall be made except upon written request (Request to Amend) by the hospital in accordance with these rules. Unless and until approved by the Board, no hospital shall exceed the projected expenditures or revenues in its current budget as approved by the Board. During the pendency of any hearing or an appeal of a final order of the Board, the levels of expenditures and revenues set forth in the current budget shall remain in effect.

(b) A hospital may file a Request to Amend to reduce a budget after Board action at any time before the end of the hospital's fiscal year. Such requests will be freely approved by the Board.

(c) Normally, a Request to Amend to increase the gross revenue per adjusted admission or net revenue per adjusted admission of a budget after Board action shall be filed, if at all, within the first nine (9) months of the hospital's fiscal year. No Request to Amend to increase gross revenue per adjusted admission or net revenue per adjusted admission of a budget shall be considered, except in circumstances which include events not foreseen or reasonably foreseeable by the hospital or which were not under the hospital's control, after the first nine (9) months of the hospital's fiscal year.

(3) Procedure to Request Amendment.

(a) Request to Amend. A Request to Amend a budget after Board action is commenced by filing a Request to Amend which consists of a written request to amend the budget together with a written narrative of the proposed changes and information supporting the amendment and an amended budget, as sought by the hospital. The amended budget shall be prepared in the manner specified in subsection (6) of Rule 10N-1.0195, F.A.C.
but each page of a proposed amendment to a budget after Board action shall be labelled "First Request to Amend Budget After Board Action", "Second Request to Amend Budget After Board Action", etc. The information supporting the Request to Amend shall include, but not necessarily be limited to, a report on the appropriate Board-approved form of the hospital's actual experience for the pre-amendment period and its projections for the remainder of the fiscal year, and statistical and financial data underlying the written narrative submitted pursuant to this paragraph.

(b) Filed When Received. A Request to Amend a budget after Board action is considered filed when received by this Board at its headquarters in Tallahassee.

(c) 120-Day Approval Period. When a Request to Amend a budget after Board action is filed, the 120-day approval period set forth in subsection (3)(a) of Section 395.509, F.S., commences. Upon agreement by the Board and the hospital, that period may be waived or extended.

(d) Revisions to Request to Amend. A hospital may revise its Request to Amend in the same manner as revising a projected budget as set forth in Rule 10N-1.0195, F.A.C. Unless otherwise agreed, the 120-day period shall be deemed tolled in the same manner as in Rule 10N-1.0195(5), F.A.C., and the waiver provisions of Rule 10N-1.0195(5), F.A.C., shall apply to revisions to Requests to Amend. Staff shall transmit a revised, amended budget to data processing within five (5) working days of receipt.

(e) Effective Date. A budget amendment approved by the Board shall be deemed effective upon the date the Request to Amend is filed pursuant to paragraph (b) above, or upon a later date, if requested by the hospital filing the Request to Amend.

(f) Review Criteria. All proposed budget amendments shall be subject to detailed review with no limit on the Board's statutory authority to reduce the budget of a hospital. However, a proposed budget amendment that would have been subject to automatic approval pursuant to section 395.509(2), F.S., or rule 10N-1.012(5)(h), if submitted as an original budget, shall not be reduced below the revenue amounts originally approved by the Board. In making such determination, the 150 day data applicable to the original budget shall apply. The hospital shall justify, based on the statutory review criteria of section 395.509, F.S., any increase requested for the remainder of the year in gross revenue per adjusted admission, over the higher of the hospital's existing board-approved gross or net revenue per adjusted admission or the hospital's board-approved gross or net revenue per adjusted admission from the previous year.
inflated by the market basket index applicable to the original budget being amended.

(g) Budget Level. An approved amended budget shall be the budget for the entire fiscal year. The level of expenditures and revenues approved for the fiscal year shall be the level resulting from a weighted average of the Board-approved gross revenue per adjusted admission multiplied by the actual number of adjusted admissions of the pre-amendment period and the projected gross revenue per adjusted admission multiplied by the projected number of adjusted admissions for the remainder of the year, except that such weighted average shall not apply to any fiscal year 1987 amended budget which would have been subject to automatic approval pursuant to section 395.509(2), F.S., if submitted as an original budget. The budget level thus derived may be adjusted for case-mix variations in the pre-amendment period.

(4) Provisional Approval

(a) Request. If a Request to Amend seeks provisional approval of any part of a budget, the hospital shall specify those parts of the budget for which provisional approval is sought, to include the date such provisional approval is requested to be effective and the reasons why provisional approval is necessary before the Board's decision on the amendments as a whole.

(b) Final Decision Supersedes Provisional Approval.

The Board may provisionally approve any part of a budget before the final decision on the request for amendment. Such provisional approval will be superceded by the final decision.

(5) Applicability of Rules. Subsections (7) and (8) of Rule 10N-1.0195, F.A.C., are applicable to Requests to Amend.

Specific Authority 395.504, 395.505(1), 395.507, 395.509(4) and 395.515(3) FS. Law Implemented 395.507(6), 395.509(1) and 395.509(3) FS. History - New 2-11-86, Amended 10-20-86, 07-30-87, Previously Numbered 27J-1.0205.

10N-1.021 Notice.

Specific Authority 395.504, 395.505, 120.53 FS. Law Implemented 395.509(3), 395.509(4), 120.53(1)(b) FS. History - New 6-30-82, Previously Numbered 4D-1.21, 27J-1.021, Amended 5-4-83, 12-29-83, Repealed 11-5-84.
10N-1.022 Continuance and Extension of Time.


10N-1.023 Hearing Panel and Presiding officer.

Specific Authority 395.504, 395.505, 120.53 FS. Law Implemented 395.509(3), 395.509(4), 120.53(1)(b) FS. History - New 6-30-82, Previously Numbered 4D-1.23, 27J-1.023, Amended 12-29-83, Repealed 11-5-84.

10N-1.024 Parties, Participants, and Witnesses.
Specific Authority 395.504, 395.505, 120.53 FS. Law Implemented 395.509(3), 395.509(4), 120.53(1)(b) FS. History - New 6-30-82, Previously Numbered 4D-1.24, 27J-1.024, Repealed 11-5-84.

10N-1.025 Procedure.

Specific Authority 395.504, 395.505, 120.53 FS. Law Implemented 395.509(3), 395.509(4), 120.53(1)(b) FS. History - New 6-30-82, Previously Numbered 4D-1.25, 27J-1.025, Repealed 11-5-84.

10N-1.026 Exhibits.


10N-1.027 Record.

Specific Authority 395.504, 395.505, 120.53 FS. Law Implemented 395.509(3), 395.509(4), 120.53(1)(b) FS. History - New 6-30-82, Previously Numbered 4D-1.27, 27J-1.027, Repealed 11-5-84.

10N-1.028 Post-hearing Memorandum.


10N-1.029 Recommended Findings.

Specific Authority 395.504, 395.505, 120.53 FS. Law Implemented 395.509(3), 395.509(4), 120.53(1)(b) FS. History - New 6-30-82, Previously Numbered 4D-1.29, 27J-1.029, Amended 12-29-83, Repealed 11-5-84.
1ON-1.030 Notice of Proposed Action.


1ON-1.031 Publication of Findings.

Specific Authority 395.504, 395.505, 120.53 FS. Law Implemented 395.509(23), 395.509(4), 120.53(1)(b) FS. History - New 6-30-82, Previously Numbered 4D-1.31, 27J-1.031, Amended 12-29-83, Repealed 11-5-84.

PART IV CHARGE DATA COLLECTION

1ON-1.032 Collection of Charge Data

(1) Hospitals shall submit itemized charge data for selected diagnoses as determined by the Board.

(2) Forms to collect such charge data for each selected diagnosis shall be approved by the Board and forwarded to those hospitals from which data is to be collected.


PART V CASE-MIX DATA COLLECTION

1ON-1.033 Submission of Case-Mix Data

(1) All acute care hospitals in operation for all of any of the reporting periods described in Chapter V, Section D of the Hospital Uniform Reporting System Manual, as adopted pursuant to Rule 1ON-1.018, shall submit case-mix data reports to the Board in the manner and according to the reporting schedule described therein.

(2) Case mix data collected pursuant to Chapter V, Section D of the manual shall not be released until the Board adopts rules to govern the release and to protect patient confidentiality in the release of such data, except that the Board may continue to release case mix data in advance of such rules, in the same manner, by diagnosis groups, as it has released such data as of January 1, 1986, that is, upon request by interested parties in a table format displaying aggregate
numbers of discharges, total days of care, and total charges for groups of diagnosis categories.


PART VI PENALTIES

10N-1.060 Reports or Other Information.

(1) (a) Any hospital which refuses to file, fails to timely file, or files false or incomplete reports or other information required to be filed under the provisions of Part II, Chapter 395, Florida Statutes, or a rule adopted thereunder, shall be subject to a fine not to exceed $1,000 per day for each day of violation to be fixed, imposed and collected by the Board as provided in subsection (2) of this rule.

(b) For purposes of this rule, a report or other information is "incomplete" when it does not contain all data required by the Board pursuant to subsection (1)(a) of Rule 10N-1.013, F.A.C. A report or other information is "false" if done or made with actual knowledge that it is not true.

(c) When a hospital refuses to file, fails to timely file or files false or incomplete reports or other information required to be filed under the provisions of Part II, Chapter 395, Florida Statutes, or a rule adopted thereunder, administrative proceedings to impose fines consistent with this rule shall be commenced immediately. When a hospital timely files true and complete information in response to a Board correction notice, no administrative action shall be commenced.

(2) Fines for designated circumstances shall not exceed $1,000 per day for each day of violation and shall normally be within the following amounts per each day of violation. If a report is false and also either complete or incomplete, add the penalties to determine the range.

(a) Timely Filing

<table>
<thead>
<tr>
<th>First Occurrence</th>
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<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Reprimand</td>
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<td></td>
</tr>
<tr>
<td>Second Occurrence</td>
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<td>$750-1,000</td>
</tr>
<tr>
<td>Third Occurrence</td>
<td>$250-500</td>
<td>$1,000</td>
</tr>
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</table>
(b) Untimely Filing

1. Failure to File on Time

<table>
<thead>
<tr>
<th></th>
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<th>False</th>
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<tbody>
<tr>
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<td>$50-100</td>
<td>$100-250</td>
<td>$500-750</td>
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<td>$250-350</td>
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<tr>
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<td>$350-750</td>
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2. Refusal to File on Time

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<tbody>
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<td>$100-250</td>
<td>$250-500</td>
<td>$500-750</td>
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<tr>
<td>Second Occurrence</td>
<td>$250-500</td>
<td>$500-750</td>
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<td>$750-1,000</td>
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</table>

(c) No Filing

1. Failure to File

<p>| | |</p>
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</thead>
<tbody>
<tr>
<td>First Occurrence</td>
<td>$750-1,000</td>
</tr>
<tr>
<td>Second Occurrence</td>
<td>$1,000</td>
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</tbody>
</table>

2. Refusal to File

$1,000 per day for each day of violation for each occurrence.

3. The Board may increase or decrease the amount of a fine but shall not impose a fine that exceeds $1,000 per day for each day of violation.


1ON-1.061 Adjustment of 1986 Budget For Net Revenues per Adjusted Admission If 1984 Audited Actual Experience Exceeds 1984 Projected Budget.

(1) The audited actual experience of each hospital for net revenue per adjusted admission for 1984 shall be compared with its 1984 projected budget for net revenue per adjusted admission, in accordance with this rule.
(2) If the audited actual experience for net revenue per adjusted admission exceeds its projections by greater than ten (10) percent, the budget of that hospital for net revenue per adjusted admission for fiscal year 1986 shall be reduced, by operation of law, by the amount of such excess which is over ten (10) percent in accordance with the procedure set forth in subsection(3) of this rule.

(3)(a) Calculate the absolute dollar amount by which 1984 actual net revenue per adjusted admission exceeds 1984 budget projections for net revenue per adjusted admission by ten (10) percent.

(b) Multiply the per adjusted admission amount calculated in (a) above by the 1984 actual adjusted admissions to arrive at the absolute dollar amount of the adjustment.

(c) Reduce the 1986 total Board-approved net revenue by the absolute dollar amount as determined in (b) above.

(d) Calculate the allowable net revenue per adjusted admission by dividing the reduced net revenue figure calculated in (c) above by the 1986 projected admissions.


10N-1.062 Penalties for Exceeding Approved Budget or Previous Year's Actual Experience.

(1) General Provisions.

The Board annually shall compare the audited actual experience of each hospital to its Board-approved projected budget for that same year, and to the audited actual experience of that hospital for the previous year.

(2) Determination of Excess.

The Board annually shall determine whether each hospital has an excess for purposes of levying a penalty pursuant to Section 395.5094, Florida Statutes, in accordance with the following procedures:

(a) Determine the absolute dollar amount of the difference between the audited actual net revenue per adjusted admission for the most recently completed fiscal year and the net revenue per adjusted admission as reported in the hospital's Board-approved projected budget for that same year.
(b) Determine the absolute dollar difference in the increase for audited actual net revenue per adjusted admission between the most recently completed fiscal year and the previous year and the absolute dollar increase determined by multiplying previous year's net revenue per adjusted admission by the maximum allowable rate of increase.

(c) The lesser amount of paragraph (2)(a) or (2)(b) is the "excess" for purposes of this rule.

(3) Adjusting the Excess.

(a) The Board shall reduce the excess determined in subsection (2) of this rule pursuant to Section 395.5094, Florida Statutes, if the hospital demonstrates its entitlement to any reduction. The burden rests on the hospital at all times to document to the Board's satisfaction the total amount of the assessment paid by the hospital pursuant to Section 395.101, Florida Statutes, during the most recently completed fiscal year, less the amount of revenues received by the hospital during that same year through operation of Section 409.266(6), Florida Statutes. In reducing the excess of any penalty to be imposed for fiscal year 1986, the Board shall reduce such excess by the amount of such assessment less such revenues, paid and received by the hospital in fiscal year 1984, fiscal year 1985 and fiscal year 1986.

(b) If a hospital's audited actual experience for the most recently completed fiscal year exceeds its Board-approved projected budget for that same year, the Board shall consider changes in case mix in levying a penalty. A hospital must demonstrate any changes in its case mix to the Board's satisfaction based on case mix data, which shall include but not be limited to, reports filed pursuant to Sections 395.504(1), 395.5094 and 395.509(7), Florida Statutes, and rules promulgated thereunder.
1. The amount determined in paragraph (2)(a) is adjusted for case mix as follows:

(i) Demonstration of changes in case mix must be based upon projected case mix data submitted at the time a hospital submits its original budget or any subsequent amendment to the budget as provided in Chapter V, Section F, FHURS manual compared to the actual fiscal year DRG data submitted with the actual report. A consistent grouper and set of weights shall be used for all periods of data submitted. The DRG grouper and DRG weights shall be identified and submitted with the DRG data. The weights used shall correspond to the grouper used as published by the Health Care Financing Administration. For 1986 and 1987, the Board shall use, in lieu of projected DRG data if projected DRG data was not submitted, a hospital's actual case mix score for the previous year inflated by the statewide average increase in case mix scores previously established for the period under consideration.

(ii) Upon satisfactory demonstration of case mix score changes, the Board shall adjust the net revenue per adjusted admission for the Board approved budget by the ratio of the actual case mix score for the hospital and the budgeted case mix score for the hospital.

(iii) The revised amount is the difference between the actual net revenue per adjusted admission and the adjusted net revenue per adjusted admission for the Board approved budget as determined in step (ii).

2. The amount determined in paragraph (2)(b) is adjusted for case mix as follows:

(i) Demonstration of changes in case mix must be based upon actual DRG data for the most recently completed fiscal year compared to actual DRG data for the previous fiscal year submitted at the time a hospital submits its actual report. A consistent grouper and set of weights shall be used for all periods of data submitted. The DRG grouper and DRG weights shall be identified and submitted with the DRG data. The weights used shall correspond to the grouper used as published by the Health Care Financing Administration.
Upon satisfactory demonstration of case mix score changes, the Board shall determine the net case mix change, where the net case mix change is the actual case mix score change less the case mix threshold. The case mix threshold will be 1.4% for 1986 actual reports. The value of the case mix threshold will be established by the Board annually based upon the most current evidence of DRG coding practice.

The revised amount is the absolute dollar difference in the increase for audited actual net revenue per adjusted admission between the most recently completed fiscal year and the previous year, and the absolute dollar increase determined by multiplying the previous fiscal year's actual net revenue per adjusted admission by the maximum allowable rate of increase and by the net case mix change determined in step (ii).

3. The case mix adjusted excess is the lesser of 1.(iii) and 2.(iii) provided that any adjustment made for case mix changes shall not result in an adjusted excess less than zero and any adjustment made for case mix changes shall not result in an adjusted excess greater than the unadjusted excess.

(c) All adjustments sought by the hospital shall be stated in terms of absolute dollar adjustments per adjusted admission based on the total adjusted admissions for the audited actual experience for the most recently completed fiscal year.

(d) The excess, less reductions, if any, is the "adjusted excess".

(4) Calculation of Penalty.

In calculating the penalty pursuant to this rule, the Board shall multiply the adjusted excess calculated in subsection (3) by the total adjusted admissions based on audited actual data for the most recently completed fiscal year. This amount is the "penalty".

(5) Reduction of Budget.

After making determination of a hospital's penalty, in accordance with the procedures set forth in this rule, the Board shall reduce the hospital's budget in accordance with the procedures set forth in this subsection. This budget reduction
imposed pursuant to this rule shall apply pro rata to the
twelve months immediately following final Board action.

(a) For the first or second occurrences within a
five-year period, the Board shall reduce the hospital's budget
for net revenues up to the amount of the adjusted excess not to
exceed five percent of the prior year's actual net revenues
inflated by MARI for the first occurrence within a five-year
period or two percent of the prior year's actual net revenue
inflated by MARI for the second occurrence within a five-year
period.

(b) For the third occurrence within a five-year period,
a fine in the amount of the penalty determined in subsection
(4) of this rule shall be imposed.

(c) For the first or second occurrence within a
five-year period, any penalty amounts in excess of the
applicable amount of the adjusted excess shall be imposed as a
fine.

(d) The Board shall determine the percentage of the
reduction to the budget by dividing the amount derived pursuant
to subsection (4) by the amount of the audited actual net
revenue for the most recently completed fiscal year.

(e) The Board shall require the hospital to reduce its
budgeted gross revenue by an amount resulting from multiplying
the amount of the hospital's most recent audited actual gross
revenue by the percentage reduction calculated pursuant to
paragraph (d) above and multiplying that amount by the
hospital's percentage of gross revenue generated from sources
other than charity care and fixed-price government payors
specified in Chapter III of the Florida Hospital Uniform
Reporting System (FHURS) manual. As used herein, "charity
care" is that defined in Chapter III, Section 5960 of the FHURS
manual, reduced by the amount received by the hospital through
restricted donations and grants for indigent care, as described
in Chapter III, Section 5970 of the FHURS manual, and further
reduced by fifty percent of the amount received by the hospital
through unrestricted tax revenue and appropriated funds, as
defined in Chapter III, Section 9130 of the FHURS manual.
Any other adjustment to the amount calculated herein must be
justified as fair and equitable to all payors.

(f) The Board shall determine gross and net revenues
per adjusted admission by dividing reduced budget figures for
gross and net revenues by adjusted admissions for the budget.
(6) Reporting Requirements.

(a) Within one hundred twenty days after the end of the hospital's fiscal year, each hospital shall file with the Board its audited actual experience for that fiscal year. Within forty days after receipt of a hospital's audited actual experience which is deemed complete, conforming and verified in accordance with Rule 10N-1.013, F.A.C., the staff shall issue a notice of intent to issue Final Order and intended Board action. The notice shall be provided to the hospital by certified mail and shall include preliminary findings regarding the amount of any excess, a statement of the amount of any budget reduction, and a statement of any fines imposed.

(b) The hospital shall have fourteen days from the date of receipt of the notice to file a response to the notice of intent and to request a hearing pursuant to Section 120.57, Florida Statutes, if desired.

(c) Within fourteen days of receipt of the hospital's response to the notice of intent, the Board staff shall respond to such response.

(7) Payment of Fines and Submission of Revised Budget.

Within thirty days after the Board has reduced a hospital's current budget pursuant to this rule, and in accordance with the procedures set forth in Section 395.5094, Florida Statutes, the hospital shall pay any fine imposed pursuant to subsection (5) of this rule and shall file a revised budget with the Board reflecting any fines and penalties imposed pursuant to this rule.

10N-2.001 Purpose.

The Hospital Cost Containment Board was created and located in the Department of Health and Rehabilitative Services pursuant to Part II, Chapter 395, Florida Statutes, to exercise those powers and perform those duties prescribed by law.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(1), 395.503(1) FS. History - New 7-7-80, Previously Numbered 4D-2.01, 27J-2.001, Amended 3-15-83, 12-29-83.

10N-2.002 The Agency Head.

(1) The agency head is the Hospital Cost Containment Board collectively.

(2) The members of the Board elect a Chairman and Vice Chairman from its members biennially. The Chairman and Vice Chairman serve 2-year terms.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(1), 395.503(1)(2)(3) FS. History - New 7-7-80, Previously Numbered 4D-2.02, 27J-2.002.

10N-2.003 General Description of Agency Organization and Operations.

(1) The Board is located within the Department of Health and Rehabilitative Services. Members of the Board are remunerated at the rate of $50 per diem while on official Board business and are reimbursed for their expenses while on official business for the Board in accordance with the provisions of Section 112.061, Florida Statutes.

(2) The administrative functions of the Board are centralized in the office of the Executive Director. The Executive Director is appointed by the Board and shall serve at its pleasure. The Executive Director, with the concurrence of the Board, shall appoint, and may terminate, a general counsel, a chief financial analyst, with at least 5 years experience in hospital financial management, a director of research, a director of public information, an assistant executive director, if any; and may appoint, with the consent
of the Board, such other staff and staff attorneys as he deems necessary.

(3) The staff is composed of the office of the Executive Director and three (3) divisions; Financial Analysis; Public Information; and Research. The office of Executive Director includes the Board's general counsel and other legal staff and Office of Technical Assistance.

The Board may create committees from its membership and may create such ad hoc advisory committees to advise the Board and its staff in specialized fields related to the functions of hospitals, as it deems necessary. The members of any ad hoc advisory committee shall be entitled to reimbursement for expenses incurred, including travel expense.

(5) The Chairman recommends to the Board the members or other persons to serve on any committee of the Board and recommends for approval of the Board, the Chairman and Vice Chairman of each committee.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(1), 395.503(1), (3), (4), (5) FS. History - New 7-7-80, Previously Numbered 4D-2.03, 27J-2.003, Amended 3-15-83, 11-5-84.

1ON-2.004 Board's Official Headquarters.

The Board's official headquarters is 325 John Knox Road, Building L, Suite 101, Tallahassee, Florida 32303. Office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday, except for state holidays.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(1), 395.503(1) FS. History - New 7-7-80, Previously Numbered 4D-2.04, 27J-2.004, Amended 12-29-83.

1ON-2.005 Meetings; Attendance; Notice of Meetings and Agenda.

(1) The Board shall meet from time to time to fulfill its responsibilities. Meetings may be called by the chairman or any five members and, except in the event of an emergency, shall be called by written notice.

(2) Attendance by Board members.

(a) All Board members are expected to attend every Board meeting.
(b) Any Board member who fails to attend more than four (4) meetings during any one calendar year shall be recommended to the appointing authority for replacement as a board member in writing by the Chairman or Vice Chairman of the Board.

(c) For purposes of this rule, absences will not be classified as excused or unexcused.

(d) A Board member will be considered to have attended a Board meeting if he or she has been present at the meeting for a majority of the session for each day of the meeting. For purposes of making this determination, a meeting day will be considered to have begun at the time stated on the agenda and will be considered to have ended at the time the meeting is recessed for that day or adjourned by the presiding officer.

(e) The Executive Director shall be responsible for keeping a record of attendance at all Board meetings. He shall report to the board the name of any member who, during any calendar year, misses more than four (4) meetings in any one (1) year.

(3) The Board shall give at least seven (7) days notice of any meeting to the public generally by publication in the Florida Administrative Weekly. The notice shall state the date, time and place of the meeting, a brief description of the purpose of the meeting, and the address where persons may write to obtain a copy of the agenda.

(4) The Board shall prepare an agenda and shall make it available in time to ensure that it is mailed at least ten (10) days before the event to any person in the state who has requested it. The agenda may be changed prior to the meeting or at the meeting, for good cause, as stated in the record.

(5) Notwithstanding the provisions of subsections (3) and (4), the Board may hold emergency meetings for the purposes of acting on emergency matters affecting the public health, safety and welfare.

(6) All Board proceedings are open to the public.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(1), 395.503 (3) FS. History - New 7-7-80, Previously Numbered 4D-2.05, 27J-2.005, Amended 12-29-83, 11-5-84.
ION-2.006 Workshops.

A workshop is a gathering where members of the Board may be present or persons designated by the Board are meeting for purposes of rule drafting or policy discussions at which no official votes are to be taken or policy adopted. The provisions of Rule ION-2.005, relating to meetings, also applies to workshops and committee meetings.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(1) FS. History – New 7-7-80, Previously Numbered 4D-2.06, 27J-2.006.

ION-2.007 Declaratory Statement.

Any person requesting a declaratory statement from the Board under Chapter 120, Florida Statutes, or Chapter 28-4, Florida Administrative Code, must do so in the manner provided in Section 120.565, Florida Statutes, or Chapter 28-4, Florida Administrative Code.

Specific Authority 120.565, 395.505(1) FS. Law Implemented 120.565 FS. History – New 7-7-80. Previously Numbered 4D-2.07, 27J-2.007.

ION-2.008 Statutory Chapters and Rules Affecting Board.

(1) The following chapters and sections of Florida Statutes, listed by chapter or section number and title, affect the operation of the Board and may be of interest to a person doing business with the Board:

(a) Chapter 395, Part II, Health Care CostContainment.
(b) Chapter 120, Administrative Procedure Act.
(c) Chapter 119, Public Records.
(d) Section 286.011, Public Meetings and Records; Public Inspection; Penalties; and Section 286.012, Voting Requirements at Meetings of Governmental Bodies.
(e) Chapter 112, Public Officers and Employees.
(f) Chapter 154, Public Health Facilities.
(g) Section 627.920(3), Reports of information on health insurance.

(2) Rules of the Board appear in the Florida Administrative Code published by the Secretary of State. The Board from time to time adopts and promulgates new rules or amends or repeals existing rules. An index listing of rules by subject matter is as follows:

1ON-1 Hospital Uniform Report System
1ON-2 Organizational and Procedural Rules
1ON-3 Rules Governing Proceedings to Resolve Objections to Preliminary Budget Findings and Recommendations

Specific Authority 395.505(1) FS. Law Implemented 120.53(1) FS. History - New 7-7-80, Previously Numbered 4D-2.08, 27J-2.008, Amended 11-5-84.

1ON-2.009 Public Information and Inspection of Records.

(1) Board records which are public records under Chapter 119, Florida Statutes (Florida's Public Records Law), are available for public inspection during business hours. Persons wishing to obtain copies of such records may request the same in writing from the Board, and, upon payment of the cost of copying, the copies will be furnished.

(2) Patient-specific records collected by the Board pursuant to Rule 1ON-1.033 and Chapter V, Section D, of the Florida Hospital Uniform Reporting System manual are exempt from disclosure pursuant to section 119.07(3)(n), Florida Statutes, and shall not be released unless modified to protect patient confidentiality as described in paragraph (2)(a) below and released in the manner described in paragraphs 2(b) and 2(c).

(a) The patient-specific record shall be modified to protect patient confidentiality as follows:

1. HCCB Hospital Number Retain
2. Record ID Number Substitute Sequential Number
3. Patient Birth Date Substitute Age
4. Patient Sex Retain
5. Patient Zipcode

Retain unless less than 500 population for zipcode per U.S. census or unless out-of-state: if less than 500 population, report a code representing a combination set of zipcodes; if out-of-state, report state, U.S. territory, or out-of-country code.

6. Type of admission

Retain

7. Source of Admission

Retain

8. Admission Date

Delete

9. Discharge Date

Substitute Length of Stay, Quarter of Discharge, Day of Week Admitted

10. Patient Discharge Status

Retain

11. Total Gross Charges

Retain

12. Principal Payer Code

Retain

13. Principal Diagnosis Code

Retain

14. Secondary Diagnosis Code

Retain

15. Secondary Diagnosis Code

Retain

16. Secondary Diagnosis Code

Retain

17. Secondary Diagnosis Code

Retain

18. Principal Procedure Code

Retain

19. Principal Procedure Date

Substitute Days from Admission to Procedure

20. Other Procedure Code

Retain

21. Other Procedure Code

Retain

22. DRG

Addition

(b) The modified discharge data records described in paragraph (2)(a) shall be released as a set of all records occurring in one calendar quarter based on date of discharge.

(c) The modified discharge data described in paragraphs (2)(a) and (b) shall be public information and shall be available to the public on or after July 1, 1988 pursuant to subsections (1) and (4) of this rule.

(3) Aggregate reports derived from patient-specific records collected pursuant to Rule 10N-1.033 and Chapter V, Section D, of the Florida Hospital Uniform Reporting System manual are public records and shall be released as described in subsections (1) and (4) of this rule, provided the aggregate reports do not include record ID number, patient birth date, patient zipcode, admission date, discharge date or principal procedure date, or provided the aggregate reports contain the combination of five or more records for any data disclosed.
(4) Requests for copies of material needed by a certain date shall be submitted sufficiently in advance to permit the staff to respond without disruption of its duties.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(2), 119.07 FS. History - New 7-7-80, Previously Numbered 4D-2.09, 27J-2.009, Amended 11-5-84, 12-15-86, 3-20-88.

10N-2.010 Official Reporter.

For purposes of complying with Section 120.53(2)(b) and (c), the Board has designated Florida Administrative Law Reports (FALR) as the Board's Official Reporter.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(4) FS. History - New 7-7-80, Previously Numbered 4D-2.10, 27J-2.010, Amended 12-29-83.

10N-2.011 Forms and Instructions.

Forms and instructions used by the Board in dealing with the public are listed below and are on file with this Board and the Department of State. Copies may be obtained by writing to the agency clerk at the Board's Official Headquarters, Woodcrest Office Park, Building L, Suite 101, 325 John Knox Road, Tallahassee, Florida 32301 904/488-1295.
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<td>Capital Asset Analysis</td>
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<td>(6) B-4</td>
<td>Medical Education Program and Medical Staff Profile</td>
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<td>Statement of Revenues and Expenses</td>
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<td>Statement of Patient Care Revenue</td>
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<td>Statement of Other Operating and Nonoperating Revenue</td>
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<td>Statement of Patient Care Service Expense</td>
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<td>(12) C-6</td>
<td>Statement of Other Operating and Nonoperating Expenses</td>
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<td>(13) C-7</td>
<td>Statement of Physician Care Service Revenue and Expenses</td>
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<td>Statement of Costs of Service from Related Organizations</td>
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<td>(15) E-1</td>
<td>Cost Allocation - Statistical Basis</td>
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<td>(16) X-1</td>
<td>Analysis of Employee Benefits</td>
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<tr>
<td>(17) X-2</td>
<td>Listing of Capital Expenditures</td>
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(1) X-3 Statement of Research and Education Expense and Revenue 02-01-82
(19) X-4 Explanations and Comments 02-01-82
(20) X-5 Statement of Patient Rates and Discount Policies Quarterly
Assessment Report Hospital Uniform Reporting System Manual
(21) CM-1 DRG Report Paper Format 05-17-84
(22) A(I) Transmittal and Certification (Interim) 11-5-84
(23)A-1(I) General Hospital Information (Interim) 11-5-84
(24) B-1(I) Daily Hospital Service Statistics (Interim) 11-5-84
(25) C-2(I) Statement of Revenues and Expenses (Interim) 11-5-84
(26) C-3(I) Statement of Patient Care Service Revenue (Interim) 11-5-84
(27) C-4(I) Statement of Other Operating and Nonoperating Expenses (Interim) 11-5-84
(28) C-5(I) Statement of Patient Care Service Expense (Interim) 11-5-84
(29) C-6(I) Statement of Other Operating and Nonoperating Expenses (Interim) 11-5-84
(30) X-4(I) Explanations and Comments (Interim) 11-5-84
(31) I-1 Short Form Interim Report 11-5-84
Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.54, 120.55 FS. History - new 7-7-80, Previously Numbered 27J-2.011, Amended 10-20-80, 2-1-82, 12-29-83, 5-17-84, 11-5-84.

10N-2.012 Agency Clerk.

The Executive Secretary of the Board is designated as the agency clerk who shall have those duties and responsibilities prescribed by Section 120.52(9), Florida Statutes, and applicable Florida Rules of Appellate Procedure. The Executive Secretary is also designated as official custodian of agency records. The Executive Secretary is located at the Board's official headquarters.

Specific Authority 120.53(1), 295.505(1) FS. Law Implemented 120.53(1) FS. History - New 7-7-80, Previously Numbered 4D-2.12, 27J-2.012, Amended 10-20-80, 11-5-84.

10N-1.023 Model Rules of Procedure.

The Board will follow and apply the Model Rules of Procedure; Chapter 28, Florida Administrative Code, to the extent that the model rules do not conflict with any rule of procedure promulgated by the Board.

Specific Authority 120.53(1), 395.505(1) FS. Law Implemented 120.53(1)(c) FS. History - New 7-7-80, Previously Numbered 4D-2.13, 27J-2.013.
10N-3.001 Scope and Purpose.

These rules govern procedures for considering and resolving objections filed by hospitals with the Board to preliminary findings and recommendations made by the staff of the Board to a hospital's budget or to an amendment to a budget. The purposes of these procedures are to permit the Board to resolve objections to preliminary findings and recommendations and, as necessary, to assist it in developing findings in a non-adversary, investigative forum.

Specific Authority 395.505 FS. Law Implemented 395.509 FS. History - New 02-03-85, Previously Numbered 4D-3.01, 27J-3.001.

10N-3.002 Definitions.

Unless the context otherwise requires,

1. "Preliminary findings and recommendations" means written findings and recommendations made by the executive staff members designated by the Board as to whether a hospital budget, or an amendment to a budget, should be approved, disapproved, disapproved in part, or amended.

2. "Objections" means those written objections actually received by the Board at its offices in Tallahassee within fourteen (14) days from receipt by the hospital of the preliminary findings and recommendations.

3. "Hearing" means a proceeding governed by the provisions of Section 120.57, Florida Statutes.

4. "Request for hearing" means a written request for a hearing received by the Board at its offices in Tallahassee within fourteen (14) days from receipt by the hospital of the preliminary findings and recommendations.

5. Calculation of time. The date of receipt by the hospital of preliminary findings and recommendations shall not be included. The fourteenth (14) day shall be included unless it is a Saturday, Sunday or legal holiday in which event the fourteen (14) day period shall run until the end of the next day which is neither a Saturday, Sunday nor legal holiday.
(6) "Objections file" means a separate file maintained for objections filed by a hospital and shall include written materials relevant to the objections. Each objections file will include the staff's preliminary findings and recommendation, the hospital's written objections, the staff's written responses and written comments from the public. The contents of objections files are open to the public and are available for copying and inspection pursuant to Rule 10N-2.009, F.A.C.

(7) "Proceeding" means Board action on hospital objections. A proceeding is commenced by the filing of written objections.


10N-3.003 Objections and Staff Response.

(1) The hospital shall file with the Board, within fourteen (14) days from its receipt of preliminary findings and recommendations, its written objections, if any, to those findings and recommendations. Those written objections shall include the following minimum information:

(a) The name and address of the hospital and the names and addresses of the hospital's chief executive officer; and its chief financial officer;

(b) When and how the hospital received notice of the preliminary findings and recommendations;

(c) A concise statement of each objection, separately stated for findings and recommendations, and a reference to facts and rules or statutes, if applicable, which entitle the hospital to relief;

(d) A statement indicating whether the hospital has filed or will file a request for a hearing;

(e) A demand for relief to which the hospital deems itself entitled;

(f) The signature of the hospital's chief executive officer or its chief financial officer; and

(g) Any other information the hospital contends is material.
(2) No amendments to written objections will be allowed.

(3) Within fourteen (14) days after receipt of the objections, the staff shall prepare and file its responses to the objections with a copy to the hospital.

Specific Authority: 395.505 FS. Law Implemented 395.509 FS.
History - New 02-03-85, Previously Numbered 4D-3.03, 27J-3.003.

10N-3.004 Resolution of Objections.

(1) Hearing Requested. If the hospital requests a hearing within fourteen (14) days from its receipt of preliminary findings and recommendations, the Board will not consider or resolve the objections until the time the Board undertakes final agency action on the issues framed in the request for hearing.

(2) No Hearing Requested. If the hospital does not request a hearing, the Board will consider and resolve the objections at a meeting of the Board. Objections may be removed from an agenda by mutual consent of the hospital and staff.

(3) Notice. Notice of date, time and place of proceedings to consider and resolve objections will be mailed to the hospital at least fourteen (14) days before the objections are to be considered. All mailing under Chapter 10N-3, F.A.C., whether to or from hospital, shall be accomplished by certified mail, return receipt requested.

(4) Location. Evaluation and resolution of objections will normally occur at regular Board meetings which will be held at dates, times and places set forth in the written notice provided to the hospital.

Specific Authority: 395.505 FS. Law Implemented 395.509 FS.

10N-3.005 Continuances.

For good cause shown, continuances may be granted or denied by the Executive Director, or in his absence, the Assistant Executive Director or in his absence, the Chief Financial Analyst, upon written request received at least seven (7) days before the objections are to be considered.

Specific Authority: 395.505 FS. Law Implemented 395.509 FS.
History - New 02-04-85, Previously Numbered 4D-3.05, 27J-3.005.
10N-3.006 Procedure.

(1) Basis for resolving objections. The Board shall consider and resolve objections in context with applicable statutory and rule criteria based on the contents of the objections file. No new issues will be considered in relation to the objections beyond those contained in the objections file.

(2) Order of presentations. The order of formal, direct presentations to the Board concerning objections will be as follows: the staff, the hospital, public counsel, the public, the staff and then the hospital. The Board may question the staff, the hospital, the public and others concerning the objections.

(3) Time limits. Because objections are to be evaluated and resolved based on materials in the objections file, formal, direct oral presentations will be limited, unless waived by the Board, to a total of 15 minutes for each of the parties, exclusive of questioning by the Board.


10N-3.007 Record.

Those wishing to preserve the Board's consideration and resolution of objections must make their own arrangements to do so.


10N-3.008 Decisions on Objections.

Objections will be resolved by majority vote. Written notice of resolution shall be mailed to the hospital within fourteen (14) days of the meeting.


10N-3.009 Publication of Findings and Conclusions.

Board Findings and Conclusions, if any, shall be mailed to the hospital and distributed to the newspaper of largest general circulation in the county where the hospital is located.
and may be distributed to other interested persons, organizations, employers, health-care providers and third party payors.

Specific Authority: 395.505 FS. Law Implemented 395.509 FS.
History - New 02-03-85, Previously Numbered 4D-3.09, 27J-3.009.
10N-4.001 Purpose.

The purpose of this chapter is to implement the provisions of sections 400.341 to 400.346, Florida Statutes, regarding the submission of financial and patient data by nursing homes licensed pursuant to Chapter 400, Part I, Florida Statutes.

Specific Authority 400.343 FS. Law Implemented 400.341-400.346 FS. History - New 09-24-86, Previously Numbered 27J-4.001.

10N-4.002 Definitions.

As used in this chapter, and in the nursing home uniform reporting system manual and forms, unless the context requires otherwise, the following shall apply:

(1) "ACLF" means an adult congregate living facility licensed pursuant to Chapter 400, Part II, Florida Statutes.

(2) "Admission" means the formal acceptance of a patient into the nursing home facility for inpatient care.

(3) "Board" means the Hospital Cost Containment Board.

(4) "Discharge" means the termination of a period of inpatient care through the formal release of the patient by the nursing home, or as a result of the patient's death.

(5) "Medicaid conversion" means the shift in the patient's primary payment category from non-Medicaid to Medicaid, as a result of the patient's eligibility to the Medicaid program.

(6) "Nursing home" means a facility licensed under Chapter 400, Part I, Florida Statutes, and Chapter 10D-29, F.A.C. excluding facilities licensed under Chapter 651, Florida Statutes.

(7) "Primary diagnosis" means the first health impairment, or the mental or physical disorder indicated on the preliminary resident assessment and the preliminary care plan prepared pursuant to Chapter 10D-29.019(6), F.A.C.

Specific Authority 400.343 FS. Law Implemented 400.341-400.346 FS. History - New 09-24-86, Previously Numbered 27J-4.002.
10N-4.003 Patient Data Reporting Requirements.

(1) The "patient data form" is incorporated by reference as the form for use by nursing homes to file the required patient data. Copies of this form may be obtained by written request to: Nursing Home Reporting Administrator, Hospital Cost Containment Board, 325 John Knox Road, Suite L101, Tallahassee, Florida 32303.

(2) A patient data form shall be completed for each patient in a facility. The form consists of three parts:

(a) Part I – Admission: This part shall be completed for each patient in a facility who is admitted during the reporting period. It consists of:

1. a unique numerical patient identifier designed to protect the patient's anonymity;
2. date of birth;
3. date of admission;
4. location from which admission was made;
5. primary diagnosis at admission; and
6. source of financial support at admission.

(b) Part II – Medicaid: This part shall be completed if the patient becomes eligible for Medicaid subsequent to admission, or if a Medicaid patient loses eligibility for this program subsequent to admission. It consists of:

1. date of conversion to Medicaid;
2. amount spent on nursing home care at the facility prior to conversion to Medicaid by payor source;
3. date of conversion from Medicaid to another payor category; and
4. payor category immediately after loss of Medicaid eligibility.

(c) Part III – Discharge: This part shall be completed for each patient in a facility who is discharged during the reporting period. It consists of:

1. date of discharge;
2. reason for discharge; and

3. location to which patient is discharged.

(3) If a patient has been admitted more than once to the same facility, a new form shall be prepared for each admission.

(4) If a patient has converted to or from Medicaid more than once at the same facility, a new part II shall be prepared. Part I shall contain only the unique numerical patient identifier.

(5) The patient data transmittal record, incorporated by reference, shall be used by each facility to transmit the patient data forms. The patient data report required each reporting period.

(6) The reporting period for patient data shall be a calendar quarter, as follows:

(a) First quarter: January 1 to March 31;

(b) Second quarter: April 1 to June 30;

(c) Third quarter: July 1 to September 30 and;

(d) Fourth quarter: October 1 to December 31.

(7) By the 15th of the month following the end of a quarter, each nursing home shall submit to the Board or its designee the patient data report required under this section. This shall include the patient data forms for patients who have been admitted or discharged during the reporting period, or who have converted to or from Medicaid during the reporting period.

(8) The first patient data report required under this section shall include a patient data form on all patients on the July 1, 1986 census of the facility or admitted between that date and September 30, 1986. Medicaid conversion and discharge data (Parts II and III) shall also be included for those patients, if applicable. If the supply of forms are provided to the facilities before July 31, 1986, the patient data report shall be due at the board's office within 60 days of the facility's receipt of the form's supply. Otherwise the patient data report shall be due within 90 days of the facility's receipt of the form's supply.

Specific Authority 400.343 FS. Law Implemented 400.343 FS. History – New 09-24-86, Previously Numbered 27J-4.003.
10N-4.004 Financial Reporting Requirements.

(1) Each nursing home not certified by the Medicare (Title XVIII) or Medicaid (Title XIX) program shall submit to the Board not more than 120 days after the end of its fiscal year, its audited financial statements for the fiscal year then ended. The auditor's report shall be by a Florida licensed certified public accountant.

(2) Each nursing home certified by the Medicaid program shall submit to the Board copies of the Medicaid audit report, desk audit or concurrence letter within 30 days from the provider's receipt of the report or letter.

(3) Each nursing home certified by the Medicare program but not by the Medicaid program shall submit to the Board copies of the Medicare "Notice of Program Reimbursement," and supporting documentation within 30 days of the provider's receipt of the notice from the Medicare fiscal intermediary. Supporting documentation shall be in sufficient detail to identify adjustments to reported revenues and expenditures.

(4) In addition to the audit required above, each nursing home shall file financial report as required in the Board publication entitled "Nursing Home Financial Reporting System", which is incorporated by reference.

Specific Authority 400.343 FS. Law Implemented 400.343 FS. History - New - 02/04/87, Previously Numbered 27J-4.004.

10N-4.005 Special Information Requests.

In the event the board requires additional financial or statistical information or related interpretation to fully understand information provided by a nursing home or to meet the intent of the law, a written request detailing the additional information, together with a time period for response will be mailed to the nursing home.

Specific Authority 400.343, FS. Law Implemented 400.343, 400.344, 400.346 FS. History - New 09-24-86, Previously Numbered 27J-4.005.


(1) Every report provided to the board pursuant to Section 400.343, Florida Statutes, and Rule 10N-4.003 or 10N-4.004, shall be stamped by the agency clerk or other designated employee as to the date received by the board.

(2) Within forty (40) days after receipt of any report, the staff shall determine and notify the facility whether the report is complete and conforms to applicable statutory and rule requirements and shall verify the data contained therein.
(3) A report shall be deemed:

(a) "Complete" when it contains all data required by the board pursuant to Rule 10N-4.003 or 10N-4.004, whichever is applicable.

(b) "Conforming" when it has been prepared in the form and manner specified by the board and otherwise conforms to applicable statute and rule regarding reports in effect at the time such report was submitted to the board.

(c) "Verified" when the mathematical accuracy and general reasonableness of the data contained in the report have been substantiated through review of supporting reconciliation, as may be required.

Specific Authority 400.343 FS. Law Implemented 400.343 FS. History - New 09-24-86, Previously Numbered 27J-4.006.

10N-4.007 Notice of Deficiencies.

(1) The board shall provide written notice by certified mail or telegram to a nursing home if staff determines that a report has not been received, is incomplete, or fails to conform to applicable statutory, rule, or reporting instructions. The notice shall clearly indicate the deficiencies found, the corrections or modifications that must be made to make it complete or conforming, as well as the time by which a corrected or modified report must be received in the board's office.

(2) A nursing home shall have no fewer than ten (10) nor more than 30 working days following receipt of notice, to return to the board's office the requested corrected or modified report.

(3) If the corrected or modified report is not returned to the board within the specified time period, the entire report shall be deemed delinquent from the original due date.

Specific Authority 400.343 FS. Law Implemented 400.343, 400.344, 400.346 FS. History - New 09-24-86, Previously Numbered 27J-4.007.

10N-4.009 Change of Ownership.

(1) A change in ownership includes, but is not limited to, the acquisition of the nursing home by any person by any means, the leasing of the nursing home when the lessee agrees to undertake or provide services at the nursing home to the
extent that legal liability for operation of the nursing home rests with the lessee, conversion of the nursing home's type or kind of business organization as a proprietary, non profit or governmental entity, merger of the nursing home corporation into a new corporation, and consolidation of the nursing home corporation with one or more corporations resulting in the creation of a new corporation In an individual proprietorship or partnership, a change in nursing home ownership shall be deemed to occur with the sale, acquisition, assignment or other voluntary or involuntary transfer of a majority of the ownership or the controlling interest of the nursing home.

(2) The new owner, or prevailing entity, shall submit written notification of such change to the Board to the Board within 30 days of the change. The notification shall include identification of the new owner, any change of address of the new owner, the effective date of the change, any change in the fiscal year end, and such other information as may be necessary to identify the new owner.

(3) The facility shall file a financial report in accordance with rule 10N-4.004(4) covering the period from the beginning of the fiscal year to the day before the change in ownership and shall be due within 120 days of the change.

Specific Authority 400.343 FS. Law Implemented 400.343, 400.344 FS. History - New 09-24-86, Previously Numbered 27J-4.009.

10N-4.010 Penalties.

(1) (a) Any nursing home which refuses to file, fails to timely file, files a false report, files an incomplete report and upon notification fails to timely file a complete report or other information required to be filed under the provisions of Sections 400.341-400.346, Florida Statutes, or a rule adopted thereunder, shall be subject to a fine not to exceed $1,000 per day for each day of violation to be fixed, imposed and collected by the board as provided in subsection (2) of this rule.

(b) For purposes of this rule, a report or other information is "incomplete" when it does not contain all data required by the board pursuant to this chapter. A report or other information is "false" if done or made with actual knowledge that it is not true.

(c) When a nursing home refuses to file, fails to timely file or files false or incomplete reports or other information required to be filed under the provisions of Sections 400.341-400.346, Florida Statutes, or a rule adopted thereunder, administrative proceedings to impose fines
consistent with this rule shall be commenced immediately. When a nursing home timely files true and complete information in response to a board correction notice, no administrative action shall be commenced.

(2) Fines for designated circumstances shall not exceed $1,000 per day for each day of violation and shall normally be within the following amounts per each day of violation. If a report is false and also either complete or incomplete, add the penalties to determine the range.

(a) Timely Filing

<table>
<thead>
<tr>
<th>First Occurrence</th>
<th>Incomplete</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Reprimand</td>
<td>$250-375</td>
<td></td>
</tr>
<tr>
<td>Second Occurrence</td>
<td>$50-125</td>
<td>$375-500</td>
</tr>
<tr>
<td>Third Occurrence</td>
<td>$250-500</td>
<td>$1,000</td>
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</table>

(b) Untimely Filing

1. Failure to File on Time

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<thead>
<tr>
<th>First Occurrence</th>
<th>Complete</th>
<th>Incomplete</th>
<th>False</th>
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</thead>
<tbody>
<tr>
<td>$25-150</td>
<td>$50-125</td>
<td>$250-375</td>
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</tr>
<tr>
<td>$50-125</td>
<td>$125-175</td>
<td>$375-500</td>
<td></td>
</tr>
<tr>
<td>$250-500</td>
<td>$350-750</td>
<td>$1,000</td>
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2. Refusal to File on Time

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<tr>
<th>First Occurrence</th>
<th>Complete</th>
<th>Incomplete</th>
<th>False</th>
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</thead>
<tbody>
<tr>
<td>$50-125</td>
<td>$125-250</td>
<td>$250-375</td>
<td></td>
</tr>
<tr>
<td>$125-250</td>
<td>$250-375</td>
<td>$375-500</td>
<td></td>
</tr>
<tr>
<td>$500-750</td>
<td>$750-1,000</td>
<td>$1,000</td>
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</table>

(c) No Filing

1. Failure to File

<table>
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<tr>
<th>First Occurrence</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>$750-1,000</td>
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</tr>
</tbody>
</table>

2. Refusal to File

$1,000 per day for each day of violation for each occurrence.
(3) The board may increase or decrease the amount of fine but shall not impose a fine that exceeds $1,000 per day for each day of violation.

Appendix E
Revenue and Expenditure Charts
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
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<tbody>
<tr>
<td>Salaries</td>
<td>60,556</td>
<td>403,032</td>
<td>515,651</td>
<td>594,133</td>
<td>618,059</td>
<td>846,913</td>
<td>1,133,943</td>
<td>1,462,591</td>
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<td>OPS</td>
<td>158,000</td>
<td>45,721</td>
<td>49,919</td>
<td>19,856</td>
<td>30,243</td>
<td>125,088</td>
<td>199,325</td>
<td>401</td>
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<td>Expenses</td>
<td>63,955</td>
<td>153,939</td>
<td>158,986</td>
<td>142,292</td>
<td>176,937</td>
<td>286,979</td>
<td>422,249</td>
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<td>OCO</td>
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<td>27,351</td>
<td>1,497</td>
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<td>Investment Exp.</td>
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<td>131</td>
<td>131</td>
<td>131</td>
<td>131</td>
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<tr>
<td>Cart. Foward Operating Expenditures Paid from FY Approp.</td>
<td>16,328</td>
<td>8,246</td>
<td>977</td>
<td>7,726</td>
<td>13,588</td>
<td>10,014</td>
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<td>Transfers</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Refunds</td>
<td>2,123</td>
<td>6,278</td>
<td>4,651</td>
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<td>Service Chg to GR</td>
<td>93,712</td>
<td>120,511</td>
<td>87,549</td>
<td>196,871</td>
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<tr>
<td>Special-Imp of HB 1661</td>
<td>45,000</td>
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<td>Imp. of HB 931</td>
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<tr>
<td>Transfer to HRS/Health Manpower Planning</td>
<td>100,000</td>
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<td></td>
<td></td>
<td>200,000</td>
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<tr>
<td>Transfer to EOC/ Admin. Charge</td>
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<td></td>
<td></td>
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<td>0</td>
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<tr>
<td>Total</td>
<td>313,547</td>
<td>739,246</td>
<td>903,807</td>
<td>1,024,439</td>
<td>1,414,342</td>
<td>2,026,193</td>
<td>2,258,079</td>
<td>2,641,241</td>
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<th>Encumbrances</th>
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<td>OPS</td>
<td>94,516</td>
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<tr>
<td>Expenses</td>
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<td>OCO</td>
<td>1,295</td>
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<td>Total</td>
<td>103,327</td>
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### REVENUE

<table>
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<th></th>
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<tbody>
<tr>
<td><strong>Fees (Nursing Home Assessments)</strong></td>
<td>724,736</td>
<td>870,640</td>
<td>770,296</td>
<td>1,175,881</td>
<td>1,453,023</td>
<td>1,815,637</td>
<td>1,275,145</td>
<td>2,810,942</td>
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<tr>
<td><strong>Hospital Assessments</strong></td>
<td>3,084</td>
<td>4,016</td>
<td>13,946</td>
<td>20,671</td>
<td>50,750</td>
<td>73,617</td>
<td>4,6959</td>
<td>44,782</td>
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<tr>
<td><strong>Miscellaneous (Various)</strong></td>
<td>11,335</td>
<td>58,689</td>
<td>81,043</td>
<td>69,912</td>
<td>88,179</td>
<td>142,141</td>
<td>68,599</td>
<td>44,782</td>
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<tr>
<td><strong>Interest (on Investments)</strong></td>
<td>29</td>
<td>31</td>
<td>177</td>
<td>12,483</td>
<td>8,573</td>
<td>902</td>
<td>27</td>
<td>902</td>
</tr>
<tr>
<td><strong>Prior Year Refunds</strong></td>
<td>50</td>
<td>15</td>
<td>15</td>
<td>27</td>
<td>27</td>
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8/24/87  
87a
Appendix F

Budget Review Chart
GR/AA = Gross Revenue Per Adjusted Admission
MARI = Maximum Allowable Rate of Increase
NHPI = National Hospital Input Price Index


APPENDIX F
Appendix G

Sunset Questionnaire
FLORIDA SENATE QUESTIONNAIRE

Prepared Pursuant to the Sunset Act, Chapter 395 Part II, Florida Statutes

Office of the Governor - Health Care Cost Containment Act

1. Please identify all sections of the Florida Statutes which relate in any way to the Hospital Cost Containment Board.

2. Why was the Board created? (Please attach any reports, correspondence, or issue papers documenting the need for the Board.)

3. Please provide an explanation of the legislative history of the creation and operation of the Board. In addition, please provide an explanation of the operation of the Act as a whole.

4. Identify and explain briefly any Federal law related to the Board or its area of responsibility.

5. What powers and responsibilities does the Board have? Please list statutory responsibilities as well as responsibilities that may be conferred by the relevant executive agency.

6. Please attach a copy of all rules and proposed rules related to the Act and its area of responsibility (including Florida Administrative Code).

7. Explain any objection by the Joint Administrative Procedures Committee to any rule or proposed rule related to the Board and its area of responsibility.

8. Please provide a copy of any and all related Federal regulations.

9. Please attach a list of current Board member names along with their addresses, terms of appointments, total number of years served, and profession or industry they each represent.
10. Describe the relationship between the Board and the executive agency.

11. If the agency provides staff support to the Board, identify the staff, describe their functions, and estimate the amount of time devoted to the Board annually.

12. If the Board employs staff, please identify each position authorized and show the salary and duties of each.

13. List the amounts and sources of all funds received by the Board for each of the last five years.

14. Describe the Board's expenses and expenditures for each of the last five years.

15. Describe all services purchased on an OPS or contract basis, their cost and purpose, and identify any appropriations or other source of funds earmarked for such services.

16. Identify any national or state organization or agencies with which the Board has an affiliation.

17. Please provide all agendas, minutes, and attendance records for the Board for the past five years.

18. Please cite and explain the goals of the Board. Provide documentation as available.

19. Please provide a list of all formal Board recommendations presented to the Legislature and show which ones were adopted.

20. Please provide a list of all formal Board recommendations presented to the executive agency over at least the past five years (by year) and show which ones were adopted.
21. Describe the accomplishments of the Board during the past five years and how these accomplishments relate to the stated goals of the board.

22. How does the existence of this Act benefit the public?

23. How would the public be affected by the abolishment of this Act?

24. How would the agency be affected by the abolishment of this Act?

25. If the Board were abolished what regulatory effect, if any, would this act retain?

26. Assess the effectiveness of the Board over the last five years and suggest any improvements or desired legislative action. Provide explanation of and reasons for any desired legislative action.

27. Please provide the agency's position on the Sunset of this Act.

28. Please identify all Attorney General Opinions and case laws which relate to this Act.
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**PRIME BILL TITLE (short title)**

Affordable Health Care

**SIMILAR/IDENTICAL BILL SUBSTITUTED BY PRIME BILL:**

88/S0904

**DOCUMENTATION REPRODUCED**

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**NOTE:** Consult the Final Legislative Bill Information (from Joint Legislative Management Committee, Division of Legislative Information, 1988) for more detailed bill history data. If prime bill number above is followed by an asterisk (*), it was amended on the floor, and the staff analysis for that bill may not be in accordance with the enacted law. The analyses reproduced here were supplied by the appropriate committee, who is solely responsible for their accuracy and completeness.

**ADDITIONAL INFORMATION:**

(FRM 25-12/88)
I. SUMMARY:

This bill reenacts the Hospital Cost Containment Board with its regulatory powers, establishes a funding source for the Statewide Health Council and the local health councils, and creates a State Center for Health Statistics within the Department of Health and Rehabilitative Services. In addition, the bill provides for three studies: A study to develop the components for a Florida-specific hospital input price index, and a severity of illness index; a study to evaluate and make recommendations on the shortage in the supply of registered nurses; and, a study to look at the fiscal impact on hospitals in Florida providing health care services to migrant and rural farmworkers.

A. PRESENT SITUATION:

Chapter 395, Part II and the Hospital Cost Containment Board are scheduled to Sunset Review pursuant to s. 11.61, F.S., on October 1, 1988, subject to Legislative review and re-enactment. Part II of Chapter 395, F.S., relates to hospital cost containment, and creates the Hospital Cost Containment Board (or board). The stated purpose of the board is to advise the Legislature on health care costs and inflationary trends in health care; to educate consumers and perform other related tasks. Another major function of the board is to review and approve hospital budgets. Each hospital is required to annually submit to the board two detailed financial statements: a projected budget, submitted 90 days prior to the beginning of each hospital's fiscal year; and a report of actual experience, submitted to the board within 120 days after the end of each hospital's fiscal year. The board reviews each hospital's projected budget based on a comparison to the hospital's previous actual experiences, and a comparison to the
performance of other hospitals of similar type. Hospitals with
budgets which exceed certain standards are subjected to detailed
review by the board.

The board was given authority in 1984 as a result of the Health Care
Access Act (Chapter 84-35, Laws of Florida), to approve, to
disapprove, or to disapprove in part, hospital budgets based on an
established maximum allowable rate of increase (MARI) for hospital
gross revenue. If a hospital's gross revenue per adjusted admission
(average charge per admission) is in the lower 50 percent of its group
or, the lower 80 percent of its group and the hospital has a rate of
increase in gross revenues below the MARI, then the hospital's budget
is approved without further action by the board. All other hospitals
must have their budgets approved by the board, based on patient-payor
mix or other standards listed in the law. The law provides penalties
for hospitals which exceed the MARI or their approved budgets.
Penalties include a prospective reduction to the hospital's budget,
fines to be paid into the Public Medical Assistance Trust Fund and
possible revocation of a hospital's license.

The membership of the board consists of 11 members which are appointed
by the Governor and confirmed by the Senate. Four members of the
board are consumers, four members are providers (two of whom must
represent hospitals, one of whom must be a nursing home provider) and
3 members are purchasers.

Sections 400.341 - 400.346, Florida Statutes, require the Hospital
Cost Containment Board to collect and disseminate information relating
to nursing home charges.

The Statewide Health Council and the local health councils are
currently funded from a State Trust Fund accrued through fees charged
to Certificate-of-Need (CON) applicants. The cost to continue these
councils is approximately $2.3 million per year. The recent
relaxation of CON requirements has cut the number of applications, and
therefore, the fees from those applications resulting in a projected
$1.2 million shortfall for fiscal year 1988-89.

Except for the Hospital Cost Containment Board's financial data bank
on hospital's and nursing home charges, a comprehensive, accessible
and centralized health care information system is unavailable.

B. EFFECT OF PROPOSED CHANGES:

This bill re-enacts Chapter 395, Part II, Florida Statutes relating to
the Hospital Cost Containment Board which was scheduled to be repealed
on October 1, 1988 pursuant s. 11.61, F.S. The bill accomplishes this
by transferring the entire part into a newly created chapter, (Chapter
407), and rearranging, amending, and renumbering the sections. In
addition, sections 400.314 - 400.246, Florida Statutes relating to
nursing home reporting are also transferred, renumbered and amended
into Chapter 407, F.S. The chapter is titled Health Care Cost
Containment, and the name of the Hospital Cost Containment Board has
been changed to the "Health Care Cost Containment Board."
This bill simplifies and streamlines the methodology by which a hospital would have to file its annual budget with the board, and be subject to detail budget review or penalties. Specifically, the bill changes the budget review process in 10 major ways.

1. Subjects all hospitals to budget review if they exceed the maximum allowable rate of increase (MARI) with the exception of those hospitals exempted under current law, the Florida Elks Children's Hospital, and certain rural hospitals.

2. Requires only hospitals requesting an increase in charges (gross revenues per adjusted admission, GR/AA) which exceed the MARI or, are requesting budget amendments which would cause the hospital to exceed the MARI, to file projected budgets and be subject to detailed budget review.

3. Hospitals not requesting increases above the MARI only file a "budget letter" which stipulates what the hospital's projected GR/AA for its next fiscal year will be, and affirms that the hospital intends to stay within the MARI for its group.

4. Allows a hospital, whose actual audited experience at the end of the fiscal year indicates it came in below the MARI, to "bank" up to a cumulative total of 3 percentage points to be used in the future.

5. Changes the definition of maximum allowable rate of increase (MARI), by allowing hospitals to increase charges by the market basket index (currently the National Hospital Input Price Index, NHIPI) plus two points as the base, and then allows for additional points to be added to the base depending on each hospital's specific experience by giving 50% credit for the proportion of Medicare days to total days, 100% credit for uncompensated charity care days to total days, and 100% credit for the proportion of Medicaid days to total days.

6. Allows budget amendments to be retroactive in certain circumstances.

7. Prioritizes review criteria ranking reasonable rate of return as the first priority, and allows the hospitals to use this criteria to justify increased charges.

8. Gives the board some discretion in using review criteria to evaluate penalty situations.

9. Allows a hospital which had increases in net revenue below the NHIPI plus 2 percentage points to bank up to a cumulative maximum of 3 net revenue percentage points to be used to offset any future year penalties for exceeding the MARI.

10. Shortens the timeframe the board has to approve a budget subject to budget review, from 120 to 90 days.

The bill also changes the current law by decreasing the number of members on the board from 11 to 9 members. The new board will consist
of three providers, including one representative of the for-profit hospitals, one representative of the not-for-profit hospitals and one representative of the nursing home industry; three members who are major purchasers of health care; and, three members who are consumers, provided, one consumer member must be 60 years of age or older. Finally, the bill provides for another Sunset Review of the Health Care Cost Containment Act (Chapter 407, F.S.) in 1992.

The bill provides for a three-part 18 month study to be conducted by the State's University System, to determine a Florida specific measure of hospital expenses (Florida Hospital Input Price Index or FHIPI). The study would also provide recommendations on a methodology and reporting system to measure the impact of changes in reimbursement levels from all government payers, to make recommendations for a statistical measure or index for severity of illness for acute care hospitals and, to make a separate recommendation for a severity index for psychiatric hospitals.

In addition, the bill directs the Health Care Cost Containment Board to conduct a study of the shortage in the supply of registered nurses and a study on the fiscal impact on hospitals for providing health care services to migrant and rural farmworkers.

A funding source for the Statewide Health Council and the local health councils is also established within the bill to supplement the declining certificate-of-need application fees. The bill provides for assessments on all health care facilities subject to licensure and is estimated to generate approximately $1,193,350. Hospitals, nursing homes and Medicare certified home health agencies are assessed an annual fee of $500.00, and all other health care facilities are assessed $150.00. The department is directed to establish rules to implement this provision.

Finally, the bill creates a State Center for Health Care Statistics with responsibilities to develop a comprehensive information system which may be utilized by the Legislature, other state agencies, and private and public entities. A 13 member advisory council is established to assist the department in reviewing and making recommendations concerning the information system.

C. SECTION-BY-SECTION ANALYSIS:


Section 2. Amends, transfers and renumbers s. 395.502, F.S., relating to definitions, to s. 407.002, F.S. Changes the definition of "Board" from Hospital Cost Containment Board to Health Care Cost Containment Board. Changes the definition of "maximum allowable rate of increase" (MARI), by establishing a base index to which a hospital specific adjustment can be added, to reach an individual MARI for each hospital. Adds a definition of "rate of return" which may include, but not be limited to four financial indicators which the board would use to determine reasonableness of the financial requirements of a hospital, and adds a definition for "rural hospital."
Section 3. Amends, transfers and renumbers s. 395.5025, F.S., relating to the Legislature's intent, to s. 407.003, F.S. Broadens the intent of the board: to promote improved consumer and purchaser understanding of government funded programs and third party reimbursement; and to recommend to the Legislature appropriate strategies to foster health care cost containment and improve access. Declares that the rising cost of health care, and cost shifting and cross subsidization by hospitals to increase revenues regardless of the cause, is of vital concern to the people of the state.

Section 4. Amends, transfers and renumbers s. 395.503, F.S., relating to the Hospital Cost Containment Board, to s. 407.01, F.S. Changes the name to Health Care Cost Containment Board. Determines board shall be a separate budget entity from the Department of Health and Rehabilitative Services and that the executive director shall be its agency head for all purposes, except for matters involving chapter 120, F.S. In such cases, the board shall act as the agency head. Decreases membership from 11 to 9 members effective with appointments after January 1, 1989. Changes the board makeup to 3 providers, one of which is a representative of the for-profit hospitals, one of which is a representative of the not-for-profit hospitals, and one of which is a representative of the nursing home industry; 3 consumers, one of which is 60 years of age or older; and 3 major purchasers.

Section 5. Amends, transfers and renumbers s. 395.504, F.S., dealing with powers and duties of board, to s. 407.02, F.S. Limits board's authority to approve, amend or disapprove budgets to only those hospitals requesting increases above the maximum allowable rate of increase (MARI). Strikes and transfers the language dealing with publishing physician data obtained from the Department of Insurance to s. 407.70, F.S. Empowers the board to investigate consumer complaints regarding problems with hospital billing practices and to issue reports in cases where the board determines the hospital engaged in unreasonable and unfair billing practices.

Section 6. Creates a new section 407.025, F.S., providing immunity to hospitals and other reporting entities for providing patient data to the board.

Section 7. Amends, transfers and renumbers s. 395.505, F.S., relating to rules to s. 407.03, F.S. Makes technical changes to replace the word "part" with the word "chapter".

Section 8. Amends, transfers and renumbers s. 395.5051, F.S., relating to effect of act on existing rules, to s. 407.035, F.S. Provides that nothing contained in the act would change rules promulgated to enact chapter 84-35, Laws of Florida, unless in direct conflict with this act. Provides that all budgets or budget amendments beginning prior to February 1, 1989 shall be filed and reviewed subject to chapter 84-35, Laws of Florida.

Section 9. Amends, transfers and renumbers s. 395.512, F.S., relating to the budget of the board to s. 407.04, F.S. Requires the board to submit its final legislative budget request directly to the Governor by November 1 of each even numbered year.
Section 10. Amends, transfers and renumbers s. 395.507, F.S., relating to uniform system of financial reporting for hospitals, to s. 407.05, F.S. Requires only hospitals requesting approval of a rate of increase in gross revenue per adjusted admission (GR/AA) in excess of the maximum allowable rate of increase (MARI) to file budgets for detailed review. Allows for the establishment of not more than 15 groups for the purpose of comparison in the budget review process.

Section 11. Amends transfers and renumbers s. 395.514, F.S., relating to hospital violation of rules, to s. 407.06, F.S. Makes technical changes by correcting references from violations of "part" to violations of "chapter".

Section 12. Amends, transfers and renumbers s. 395.508, F.S., relating to hospital costs and finances; analysis, studies and reports, to s. 407.07, F.S. Changes section title from "hospital" to "health care". Adds authority for board to study effects of Medicare, Medicaid and other government reimbursement mechanisms. Gives the board authority to conduct analysis and research on impact of uncompensated care on hospital budgets. Gives the board authority to conduct analysis and research on the state's role in funding indigent care.

Section 13. Amends, transfers and renumbers s. 395.513, F.S., relating to program accountability, to s. 407.08, F.S. Expands the requirements of the board's annual report to include an analysis of the reasons for existing levels of cross subsidization. Expands the report to include the extent to which public funding policies may be affecting health care costs. Also expands the report to include the extent to which other factors, such as uncompensated care, skilled employee shortages, changes in technology and shifts from institutional to ambulatory care may be affecting health care costs.

Section 14. Amends, transfers and renumbers s. 395.5085, F.S., relating to collection and dissemination of hospital charge information, to s. 407.09, F.S. Allows board to distribute information utilizing the Consumer Information and Advisory Council created in s. 407.10, F.S., or by any other appropriate means available. Strikes language relating to Consumer Information Network and moves most of the language into s. 407.10, F.S.

Section 15. Creates s. 407.10, F.S., relating to the Consumer Information and Advisory Council, previously known as the Consumer Information Network. In addition to responsibilities previously handled by Consumer Information Network, it allows the council to conduct or sponsor consumer information or education seminars at locations throughout the state. It further gives the Council authority to hold public hearings in order to solicit consumer concerns or complaints relating to health care costs and as a result of those hearings, make recommendations to the board for study, action or investigation.

Section 16. Amends, transfers and renumbers s. 395.5042, F.S., relating to the Office of Technical Assistance, to s. 407.11, F.S. Expands the responsibilities of the office to include: developing cost containment strategies for providers, employers and consumers;
serving as a clearinghouse for information concerning federal and state legislative initiatives affecting health care delivery system and government health care programs; and, developing an outreach program to assist small business to include cost containment initiatives for small business insurance plans.

Section 17. Transfers and renumbers s. 395.511, F.S., relating to quality assurance monitoring to s. 407.12, F.S. Requires hospitals to maintain a quality assurance program and make quality assurance plans available to the board upon request. Allows the board to request information from the Department of Health and Rehabilitative Services, the Department of Professional Regulation, and the Department of Insurance which would enable it to monitor a hospital's quality assurance.

Section 18. Amends, transfers and renumbers s. 395.515., F.S., relating to prospective payment arrangements, to s. 407.13, F.S. Provides for technical changes to name of board.

Section 19. Amends, transfers and renumbers s. 400.341, F.S., relating to legislative intent - nursing home costs, to s. 407.30, F.S. Provides for technical changes.

Section 20. Amends, transfers and renumbers s. 400.343, F.S., relating to uniform system of financial reporting for nursing homes to s. 407.31, F.S. Provides technical changes in statutory cites.

Section 21. Amends, transfers and renumbers s. 400.344, F.S., relating to nursing home revenues and financial analysis, studies and reports, to s. 407.32., F.S. Provides technical changes relating to other statutory cites. Allows the board to prepare and file supplementary studies and reports based on information analyzed relating to nursing home data.

Section 22. Amends, transfers and renumbers s. 400.345, F.S., relating to nursing home assessments to fund the budget of board to conduct nursing home financial disclosure program, to s. 407.33., F.S. Provides for technical changes.

Section 23. Amends, transfers and renumbers s. 400.346, F.S., relating to nursing homes violations of law or rules, to s. 407.34, F.S. Provides technical changes to other statutory cites.

Section 24. Substantially amends, transfers and renumbers s. 395.509, F.S., relating to review of hospital budgets, to s. 407.50, F.S. Eliminates hospitals from filing a detailed budget with the board unless the hospital wishes to exceed the maximum allowable rate of increase (MARI). Requires, as an alternative, for hospitals to file a "budget letter" which specifies what the hospitals expected gross revenues per adjusted admission will be for its next fiscal year, and a statement affirming it intends to stay within the MARI. Requires all hospitals which exceed the MARI, either through submission of a budget request or by filing a budget amendment, to be subject to detailed budget review regardless of where they fall in their group. Allows hospitals staying below the MARI to "bank" percentage points to be used in the future, up to a cumulative maximum of 3 points.
Changes the "a" through "k" review criteria and prioritizes them. Exempts from budget review the Florida Elks Children's Hospital, certain rural hospitals, those hospitals exempted under current law, and any hospital in which at least 90 percent of its admissions are contracted through a prospective payment system.

Section 25. Amends, transfers and renumbers s. 395.5094, F.S., relating to exceeding approved budget and penalties, to s. 407.51, F.S. Retains current law which places a hospital in a potential penalty situation when its actual net revenues per adjusted admission exceed the previous year's actual by more than the MARI, or exceed the projected budget as approved by the board. Requires the board to establish a proxy for psychiatric case mix to reduce the amount of excess a psychiatric hospital may be liable for. Allows the board to reduce a hospital's excess in certain unforeseen circumstances which occurred in the last three months of a hospital's fiscal year or, if the imposition of the penalty would have a severe adverse effect which would jeopardize the continued existence of an otherwise economically viable hospital. Allows a hospital whose increase in net revenues was less than the NHIPI plus 2 percentage points, to bank up to a cumulative maximum of 3 net revenue percentage points to be used to offset any future year penalties for exceeding the MARI.

Section 26. Transfers and renumbers s. 395.5125, F.S., relating to operating costs; non-deductible items, to s. 407.52, F.S. Leaves the original language intact.

Section 27. Transfers and renumbers s. 395.5135, F.S., relating to burden of proof, to s. 407.53, F.S. Leaves the original language intact.

Section 28. Amends, transfers and renumbers s. 395.5092, F.S., relating to duty of Public Council; to s. 407.54, F.S. Clarifies that Public Council may represent consumers before the board, its advisory panels, in administrative hearings or before any other state and federal agencies or courts in any issue related to budget review.

Section 29. Amends, transfers and renumbers s. 395.52, F.S., relating to information on physician's charges, to s. 407.70, F.S. Moves current language dealing with physician information to this section. Specifically, it exempts physicians from any provisions of this act if the physician bills his services independently of the hospital. Requires board to publish an annual report containing available physician charge comparisons from information obtained by insurers. Requires insurers to submit physician data directly to the Health Care Cost Containment Board instead of being reported to the Department of Insurance.

Section 30. Requires the board to contract with the State University System to conduct a study which would develop and recommend a Florida specific hospital input price index (FHIPI) to measure hospital expenses and, a statistical indicator or index to measure severity of illness for acute care hospitals and psychiatric hospitals.
Section 31. Requires the Health Care Cost Containment Board to conduct a study of the shortage in the supply of registered nurses by February 1, 1990.

Section 32. Requires the Health Care Cost Containment Board to conduct a study by January 31, 1989 on the impact on hospital for providing health care services to migrant and rural farmworkers.

Section 33. Repeals section 24, chapter 82-182, Laws of Florida, relating to Sunset Review of chapter 395, Part II, Florida Statutes, and reenacts the Hospital Cost Containment Board as amended and transferred to chapter 407, F.S.

Section 34. Provides that Chapter 407 shall stand repealed on October 1, 1992, subject to future review of the Legislature pursuant to s. 11.61, F.S.

Section 35. Amends s. 381.703, F.S., relating to funding the Statewide and local health councils. Provides for assessments on all health care facilities subject to licensure to help fund the councils. Assesses hospitals, nursing homes and Medicare certified home health agencies an annual fee of $500.00, and all other facilities $150.00. Directs the department to establish rules to implement this provision.

Section 36. Repeals s. 400.342, F.S., relating to definitions for nursing home financial reporting. Incorporates it into the definition section of s. 407.002, F.S. Repeals s. 627.9175(3), F.S., relating to the requirement insurers provide data on physician charges to Department of Insurance. Reports will now be made directly to the Health Care Cost Containment Board.

Section 37. Establishes appropriation language to fund budget issues which were incorporated into the bill after the Appropriations Bill had passed out of Appropriations Committee.

Section 38. Establishes legislative intent for the Center for Health Statistics. Provides that information compiled by the comprehensive health information system be made available to interested persons to improve decision-making processes, and to require providers and other health care related entities to provide information necessary to operate the comprehensive health information system.

Section 39. Establishes the Center for Health Statistics within the Department of Health and Rehabilitative Services to collect and disseminate data on health care status, resources, costs, trends and other areas relating to funding and providing health care services to residents of the state. Provides that the department create a comprehensive health information system to coordinate the data collection efforts of other state local and federal agencies. Provides that funding to operate the center shall come from fees, grants and appropriations from the General Revenue Fund to be deposited into the Comprehensive Health Information System Trust Fund. Creates a 13 member state comprehensive health information system advisory council to assist the center in reviewing the comprehensive health information system and to recommend improvements for such system. Provides qualifying language which precludes the center from...
restricting, affecting, or controlling the collection, analysis, release or publication of data pursuant to the Health Care Cost Containment Act as passed in this bill, or by any other state agency pursuant to its statutory authority, duties or responsibilities.

Section 40. Instructs the Division of Statutory Revision and Index of the Joint Legislative Management Committee to prepare a reviser's bill for submission to the 1989 regular session to conform cross-references, to renumber sections, and to replace the name of the "Hospital Cost Containment Board" to Health Care Cost Containment Board wherever it appears in statutes.

Section 41. Provides that October 1, 1988 is the effective date unless otherwise provided within the bill.

II. FINAL FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:
(Prepared by Committee on Health Care)

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

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B. FISCAL COMMENTS:
(Prepared by Committee on Health Care)

Hospitals currently submitting budgets within the MARI should realize cost savings because they would no longer be required to submit budgets. Because all budgets exceeding the MARI would be subject to budget review under this bill versus less than 50 percent under the current system, hospitals not previously subject to board scrutiny in the past because of where they fell within their group may incur additional costs for justifying their need for increases above the MARI. Assuming one-half of the 293 hospitals which filed budgets in fiscal year 1987-88 did not exceed the MARI, there is potential for administrative cost savings of approximately 15 to 25 percent.

No monies were appropriated in this bill or in the Appropriations Bill which were specifically allocated to fund the State Center for Health Statistics. It is assumed that the Department of Health and Rehabilitative Services would need to create the Center within its currently available resources, which would include any fees, grants or donations it is authorized by the bill to accept. The department estimates that 20 positions and $700,000 would be required to fully fund the center. This figure does not include resources for the computer and software requirements which will undoubtedly be necessary to implement the comprehensive health information system called for in the legislation.

III. LONG RANGE CONSEQUENCES:

The reenactment of Chapter 395, Part II, Florida Statutes (proposed Chapter 407, Florida Statutes) is consistent with the State Comprehensive Plan which sets as a goal the need to help assure access to affordable, quality health care and to reduce health care cost as a percentage of the total financial resources available to the state and its citizens. The long range impact of keeping a process in place which requires hospitals to justify any increase in charges over certain established thresholds should provide some assurance that the ratio between costs and charges for hospital care is fair and equitable, and that the public's right to affordable health care is protected. This assurance becomes even more critical at least until the current volatile and rapidly changing health care delivery system begins to settle down and stabilize. The Center for Health Statistics has the potential for providing data which will assist planners and economists over the long term to better manage the health care resources available to the state and the private sector.

IV. COMMENTS:

Clearly the most controversial sections of this bill deal with the Health Care Cost Containment Board, and specifically with the regulatory powers conferred on the Board. The major debate has centered on 4 major issues.

GROSS VERSUS NET REGULATION - The first and probably the most important issue is whether to regulate hospitals on "gross revenues" or "net revenues." In hospital "lingo," gross revenue means the
amount the hospital charges to patients, regardless of who pays the bill. This number is consistent across all payor groups within the hospital, and it is the number from which all revenue deductions are subtracted. Net revenue means the amount of money a hospital actually collects from all patients. This number is not consistent among payor groups and can vary significantly depending on who is paying or not paying the bill. For example, Medicare pays based on a fixed fee per diagnosis and ignores charges; charity care patients often pay nothing; and PPO and HMO payors usually pay a discounted rate. The shortfalls from these discounted payors are often cost-shifted into the gross revenue charged to private pay and insured patients.

Under the current regulatory system, which is based on gross revenues, the amount a hospital can increase charges and cost-shift the increase to private or full pay patients is limited. This is the case, because the increase in charges is capped equally to all payor groups, regardless of what percentage the patient pays. For example, if a 10 percent increase in gross revenues is allowed, the maximum a private or full pay patient's charges can be increased is 10 percent.

Under a net review system, there is no limit on the amount a hospital can increase gross revenues (charges), and cost-shift the increase to the private pay patient. Net revenue regulation only controls the amount the hospital can collect. Because a hospital collects different revenues from each payor group, and in charity cases no revenues, the effect of a 10 percent increase in allowable collections would permit the hospital to charge the private pay patients whatever the market will bare to make up for the shortfalls in other payor collections. The practical result is no regulation of charges at all. This bill retains regulation on gross revenue.

**MARI** - The maximum allowable rate of increase or MARI is the threshold established in law which, if exceeded by certain high charge hospitals, would place the hospital in a detailed budget review situation. The bill allows a hospital to increase its charges above the MARI if it can justify to the board that the increase is reasonable and necessary. Current law establishes the MARI at the national hospital input price index (NHIPI) plus 3 points to reflect the higher cost of providing services in Florida. The hospital industry has argued for significant increases in the MARI, which would effectively reduce the number of hospitals exceeding the threshold. These hospitals, therefore, would not be required to justify increases in charges. The bill provides for a base MARI, which is set at the NHIPI (the national inflation index for hospital's cost) plus 2 additional points. Added to this, the bill allows for additional points to be added, on a hospital specific basis, which would give a hospital credit for 100 percent of the Medicaid and charity care days it provides, and 50 percent credit for the number of Medicare days it provides. The practical effect of computing the MARI in this manner is that it allows those hospitals providing charity care, Medicaid and Medicare to increase charges at a higher rate to cover the cost of providing those services, but does not allow a hospital to cost shift to the private pay patients the losses from its bad debts, contractual discounts to HMO's and PPO's, courtesy discounts, or 50 percent of its Medicare days. The average
MARI computed by the board on this model, based on 1986 actual audited data, was 9.8 percent. This compares to an average rate of increase of approximately 13.7 percent for the same fiscal year for all hospitals (regulated and unregulated), under the current MARI for the same time period.

REGULATE ALL VERSUS ONLY SOME HOSPITALS - Under the current law, hospitals ranked in the lower 50th percentile based on gross revenues per adjusted admission, are not subject to budget review and, another 30% of higher charge hospitals can escape budget review if they stay within the MARI. For non-regulated hospitals falling below the 50th percentile, the mean budgeted rate of increase in charges from 1987 to 1988 was 19.0% compared to an average mean of 8.5% for hospitals subject to regulation. This trend has persisted since the budget regulation authority was imposed on the board. The expectation that competition, rather than regulation, would help to contain increases in charges has apparently not materialized. This is evidenced by rates of increase by non-regulated hospitals equating to twice as high as increases in regulated hospitals. When analyzing the projected rates of increase from 1987-1988, it is clear that the 85 hospitals between the 50th and the 80th percentile were constrained by the MARI threshold. When the case mix allowance, (which can be added to the MARI under board rule without triggering a budget review), was deducted from the hospitals projected rate of increase, 47 hospitals submitted their budgets directly at the MARI; 9 hospitals submitted their budgets at one percent below the MARI; and, 8 hospitals submitted budgets at three percent below the MARI. In total, after deducting the case mix add-on only 9 out of the 85 hospitals falling within this range submitted budgets with rates of increases above the MARI. By staying within this threshold, all these hospitals were able to escape detailed budget review thus affirming the board's sentinel effect over rates of increase. This bill would exempt only hospitals not subject to review under current law, certain rural hospitals, the Elks Children's Hospital and hospitals with prospective payment arrangements affecting 90 percent of their patients.

COMPOSITION OF BOARD - The fourth major area of controversy focuses on the make-up of the board. The American Association of Retired Persons and the Commissioner of Insurance strongly support an autonomous full-time, non-provider board. Arguments focus on the fact that the current board appears to be provider dominated, and cannot be an effective advocate for the health care consumers. The current 11 member board consists of one member employed by a for-profit hospital chain, one member employed as an administrator of a not-for-profit hospital, one consumer member who was a former hospital administrator, one consumer member who was a former trustee on the board of a hospital, and one purchaser member who was a former finance office for a hospital. In addition, hospitals provide significant representation on various technical advisory panels which make policy recommendations to the board. The bill provides for a nine member part-time board consisting of 3 providers.
V. BILL HISTORY:

4/6/88 Passed out of Health Financing Subcommittee as HC PCB 88-08 with 10 amendments. Amendments included provisions which would make the board a 3 member full-time board, and defined MARI as the NHIPI with no additional percentage points.

5/3/88 Passed out of Health Care Full Committee with 13 amendments. Amendments reverted back to a part-time nine member board, set MARI at what was passed in final version of bill, and added the "Rural Hospital Act" (HC PCB 88-09).

5/11/88 Introduced as HB 1673 and referred to Appropriations Committee

5/17/88 Amended and passed out of Appropriations as a Committee Substitute. Amendments included the addition of HB 1561 (Nurse Shortage Study).

5/24/88 Passed House (111 yeas, 3 nays), placed in Senate messages.

5/30/88 Amended and substituted for SB 904, and passed Senate as amended (37 yeas, 0 nays). Removed the indigent care components of the bill (see CS/CS/SB 534), and added the Center for Health Statistics and funding for the Statewide and local health councils.

5/31/88 Amended and passed the House (115 yeas, 0 nays).

6/2/88 Amended and passed the Senate (36 yeas, 0 nays).

6/3/88 House concurred in Senate Amendments (113 yeas, 0 nays) Ordered engrossed and then enrolled.

VI. SIGNATURES:

SUBSTANTIVE COMMITTEE:
Prepared by: Cath ee Herndon

Staff Director: Michael P. Hansen

FINANCE & TAXATION:
Prepared by: 

Staff Director:

APPROPRIATIONS:
Prepared by: Lynn Dixon

Staff Director: James A. Zingale

STANDARD FORM 5/88
A bill to be entitled
An act relating to health care cost
containment: amending ss. 395.501, 395.502,
395.5025, 395.503, 395.5042, 395.508, 395.5094,
395.512, 395.513, 395.515, F.S.; renaming the
Health Care Cost Containment Act of 1979;
redesignating the Hospital Cost Containment
Board as the Health Care Cost Containment Board
and the Hospital Cost Containment Trust Fund as
the Health Care Cost Containment Trust Fund;
providing additional legislative intent,
providing additional duties for the Health Care
Cost Containment Board; deleting obsolete
language; creating s. 395.5065, F.S.; providing
immunity from civil liability and criminal
penalties for certain actions taken with
respect to reporting patient or financial data;
amending ss. 112.153, 119.07, 215.22, 381.601,
381.703, 395.017, 395.101, 400.341, 400.342,
400.345, 400.609, 409.2663, 440.13, 627.9175,
F.S.; conforming such sections to the
redesignations of the Hospital Cost Containment
Board and Hospital Cost Containment Trust Fund;
reviving and readopting ss. 395.501, 395.502,
395.5025, 395.503, 395.504, 395.505, 395.507,
395.508, 395.5085, 395.509, 395.5092, 395.5094,
395.511, 395.512, 395.5125, 395.513, 395.5135,
395.514, 395.515, F.S., which sections were
scheduled for repeal pursuant to the Regulatory
Sunset Act; repealing ss. 395.502, 395.502,
395.5025, 395.503, 395.504, 395.5042, 395.505,
...
Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.501, Florida Statutes, is amended to read:

395.501 Short title.--This part shall be known and may be cited as the "Health Care Cost Containment Act of 1979."

Section 2. Subsection (3) of section 395.502, Florida Statutes, is amended to read:

395.502 Definitions.--As used in this act, the term:

(3) "Board" means the Health Care Cost Containment Board created by s. 395.503.

Section 3. Section 395.5025, Florida Statutes, is amended to read:

395.5025 Legislative intent to assure affordable health care.--It is the intent of the Legislature to assure that adequate health care is affordable and accessible to all the citizens of this state. To further the accomplishment of this goal, the Health Care Cost Containment Board is created to advise the Legislature regarding health care costs; inflationary trends in health care costs; the impact of health care costs on the state budget; the impact of hospital charges and third-party reimbursement mechanisms on health care costs; to educate and the education of consumers and providers of health care services in order to encourage price competition in the health care marketplace; and to promote improved
consumer understanding of government health care funding and third-party reimbursement. The Legislature finds and declares that rising hospital costs and cost shifting are of vital concern to the people of this state because of the danger that health care hospital services are becoming unaffordable and thus inaccessible to residents of the state. It is further declared that hospital costs should be contained through improved competition between hospitals and improved competition between insurers, through financial incentives which foster efficiency instead of inefficiency, and through sincere initiatives on behalf of providers, insurers, and consumers to contain costs, and through improved consumer information relating to the health care marketplace. As a safety net, it is the intent of the Legislature to establish a program of prospective budget review and approval in the event that competition-oriented methods do not adequately contain costs and the access of Floridians to adequate hospital care becomes jeopardized because of unaffordable costs.

Section 4. Section 395.503, Florida Statutes, is amended to read:

395.503 Health Care Hospital Cost Containment Board.--

(1)(a) There is created the Health Care Hospital Cost Containment Board. The board shall be administratively located within the office of the secretary of the Department of Health and Rehabilitative Services and shall be composed of eleven members appointed by the Governor and confirmed by the Senate. Four members must be providers of health care, including two representatives of the hospital industry and one representative of the nursing home industry; three members must be major purchasers of health care; and four members must be consumers with no direct involvement in health care.
members of the board must be permanent residents of the state, and at least one member of the board must be 60 years of age or older.

(b) Each appointment to the board shall be for a 3-year term, except that the initial appointment of the provider member added by chapter 87-92, Laws of Florida, shall be for a term ending December 31, 1989, and the initial appointment of the consumer member added by chapter 87-92, Laws of Florida, shall be for a term ending December 31, 1989. No member is eligible for appointment for more than two consecutive terms, regardless of the length of any one term. A vacancy on the board shall be filled within 60 days from the date on which the vacancy occurs, which appointment shall be made for the remainder of the unexpired term.

(c) The Governor may remove from office any member who would no longer be eligible to serve on the board by virtue of the requirement that he be a provider, purchaser, consumer, or resident of the state; who becomes disqualified for neglect of any duty required by law; or who misses more than four meetings in any one year.

(2) (a) The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall meet from time to time to fulfill its responsibilities. Meetings may be called by the chairperson or any five members and, except in the event of an emergency, shall be called by written notice. Meetings shall be called in advance and be open to the public. Five voting members of the board constitute a quorum.

(b) Board members shall be remunerated at the rate of $50 per diem while on official board business and shall be
reimbursed for their expenses while on official business for
the board in accordance with the provisions of s. 112.061.

(3)(a) The board shall appoint an executive director
who shall serve at the pleasure of the board and who shall
have had experience in the organization, financing, or
delivery of health care. The executive director shall perform
the duties delegated to him by the board. The executive
director, with the concurrence of the board, shall appoint,
and may terminate, a general counsel, a chief financial
analyst with at least 5 years’ experience in hospital
financial management, a director of public information, and a
director of research and may appoint, with the consent of the
board, such other staff and staff attorneys as the board deems
necessary. The board may contract with persons outside the
board for services necessary to carry out its activities when
this will promote efficiency, avoid duplication of effort, and
make the best use of available expertise.

(b) The board may apply for and receive and accept
grants, gifts, and other payments, including property and
service from any governmental or other public or private
entity or person, and make arrangements as to the use of same,
including the undertaking of special studies and other
projects relating to health care costs.

(4) The board may create committees from its
membership and may create such ad hoc advisory committees to
advise the board and its staff in specialized fields related
to the functions of hospitals as it deems necessary. The
members of any ad hoc advisory committee shall be entitled to
reimbursement for expenses incurred, including travel
expenses.
Section 5. Section 395.5042, Florida Statutes, is amended to read:

395.5042 Office of Technical Assistance within board.--It is the intent of the Legislature to create a single entity to serve as a focal point for governmental efforts and activities to promote health care cost containment by providing technical assistance to persons, businesses, and purchaser coalitions interested in containing the costs of health care. Therefore, there is created within the Health Care Hospital Cost Containment Board the Office of Technical Assistance, which shall include such professional, technical, and clerical staff as may be necessary to enable it to carry out its duties. The Office of Technical Assistance shall.

1. Assist employers in the formation of health care coalitions around the state.

2. Develop model health care benefit packages for use by employers and providers in implementing health benefit plans which promote the cost-effective delivery of adequate care.

3. Serve as a clearinghouse for information concerning innovations in the delivery of health care services and the enhancement of competition in the health care marketplace.

4. Pursue the implementation of mechanisms through which state government will lead by example in the prudent purchase of adequate health services.

5. Work with existing health coalitions and local health councils in carrying out their respective goals in an efficient and effective manner.

Section 6. Section 395.5065, Florida Statutes, is created to read:

CODING: Words struck are deletions; words underlined are additions.
395.506 Reporting and use of data; immunity.--Except as provided in s. 395.514, no hospital or other reporting entity, or its employees or agents, shall be held liable for civil damages or criminal penalties as a result of such entity reporting patient or financial data to the Center for Health Care Statistics or any other state agency as required by law or pursuant to this part. Likewise, no hospital or other reporting entity, or its employees or agents, shall be held liable for civil damages or criminal penalties which result from the use of such data by any state agency or any consumer of such data.

Section 7. Section 395.508, Florida Statutes, is amended to read:

395.508 Hospital costs and finances; analyses, studies, and reports.--

The board shall from time to time undertake analyses and studies relating to health care costs, making maximum use of local health councils and the designated state health planning agency whenever possible, and relating to the financial status of any hospital or hospitals subject to the provisions of this part. The board and the department shall jointly develop criteria to analyze and study the effect upon health care costs of third-party reimbursement mechanisms. The board shall incorporate into its reports the findings of the department relating to the effect upon health care costs of third-party reimbursement mechanisms, including health insurance as defined in ss. 624.603 and 627.652, health care service plans as defined in s. 641.01, and health maintenance organizations as defined in s. 641.19(6). The board shall disseminate information to consumers which will assist them in understanding government funding programs and third-party

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reimbursement. The board may publish and disseminate such
information as it deems desirable in the public interest.

+2) The board shall also prepare and file such
summaries and compilations or other supplementary reports
based on the information analyzed by the board hereunder as
will advance the purposes of this part.

Section 8. Subsection (1) of section 395.5094, Florida
Statutes, is amended to read:

395.5094 Exceeding approved budget or previous year's
actual experience by more than maximum rate of increase;
allowing or authorizing operating revenue or expenditures to
exceed amount in approved budget; penalties.--

(1) The board shall annually compare the audited
actual experience of each hospital to the audited actual
experience of that hospital for the previous year. If the
board determines that the audited actual experience of a
hospital exceeded its previous year's audited actual
experience by more than the maximum allowable rate of increase
or exceeded the projected budget as approved by the board,
whichever is greater, the amount of such excess shall be
determined by the board, and a penalty shall be levied against
such hospital based thereon, as follows:

(a) For the first occurrence within a 5-year period,
the board shall prospectively reduce the current budget of the
hospital by the amount of the excess up to 5 percent; and, if
such excess is greater than 5 percent over the maximum
allowable rate of increase, any amount in excess of 5 percent
shall be levied by the board as a fine against such hospital,
to be deposited in the Public Medical Assistance Trust Fund,
as created in s. 409.2662.
(b) For the second occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall prospectively reduce the current budget of the hospital by the amount of the excess up to 2 percent; and, if such excess is greater than 2 percent over the maximum allowable rate of increase, any amount in excess of 2 percent shall be levied by the board as a fine against such hospital, to be deposited in the Public Medical Assistance Trust Fund.

(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:

1. Levy a fine against the hospital in the total amount of the excess, to be deposited in the Public Medical Assistance Trust Fund.

2. Notify the Department of Health and Rehabilitative Services of the violation, whereupon, the department shall not accept any application for a certificate of need pursuant to ss. 381.701-381.715 from or on behalf of such hospital until such time as the hospital has demonstrated, to the satisfaction of the board, that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected budget for a period of at least 1 year. However, this provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.

3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the Department of Health and Rehabilitative Services, whereupon the department shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.

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The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital pursuant to s. 409.266(7) or s. 409.2663. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.101 minus the amount of revenues received by the hospital through the operation of s. 409.266(7) or s. 409.2663. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, its entitlement to such reduction. It is the intent of the Legislature that any penalty imposed against a hospital for exceeding its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, any change in its case mix.

Section 9. Subsection (1) of section 395.512, Florida Statutes, is amended to read:

395.512 Budget; expenses; assessments; hospital cost containment program account.--

(1) The board shall biennially prepare a budget which shall include an estimate of income and expenditures for administration and operation of the hospital cost containment program for the biennium, to be submitted to the Governor for transmittal to the Legislature for approval. Subject to the approval of the Legislature, expenses of the program shall be financed by assessments against hospitals in an amount to be determined biennially by the board, but not to exceed 0.04 percent of the gross operating costs of each hospital for the
Every new hospital shall pay its initial assessment upon being licensed by the state and shall base its assessment payment during the first year of operation upon its projections for gross operating costs for that year. Each hospital under new ownership shall pay its initial assessment for the first year of operation under new ownership based on its gross operating costs for the last fiscal year under previous ownership. The assessments shall be levied and collected quarterly. All moneys collected are to be deposited by the Treasurer into the Health Care Hospital Cost Containment Trust Fund in the general fund, which account is hereby created. The Health Care Hospital Cost Containment Trust Fund shall be subject to the service charge imposed pursuant to chapter 215.

Section 10. Section 395.513, Florida Statutes, is amended to read:

395.513 Program accountability.--On or before March 1 of each year, the board shall prepare and transmit to the Governor and the Legislature a report of hospital cost containment program operations and activities for the preceding year. This report shall include copies of summaries, compilations, and supplementary reports required by this part, together with such facts, suggestions, and policy recommendations as the board deems necessary. The board shall specifically state its findings and recommendations on the following issues:

(1) The extent to which cross-subsidization affects the rates and charges for different types of hospital services and an analysis of the reasons for existing levels of cross-subsidization.

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Section 11. Subsection (3) of section 395.515, Florida Statutes, is amended to read:

395.515 Prospective payment arrangements.--

(3) Hospitals, as defined in s. 395.002, and health insurers, regulated pursuant to parts VI and VII of chapter 627, shall establish by no later than March 31, 1987, prospective payment arrangements that provide hospitals with financial incentives to contain costs. Each hospital shall negotiate with each health insurer which represents 10 percent or more of the private-pay patients of the hospital to establish a prospective payment arrangement. Beginning October 1, 1985, and annually thereafter, hospitals and health insurers regulated pursuant to this section shall report on October 1 annually the results of each specific prospective payment arrangement adopted by each hospital and health insurer to the Health Care Hospital Cost Containment Board, hereinafter referred to as the "board." In the event that a hospital or a health insurer does not comply with the requirements of this section, such hospital or health insurer shall have 60 days in which to justify the reasons for its failure to comply to the board.
The board shall take into account the failure of the hospital to comply in its approval or disapproval of the budget of the hospital. In addition, the board shall report a health insurer's failure to comply to the Department of Insurance, which shall take into account the failure by the health insurer to comply in conjunction with its approval authority under s. 627.410. The board shall adopt any rules necessary to carry out its responsibilities required by this section.

Section 12. Section 112.153, Florida Statutes, is amended to read:

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

Section 13. Paragraph (n) of subsection (3) of section 119.07, Florida Statutes, is amended to read:

119.07 Inspection and examination of records; exemptions.--

(3)

(n) A patient record obtained by the Health Care Hospital Cost Containment Board established under s. 395.503, which record contains the name, residence or business address, telephone number, social security or other identifying number, or photograph of any person or the spouse, relative, or

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guardian of such person or which record is patient-specific or otherwise identifies the patient, either directly or indirectly, is exempt from the provisions of paragraph (1)(a).

Section 14. Subsection (18) of section 215.22, Florida Statutes, is amended to read:

215.22 Certain moneys and certain trust funds enumerated.--The following described moneys and income of a revenue nature deposited in the following described trust funds, by whatever name designated, shall be those from which the deductions authorized by s. 215.20 shall be made:

(18) The Health Care Hospital Cost Containment Trust Fund established pursuant to s. 395.512.

The enumeration of the above moneys or trust funds shall not prohibit the applicability thereto of s. 215.24 should the Governor determine that for the reasons mentioned in s. 215.24 the money or trust fund should be exempt herefrom, as it is the purpose of this law to exempt all trust funds from its force and effect when, by the operation of this law, federal matching funds or contributions to any trust fund would be lost to the state.

Section 15. Paragraph (a) of subsection (6) of section 381.601, Florida Statutes, is amended to read:

381.601 Blood transfusions.--

(6) UNIFORM SYSTEM OF FINANCIAL REPORTING.--

(a) The department shall, in consultation with the Florida Health Care Hospital Cost Containment Board, develop a uniform system of financial reporting consistent with the reporting system for hospital blood service departments under s. 395.507. Existing reporting systems and data developed by the Florida Health Care Hospital Cost Containment Board shall

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be utilized by the department whenever applicable in carrying out the provisions of this section. Appropriate professional advisory bodies, existing proposed systems of accounting and reporting utilized by hospital and community blood banks and other blood service operations may be considered, but every attempt should be made to develop a reporting system consistent with that developed under s. 395.507. No system of financial reporting required under this section shall require the filing of reports which duplicate existing cost containment reporting requirements. The system shall be based on a uniform chart of accounts and generally accepted accounting principles for all facilities in the state which collect, store, process, or transfuse blood. Information relating to the consumer and provider, the costs, the percentage of profits, the fees obtained from nonreplacement assessments, the quantity of blood replaced under the individual responsibility concept, the recruitment costs, and other appropriate information may be included within the system as provided in s. 395.507.

Section 16. Paragraph (c) of subsection (2) of section 381.703, Florida Statutes, is amended to read:

381.703 Local and state health planning --

(2) STATEWIDE HEALTH COUNCIL.--The Statewide Health Council is hereby established as a state-level comprehensive health council which is advisory to the department. The Statewide Health Council shall be composed of the 11 chairmen of the local health councils, two members appointed by the Governor, two members appointed by the President of the Senate, and two members appointed by the Speaker of the House of Representatives. At least one of the two members appointed by the Governor, the President of the Senate, and the Speaker
of the House of Representatives, respectively, shall be a health care consumer or a health care purchaser. Appointed members of the council shall serve for a 2-year term commencing on January 1 of each odd-numbered year. The Statewide Health Council shall:

(c) Consult with local health councils, the Health Care Hospital Cost Containment Board, the Department of Insurance, the Department of Health and Rehabilitative Services, and other appropriate public and private entities, including health care industry representatives regarding the development of health policies;

Section 17. Paragraph (c) of subsection (3) of section 395.017, Florida Statutes, as amended by section 5 of chapter 88-1, Laws of Florida, is amended to read:

395.017 Patient records; copies; examination.--

(3) Patient records shall have a privileged and confidential status and shall not be disclosed without the consent of the person to whom they pertain, but appropriate disclosure may be made without such consent to:

(c) The Health Care Hospital Cost Containment Board;

Section 18. Paragraph (d) of subsection (1) of section 395.101, Florida Statutes, is amended to read:

395.101 Annual assessments on net operating revenues to fund public medical assistance, administrative fines for failure to pay assessments when due.--

(1) For the purposes of this section, the term:

(d) "Health Care Hospital Cost Containment Board" or "board" means the Health Care Hospital Cost Containment Board created by s. 395.503.

Section 19. Section 400.341, Florida Statutes, is amended to read:

CODING: Words struck are deletions; words underlined are additions.
Legislative intent, nursing home costs.--The Legislature finds it to be in the best interest of the state that nursing home care be affordable and accessible to all persons requiring these services. Further, the Legislature finds there is a paucity of information on nursing home revenues and growth in those revenues, the equity of the burden in providing charity care, and nursing home rates and charges. The potential for growth in nursing home revenues and the effect of such growth on state and local government budgets and on the ability of persons to purchase nursing home care makes it vital that nursing home revenues and expenditures be documented and analyzed. The Legislature finds that the Health Care Hospital Cost Containment Board is the agency best qualified to collect, analyze, and monitor nursing home financial data and intends that the board carry out this responsibility in conjunction with the department and the State Nursing Home and Long-Term Care Facility Ombudsman Council and district nursing home and long-term care facility ombudsman councils.

Section 20. Subsection (1) of section 400.342, Florida Statutes, is amended to read:

400.342 Definitions.--As used in ss. 400.341-400.346:

(1) "Board" means the Health Care Hospital Cost Containment Board.

Section 21. Paragraph (c) of subsection (1) of section 400.345, Florida Statutes, is amended to read:

400.345 Budget, expenses, assessments.--

(1) Assessments shall be levied and collected annually by the department. Moneys collected shall be deposited by the department into the Health Care Hospital Cost Containment

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Board Trust Fund as collected, but such funds shall be
maintained in a separate account.

Section 22. Subsection (2) of section 400.609, Florida
Statutes, is amended to read:

400.609 Components of hospice programs of care.--Each
hospice program shall consist of three components or modes of
care which afford the terminally ill individual and the family
of the terminally ill individual a range of service delivery
which can be tailored to specific needs and preferences of the
patient and family at any point in time. These three
components are:

(2) INPATIENT HOSPICE CARE.--The inpatient component
of care is an adjunct to hospice home care and shall primarily
be used only for short-term stays. The facility or rooms
within a facility used for the hospice inpatient component of
care, shall be arranged, administered, and managed in such a
manner to provide privacy, dignity, comfort, warmth, and
safety for the terminally ill patient and the family. Every
possible accommodation shall be made to create as homelike an
atmosphere as practicable. To facilitate overnight family
visitation within the facility, rooms shall be limited to no
more than double occupancy; and, whenever possible, both
occupants shall be hospice patients. There shall be a
continuum of care and a continuity of care givers between the
hospice home program and the inpatient aspect of care to the
extent practicable and compatible with the preferences of the
patient and his family. Fees charged for inpatient hospice
care, whether provided directly by the hospice or through
contract, shall be made available upon request to the Health
Care Hospita1 Cost Containment Board created in s. 395.503.
The hours for daily operation and the location of the place

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where the services are provided shall be determined, to the extent practicable, by the accessibility of such services to the patients and families served by the hospice program.

Section 23. Paragraph (d) of subsection (2) of section 409.2663, Florida Statutes, is amended to read:

409.2663 Redistribution of funds in the Public Medical Assistance Trust Fund.--

(2) DEFINITIONS.--As used in this section

(d) "Board" means the Health Care Hospital Cost Containment Board as established in s. 395.503.

Section 24. Paragraph (a) of subsection (4) of section 440.13, Florida Statutes, is amended to read:

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

(4)(a) A three-member panel is created, consisting of the Insurance Commissioner and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall annually determine schedules of maximum reimbursement allowances for such medically necessary remedial treatment, care, and attendance. Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, shall not exceed the amounts provided by the schedules of maximum reimbursement allowances as determined by the panel and adopted by rule by the department. The schedules shall have statewide applicability and shall be

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uniform throughout the state. An individual health care
provider or hospital shall be paid either his usual charge for
treatment, care, and attendance or the maximum reimbursement
allowance as set forth in the applicable schedule, whichever
is less. In determining the schedules, the panel shall first
approve the bodies of medical and hospital data which it finds
representative of prevailing charges in the state for such
treatment, care, and attendance in the state for similar
treatment, care, and attendance of injured persons. In
determining the schedule for hospitals after January 1, 1987,
the panel shall approve and use charge data submitted by
hospitals to the Health Care Hospital Cost Containment Board
as representative of charges for the treatment, care, and
attendance in the state of injured persons. Payment of a
compensable charge to a hospital for treatment, care, and
attendance not specifically itemized in the applicable
schedule shall be at 80 percent of the hospital's usual charge
for such treatment, care, and attendance. Each health care
provider or health care facility receiving workers'
compensation payments shall maintain records verifying their
usual charges. Using the approved bodies of data when
arrayed, the panel shall establish percentiles upon which the
schedules of maximum reimbursement allowances will be
calculated. In establishing the schedules of maximum
reimbursement allowances, the panel shall consider the
following:

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

2.a. The impact upon cost to employers for providing a
level of reimbursement for treatment, care, and attendance

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which will ensure the availability of treatment, care, and
attendance required by injured workers; and

b. The potential change in workers' compensation
insurance premiums or costs attributable to the level of
treatment, care, and attendance provided; and

3. The financial impact of the reimbursement
 allowances upon health care providers and health care
facilities and its effect upon their ability to make available
to injured workers such medically necessary remedial
treatment, care, and attendance.

The schedules of maximum reimbursement allowances shall be
reasonable, shall promote health care cost containment and
efficiency with respect to the workers' compensation health
care delivery system, and shall be sufficient to ensure
availability of such medically necessary remedial treatment,
care, and attendance to injured workers.

Section 25. Subsection (3) of section 627.9175, Florida Statutes, is amended to read:

627.9175 Reports of information on health insurance.--
(3) Each health insurer shall annually submit to the
department available information related to physician charges.
The department shall provide by rule a uniform format for the
submission of this information in order to allow for
meaningful comparisons of physician charge data. The
department, in conjunction with the health insurance industry
and the Hospital Cost Containment Board, shall make an initial
report to the 1985 regular session of the legislature as to
the feasibility of subdividing total physician charges by
specialty and subdividing the most commonly used procedures by
location in this state. The department shall provide

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1 information collected under this subsection to the Health Care
2 Hospital Cost Containment Board for dissemination under the
3 provisions of s. 395.504(9)(b).

Section 26. Notwithstanding the provisions of the
5 Regulatory Sunset Act or any other law providing for the
6 repeal and review of such sections, sections 395.501, 395.502,
7 395.5025, 305.503, 395.504, 395.505, 395.507, 395.508,
8 395.5085, 395.509, 395.5092, 395.5094, 395.511, 395.512,
9 395.5125, 395.513, 395.5135, 395.514, and 395.515, Florida
10 Statutes, shall not stand repealed on October 1, 1988, as
11 scheduled by such acts, but such sections, as amended, are
12 hereby revived and readopted.

Section 27. Sections 395.501, 395.502, 395.5025,
14 305.503, 395.504, 395.5042, 395.505, 395.5051, 395 5065,
15 395.507, 395.508, 395.5085, 395.509, 395.5092, 395.5094,
16 395.511, 395.512, 395.5125, 395.513, 395.5135, 395.514,
17 395.515, and 395.52, Florida Statutes, are repealed on October
18 1, 1998, and shall be reviewed by the Legislature prior to
19 that date pursuant to section 11.61, Florida Statutes.

Section 28. This act shall take effect October 1,

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SENATE SUMMARY

Revives and readopts the Health Care Cost Containment
Act, ss. 395.501-395.515, F.S., which was scheduled for
repeal on October 1, 1988, pursuant to the Regulatory
Sunset Act. Redesignates the Hospital Cost Containment
Board as the Health Care Cost Containment Board, and the
Hospital Cost Containment Trust Fund as the Health Care
Cost Containment Trust Fund. Provides additional
legislative intent. Provides immunity from civil
liability and criminal penalties which might otherwise
result from reporting patient or financial data to a
state agency. Provides for dissemination of information
to consumers. Requires the board to report on the extent
to which public funding policies and "problems in the
health care marketplace" affect health care costs.
Repeals obsolete material.

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A bill to be entitled
An act relating to health care; creating the
Health Care Cost Containment Act; creating
chapter 407, F.S.; amending and transferring
part II of chapter 395, F.S., relating to the
Health Care Cost Containment Act of 1979, to
chapter 407, F.S.; providing a short title;
providing definitions; prescribing the maximum
allowable rate of increase in hospital rates;
providing legislative intent; establishing
administrative authority; revising composition
of the Hospital Cost Containment Board;
deleting obsolete language; revising board
procedures; revising powers and duties of the
board; requiring a threshold by which budgets
are subject to board review; providing immunity
to hospitals for releasing certain data;
prescribing law governing hospital budgets and
budget amendments; revising the uniform system
of financial reporting for hospitals and
providing procedures for grouping hospitals;
requiring all hospitals exceeding certain
thresholds to submit budgets; providing
penalties relating to required reports and
information; providing for analyses, studies,
and reports by the board; requiring accessible
data base; abolishing the Office of Technical
Assistance; deleting certain technical
assistance responsibilities; revising
procedures establishing prospective payment
arrangements; requiring hospitals not exceeding
maximum allowable rate of increase to file budget letters with board instead of detailed budget; establishing detailed budget review threshold; allowing hospitals to accumulate percentage points for use in future; providing rulemaking authority; revising board budget review and approval review processes; requiring hospitals requesting increases above the maximum allowable rate of increase to file budgets; establishing hospital groupings; providing for budget review; providing for budget amendment; establishing criteria for budget review; providing for preliminary findings; providing for objections; providing for hearings; providing for exceptions; providing exemptions for certain hospitals from detailed budget review; providing an effective date for revised budget review and approval procedures; modifying penalty provisions; providing for accumulation of net revenue percentage points to offset penalties; providing for waiver of penalty; specifying duties of Public Counsel; repealing s. 395.52, F.S., relating to information or physician charges; providing for studies and reports by the board; providing an appropriation; providing for a hospital expenditure and revenue study; providing for rules; revising and readopting provisions of part II of chapter 395, F.S., as amended and transferred, notwithstanding repeals scheduled under the

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Regulatory Sunset Act, providing for future review and repeal of such provisions; creating chapter 389, F.S.; amending and transferring ss. 381.025, 381.703, 400.341, 400.343-400.346, F.S., to chapter 389, F.S.; creating the "Health Planning Act"; providing legislative intent; providing definitions; designating the state health planning agency; authorizing health planning studies, analyses, and reports; providing for biennial health care plans; providing departmental cost containment responsibilities; providing for an annual health care cost containment plan; creating an Office of Technical Assistance within the department; establishing technical assistance responsibilities; establishing a state center for health statistics; providing for a comprehensive health information system; establishing center functions; providing for center technical assistance; providing for center publications, reports, and special studies; providing for data confidentiality; providing a penalty; limiting provider reporting; providing for center budget, fees, and trust fund; providing an appropriation; establishing a Comprehensive Health Information System Advisory Council; providing for appointments; providing for staggering of terms; providing for meetings; providing for uniform system of financial reporting to the department by nursing homes; providing for

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monitoring of certificate-of-need projects;
providing for assessments on certain health
care facilities; providing a fine for
noncompliance; providing a penalty; providing
for a study on health care coverage for the
uninsured; providing for interim and final
reports; providing an appropriation; amending
s. 381.704, F.S.; revising duties and
responsibilities of department; creating s.
409.2665, F.S.; providing for a Medicaid
selective contracting plan; repealing s.
400.342, F.S., relating to definitions;
amending ss. 119.07, 215.22, 381.601, 381.710,
395.101, 400.609, 409.2663, 627.9175, 768.81,
F.S.; conforming cross-references; providing an
effective date.

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

Section 1. This act may be cited as the "Health Care
Cost Containment Act."

Section 2. Section 395.501, Florida Statutes, is
renumbered as section 407.001, Florida Statutes, and amended
to read:

407.001 395-501 Short title.--This chapter pert-nail
be-known-and may be cited as the "Hospital Health-Care Cost
Containment Board Act of-1979."

Section 3. Section 395.502, Florida Statutes, is
renumbered as section 407.004, Florida Statutes, and amended
to read:

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407.004 395-502 Definitions.—As used in this chapter, the term:

(1) "Adjusted admission" means the sum of acute admissions and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(2) "Audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards.

(3) "Board" means the Hospital Cost Containment Board created by s. 407.011 ss.395-503.

(4) "Budget" means the projections by the hospital, for a specified future time period, of expenses expenditures and revenues, with supporting statistical indicators.

(5) "Case-mix index" means a measurable calculated index for each hospital based on financial accounting or and case-mix data which shows collection-as-set forth in s. 395-5047—reflecting the relative costliness of the mix of cases of a hospital compared to itself in prior years or compared to a state or national mix of cases.

(6) "Commissioner" means the Insurance Commissioner.

(7) "Comprehensive rehabilitative hospital" means a hospital licensed by the Department of Health and Rehabilitative Services as a specialty hospital, as that term is defined in s. 395.002(14); provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the...
hospital are classified as "comprehensive rehabilitative beds" pursuant to s. 395.003(4), and are not classified as "general beds."

(8) "Consumer" means any person other than a person who administers health activities, provides health services, has a fiduciary interest in a health facility or other health agency, or has a material financial interest in the rendering of health services.

(9) "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing such service as to offset some of the costs of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.

(10) "Department" means the Department of Health and Rehabilitative Services Insurance.

(11) "Florida Price Level Index" is the index developed by the Executive Office of the Governor to measure the differences from county to county in the cost of purchasing a specific market basket of goods and services at a particular time.

(12) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue. Gross revenues do not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors.

(13) "Hospital" means a health care institution as defined in s. 395.002(6).

(14) "Hospital-specific case-mix score" means the increase, without a threshold or limitation, in the case-mix score.
index and severity-of-illness index between the previous year's audited actual case-mix index and severity-of-illness index and the projected case-mix index and severity-of-illness index for the ensuing budget year.

(15) "Local health council" means the agency created under s. 389.347 defined in s. 389.493.

(16) "Major health care purchaser" means 1 of the 10 largest private employers in the state, a commercial health insurer, or a health care services plan certificate under chapter 641.

(17) "Maximum-allowable-rate-of-increase" or "MAR" means the maximum rate at which a hospital is expected to increase its average gross revenues per adjusted admission for a given period. The maximum-allowable-rate-of-increase is composed of two parts: the market basket index and plus points, which are defined as follows:

(18) "Market basket index" means the revised market basket index used to measure the inflation in hospital input prices as employed on January 1, 1988, by the Secretary of the United States Department of Health and Human Services for Medicare reimbursement. If the measure ceases to be calculated in this manner, the inflation index shall be the index approved by rule adopted promulgated by the board. The method used in determining the index approved by rule shall be substantially the same as the method employed on January 1, 1988, for determining the inflation in hospital input prices by the Secretary of the United States Department of Health and Human Services for purposes of Medicare reimbursement.

(19) "Plus-points" means additional percentage points added to the market basket index to adjust for the Florida
specific experience—the-plus-points-to-be-added-to-the
market-basket-index-shall-be-5-percent-for-calendar-year-1985;
4-percent-for-calendar-year-1986—and-3-percent-for-each-year
thereafter;

(18) "Maximum allowable rate of increase" means the
maximum rate at which a hospital is normally expected to
increase its average gross revenues per adjusted admission for
a given period. The board, using the most recent audited
actual experience for each hospital, shall calculate the
maximum allowable rate of increase for each hospital as
follows. The projected rate of increase in the market basket
index shall be divided by a number which is determined by
subtracting the sum of one half of the proportion of Medicare
days plus the proportion of Medicaid days and the proportion
of charity care days from the number one. Two percentage
points shall be added to this quotient. The formula to be
employed by the board to calculate the maximum allowable rate
of increase shall take the following form:

\[
\text{NHIPI} = \frac{\text{MARI}}{1 - \left(\left(\text{Me} \times 0.5\right) + \text{Md} + \text{Cc}\right)} + 2
\]

where:

(a) \text{MARI} = \text{maximum allowable rate of increase applied}
to gross revenue.

(b) \text{NHIPI} = \text{national hospital input price index, which}
shall be the projected rate of change in the market basket
index.

(c) \text{Me} = \text{proportion of Medicare days, including, when}
available and reported to the board, Medicare HMO days to
total days.
(d) \( Md = \) proportion of Medicaid days, including, when available and reported to the board, Medicaid HMO days to total days.

(e) \( Cc = \) proportion of charity care days to total days with a 50 percent offset for restricted grants for charity care and unrestricted grants from local governments.

(19) "Medically indigent person" means a person who has insufficient resources and or assets to pay for needed medical care without using his resources required to meet his basic needs for shelter, food, or and clothing.

(20) "Net revenue" means gross revenue minus deductions from revenue.

(21) "Operating expenses" or "operating expenditures" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses, and other operating expenses, excluding income taxes.

(22) "Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.

(23) "Rate of return" means the financial indicators which the board uses to determine reasonableness of the financial requirements of a hospital and which may include, but not be limited to, return on assets, return on equity, total margin, and debt service coverage.

(24) "Rural hospital" means an acute care hospital which is licensed under chapter 395, which has 85 or fewer beds, and which is:

(a) The sole provider within a county that has a population density of no greater than 100 persons per square mile;

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(b) An acute care hospital within a county that has a population density of no greater than 100 persons per square mile and is at least 30 minutes of travel time, on normally travelled roads under normal traffic conditions, from another acute care hospital within the same county; or

(c) A provider supported by a hospital tax district the boundaries of which encompass a population of 100 or fewer persons per square mile.

(25) "Severity-of-illness index" means a measurable index for each hospital based on financial accounting data which shows the differential levels of resource consumption of treating patients within the same mix of cases.

(26) "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the board in meeting its responsibilities pursuant to this chapter part.

(27) "State-health-planning-agency" means the agency designated by the Governor to perform the health planning and development functions prescribed by § 15237-52 of the National Health Planning and Resources Development Act of 1974.

(28) "Teaching hospital" means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as indicated reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

(29) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy...
discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care to medically indigent persons.

Section 4. Section 395.5025, Florida Statutes, is renumbered as section 407.007, Florida Statutes, and amended to read:

407.007 395.5025 Legislative intent to assure affordable hospital health care.--It is the intent of the Legislature to assure that adequate hospital health care is affordable and accessible to all the people citizens of this state. To further the accomplishment of this goal, the Hospital Cost Containment Board is created to advise the Governor, the President of the Senate, and the Speaker of the House of Representatives legislature regarding health-care costs of hospital care; inflationary trends in health-care costs of hospital care; the impact of health-care costs of hospital care on the state budget; the impact of hospital charges and third-party reimbursement mechanisms on health care costs of hospital care; and the education of consumers and providers of hospital health-care services in order to encourage price competition in the hospital industry health care-marketplace. The Legislature finds and declares that rising hospital costs of hospital care and cost shifting are of vital concern to the people of this state because of the danger that hospital services are becoming unaffordable and thus inaccessible to residents of the state. It is further declared that costs of hospital care costs should be contained through improved competition between hospitals and improved competition between insurers, through financial incentives which foster efficiency instead of inefficiency, and through sincere initiatives on behalf of providers, insurers, and

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consumers to contain costs. However, as a safety net, it is the intent of the Legislature to establish a program of prospective budget review and approval which will contain hospital revenues which exceed certain thresholds where in-the event-that competition-oriented methods do not adequately contain costs and to ensure the access of Floridians to adequate hospital care which could become jeopardized because of unaffordable costs. The Legislature further finds that there is insufficient information regarding the extent to which various factors affect the rates of increase in costs of and charges for hospital care and the effect of prospective budget review and approval on the containment of costs of and charges for hospital care.

Section 5. Section 395.503, Florida Statutes, is renumbered as section 407.011, Florida Statutes, and amended to read:

407.011 395.503 Hospital Cost Containment Board.--
18 (1)(a) There is created the Hospital Cost Containment Board. The board shall be administratively located within the office of the secretary of the department of Health-and Rehabilitative-Services and shall be composed of eleven members. Ten members shall be appointed by the Governor, subject to confirmation and-confirmed by the Senate. Three Peer members must be providers of hospital health care, including-two-representatives-of-the-hospital-industry-and-one representative-of-the-nursing-home-industry; three members must be major purchasers of health care; and four members must be consumers with no direct involvement in health care. The Deputy Assistant Secretary for Regulation and Health Facilities of the department shall be a member of the board. All members of the board must be permanent residents of the

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state, and at least one member of the board must be 60 years of age or older.

(b) Except for the Deputy Assistant Secretary for Regulation and Health Care Facilities of the department, each appointment to the board shall be for a 3-year term—except that the initial appointment of the provider member added by chapter 87-927, laws of Florida, shall be for a term ending December 31, 1987, and the initial appointment of the consumer member added by chapter 87-927, laws of Florida, shall be for a term ending December 31, 1988. Except for the Deputy Assistant Secretary for Regulation and Health Care Facilities of the department, no member is eligible for appointment for more than two consecutive terms, regardless of the length of any one term. A vacancy on the board shall be filled within 60 days from the date on which the vacancy occurs, which appointment shall be made for the remainder of the unexpired term.

(c) The Governor may remove from office any member who he appointed and who would no longer be eligible to serve on the board by virtue of the requirement that he be a provider, purchaser, consumer, or resident of the state or— who becomes disqualified for neglect of any duty required by law, or—who misses more than four meetings in any one year.

(2)(a) The members of the board shall biennially elect a chairperson and a vice-chairperson from its membership. The board shall meet from time to time to fulfill its responsibilities. Meetings may be called by the chairperson or any five members and, except in the event of an emergency, shall be called by written notice. Meetings shall be called in advance and be open to the public. Six five-voting members of the board constitute a quorum.
(b) Board members shall be remunerated at-the-rate-of
$50-per-day while on official board business and shall be
entitled to be reimbursed for their expenses while on official
business for the board in accordance with the-provisions-of s.
112.061.

(3)(a) The board shall appoint an executive director
who shall serve at the pleasure of the board and who must
shall have had experience in the organization, financing, or
delivery of health care. The executive director shall perform
the duties delegated to him by the board. The executive
director, with the concurrence of the board, shall appoint,
and may terminate, a general counsel, a chief financial
analyst who has with at least 5 years' experience in hospital
financial management, a director of public information, and a
director of research and may appoint, with the consent of the
board, such other staff and staff attorneys as the board deems
necessary. The board may contract with persons outside the
board for services necessary to carry out its activities when
this will promote efficiency, avoid duplication of effort, and
make the best use of available expertise.

(b) The board may apply for and receive and accept
grants, gifts, and other payments, including property and
service from any governmental or other public or private
entity or person, and make arrangements as to the use of same,
including the undertaking of special studies and other
projects relating to health-care costs of hospital care.

(4) The board may create committees from its
membership and may create such ad hoc advisory committees to
advise the board and its staff in specialized fields related
to the functions of hospitals as it deems necessary. The
members of any ad hoc advisory committee shall be entitled to

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reimbursement for expenses incurred, including travel expenses.

Section 6. Section 395.504, Florida Statutes, as amended by section 7 of chapter 88-1, Laws of Florida, is renumbered as section 407.014, Florida Statutes, and amended to read:

407.014 395.504 Powers and duties of board.--To properly carry out its authority, the board:

1. Shall require the submission by hospitals of such case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups as the board deems necessary in order to have available the statistical information necessary to properly conduct financial analyses and budget review and approval and to carry out its public information and education functions as contained in s. 407.044;

(a) Such requirement shall be adopted promulgated by rule if the submission of case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups is being required of all hospitals or of any group thereof; however, rules are not required for the submission of data for a special study or when information is being requested for a single hospital.

(b) Such data may include, but are not limited to: leases, contracts, itemized patient bills, medical record abstracts, and related diagnostic information necessary to evaluate the case-mix index, case-mix of a hospital and to identify actual charges and lengths of stay associated with specific diagnostic groups; necessary operating expenses; appropriate expenses incurred for rendering services to patients who cannot or do not pay; all properly incurred

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interest charges; and reasonable depreciation expenses based on the expected useful life of the property and equipment involved.

(2) Shall approve, disapprove approve-as-amended-by the-board, or disapprove in part the budget of each hospital which requests increases above the maximum allowable rate of increase, including its projected expenses expenditures and projected revenues.

(3) May contract with local health councils to disseminate information to the public on hospital health care costs.

(4) Shall cooperate with the comprehensive-Health Planning Office of the Regulation and Health Facilities of the department of Health-and-Rehabilitative-Services in the development of a biennial work plan defining the roles and responsibilities of the board and the comprehensive-Health Planning Office of Regulation and Health Facilities in the establishment of the State Center for Health Statistics on integrated-health-care-data-base and shall consult with and make recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives board and the secretary of the department Health-and-Rehabilitative Services with respect to analyses and studies of hospital health care costs, capital expenditures by hospitals and their relationship to health care costs, and related matters which may be undertaken by the board.

(5) May inspect and audit hospital books and records, including records of individual or corporate ownership, for compliance with this chapter part. Upon presentation of a written request for inspection to a hospital by the board or its staff, the hospital shall make available to the board or
its staff for inspection, copying, and review all books and
records relevant to the determination of whether the hospital
has complied with this chapter part.

(6) Shall publish and make available to the public a
toll-free telephone number for the purpose of handling
consumer complaints regarding hospital charges and shall serve
as a liaison between consumer entities and other private
entities and governmental entities for the disposition of
billing problems identified by consumers of hospital care.

(7) Shall monitor and report on the effects of
prospective payment arrangements preferred-provider
organizations and changes in reimbursement methodologies for
Medicare on cost shifting.

(8) Shall designate executive staff members to issue
preliminary findings pursuant to s. 407.057(7).

(9) May investigate consumer complaints relating to
problems with hospital billing practices and issue reports to
be made public in any cases that the board determines the
hospital has engaged in erroneous billing practices. Shall
publish, based on information provided by the Department of
insurance under s. 627.9175(3), an annual report containing
premium and benefit comparisons or the equivalent thereof,
for policies of individual health insurance and shall
disseminate the report in the manner provided in s. 395.5805.
The report shall also indicate, as applicable, the extent to
which the premiums charged by a given entity have increased
over the prior premium year.

(b) Shall publish, based on information provided by
the Department of insurance under s. 627.9175(3), an annual
report containing available physician charge comparisons.

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Section 7. Section 407.017, Florida Statutes, is created to read:

407.017 Reporting and use of data; immunity.--A hospital or other reporting entity or its employees or agents are not subject to criminal penalties, or liable to any consumer or purchaser for civil damages, as a result of disclosure by someone other than such entity of patient data reported by such entity to the board as required under this chapter.

Section 8. Section 395.505, Florida Statutes, is renumbered as section 407.021, Florida Statutes, and amended to read:

407.021 Rules; public hearings; investigations; subpoena power.--In addition to the powers granted to the board elsewhere in this chapter part, the board may is-authorized-to:

(1) Adopt, amend, and repeal rules respecting the exercise of the powers conferred by this chapter part which are applicable to the adoption promulgation of rules.

(2) Hold public hearings, conduct investigations, and subpoena witnesses, papers, records, and documents in connection therewith. The board may administer oaths or affirmations in any hearing or investigation.

(3) Exercise, subject to the limitations and restrictions herein imposed in this chapter, all other powers which are reasonably necessary or essential to carry out the expressed objects and purposes of this chapter part.

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Section 9. Section 395.5051, Florida Statutes, is renumbered as section 407.024, Florida Statutes, and amended to read:

407.024 395.5051 Effect of ch-84-357-Laws-of-Florida, on existing rules.—Nothing contained in this chapter, chapter 84-357-Laws-of-Florida, is intended to repeal or modify any of the existing rules of the Hospital Cost Containment Board, as created to implement chapter 84-35, Laws of Florida in-sr, 395.503, unless such rule or part thereof is in direct conflict with the provisions of this chapter 84-35. However, any budget or budget amendment for fiscal years beginning prior to February 1, 1989, must be filed and reviewed pursuant to chapter 84-35, Laws of Florida, and rules adopted by the board pursuant thereto.

Section 10. Section 395.512, Florida Statutes, is renumbered as section 407.027, Florida Statutes, and amended to read:

407.027 395.512 Budget; expenses; assessments; hospital cost containment program account.—

(1) The board shall biennially prepare a budget which shall include an estimate of income and expenditures for administration and operation of the hospital cost containment program for the biennium, to be submitted to the Governor for transmittal to the Legislature for approval. Subject to the approval of the Legislature, expenses of the program shall be financed by assessments against hospitals in an amount to be determined biennially by the board, but not to exceed 0.04 percent of the gross operating costs of each hospital for the provision of hospital services for its last fiscal year. Each new hospital shall pay its initial assessment upon being licensed by the state and shall base its assessment payment...
during the first year of operation upon its projections for 
gross operating costs for that year. Each hospital under new 
ownership shall pay its initial assessment for the first year 
of operation under new ownership based on its gross operating 
costs for the last fiscal year under previous ownership. The 
assessments shall be levied and collected quarterly. All moneys 
collected are to be deposited by the Treasurer into the Hospital 
Cost Containment Trust Fund which-account-is-hereby-created. The Hospital Cost 
Containment Trust Fund shall be subject to the service charge 
imposed pursuant to chapter 215.

(2) Any amounts raised by the collection of assessments from hospitals provided for in this section which are not required to meet appropriations in the budget act for the current fiscal year shall be available to the board in succeeding years.

(3) Hospitals operated by the Department of Health and Rehabilitative Services or the Department of Corrections are exempt from the assessments required under this section.

Section 11. Section 395.507, Florida Statutes, is renumbered as section 407.031, Florida Statutes, and amended to read:

407.031 Uniform system of financial reporting.--

(1) The board shall, by rule, after consulting with appropriate professional and governmental advisory bodies and holding public hearings, and considering existing and proposed systems of accounting and reporting utilized by hospitals, specify a uniform system of financial reporting based on a uniform chart of accounts developed after considering the American Hospital Association Chart of Accounts, the American
Institute of Certified Public Accountants Hospital Audit Guide, and generally accepted accounting principles. However, this subsection does not authorize the board to require hospitals to adopt a uniform accounting system. As a part of such uniform system of financial reporting, the board may require the filing of any information relating to the cost, to both the provider and the consumer, of any service provided in such hospital except the cost of a physician's services which is billed independently of the hospital.

(2) For the purposes of this chapter part, and in order to allow meaningful comparisons, the board shall, by rule, group hospitals into statistically valid and reliable groups according to characteristics, including, but not limited to, a measure of the nature and range of services provided, teaching hospital status, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, average daily census, geographical differences, service intensity, resident doctors per bed, average length of stay, wage index, Medicaid inpatient days, charity care days, and case-mix index when available, case mix. The rule shall provide for the establishment of ten general groups and for the establishment of additional specialty groups as needed. However, no group shall contain fewer than five hospitals.

(3) In establishing such uniform reporting procedures, the board shall, among other issues, take into consideration the need for financial data which reflects the average bill per day and the average bill per stay billed by the hospital and the degree of cross-subsidization by cost center.

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(4) When appropriate, the reporting system shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred in connection with educational research and other non-patient-related activities, including, but not limited to, charitable activities of such hospitals.

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

(6) At least 90 days prior to the commencement of its next fiscal year, each hospital requesting approval of a rate of increase in gross revenues per adjusted admission in excess of the maximum allowable rate of increase for such next fiscal year must file with the board, on forms adopted by the board and based on the uniform system of financial reporting:

(a) Its budget for the next fiscal year, including projected expenditures, projected revenues, and statistical measures necessary for the board to evaluate these projections. Any hospital the final budget of which requires public review and approval may submit its budget prior to public review and approval and must subsequently file any amendments adopted during the public review process at least 45 days prior to the beginning of the fiscal year of the hospital.

(b) Its actual experience for the first 6 months of its current fiscal year, including actual expenditures, actual revenues, and statistical measures necessary for the board to evaluate the actual experience.

(c) Its estimated experience for the last 6 months of its current fiscal year, including estimated expenditures.
estimated revenues, and statistical measures necessary for the board to evaluate these estimates.

(d) Information necessary for the board to evaluate the effectiveness of current services and the justification of the hospital for increased costs to continue current services, improve existing services, and provide new services.

(e) Its schedule of projected rates which will be implemented to generate projected revenues.

(7) Within 120 days after its fiscal year ends, each hospital shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting, its actual audited experience for that fiscal year, including expenditures, revenues, and statistical measures.

(8) The board may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of this chapter part.

(9) The Shriners Hospital for Crippled Children, located in Tampa, is exempt from the financial reporting requirements of this chapter part until such time as it first receives revenues from or on behalf of any individual patient.

Section 12. Section 395.514, Florida Statutes, is renumbered as section 407.034, Florida Statutes, and amended to read:

407.034 395.514 Violation of chapter part or rule; penalties.--Refusal Any hospital which refuses to file, failure fails to timely file, or filing files false or incomplete reports or other information required to be filed under the provisions of this chapter part, or violation of which violates any other provision of this chapter part or rule adopted under this chapter part, is punishable shall-be punished by a fine not exceeding $1,000 a day for each day the

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In violation occurs, to be fixed, imposed, and collected by
the board. Each day the in violation continues shall be
considered a separate offense. The violation of any provision
of this chapter or of a rule adopted under this chapter,
or the knowing and willful falsification of a report
required under this chapter, is a ground for the
imposition of an administrative fine not to exceed $20,000, to
be fixed, imposed, and collected by the department of Health
and-Rehabilitative-Services.

Section 13. Section 395.508, Florida Statutes, is
renumbered as section 407.037, Florida Statutes, and amended
to read:
407.037 395-508 Hospital costs and finances; analyses,
studies, and reports.—

(1) The board may: shall-from-time-to-time-undertake
(a) Collect data and conduct analyses and studies
relating to hospital health care costs, making maximum use of
local health councils and the department designated-state
health-planning-agency whenever appropriate; possible—and
(b) Conduct analyses and research relating to the
financial status of any hospital or hospitals subject to the
provisions of this chapter; part—The board and the
department shall
(c) Jointly develop with the department and the
Department of Insurance, criteria to analyze and study the
continuous effect upon hospital health care costs of third-
party reimbursement mechanisms, including the effects of
Medicare, Medicaid, uncompensated care, and other governmental
reimbursement mechanisms. The board shall incorporate into
its reports the findings of the department and the Department
of Insurance relating to the effect upon hospital health care

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costs of third-party reimbursement mechanisms, including
health insurance as defined in ss. 624.603 and 627.652, health
care service plans as defined in s. 641.01, and health
maintenance organizations as defined in s. 641.19(6)
(d) Conduct analyses and research relating to the
effects of uncompensated charity care on hospital budgets; and
(e) The board may publish and disseminate such
information as the board deems desirable and in the public
interest, including information which will assist consumers
and purchasers to understand the impact government-funded
programs and third-party reimbursement mechanisms may have on
hospital finances.
(2) The board shall also prepare and file such
summaries and compilations or other supplementary reports
based on the information analyzed by the board hereunder as
will advance the purposes of this chapter part.
Section 14. Section 395.513, Florida Statutes, is
renumbered as section 407.041, Florida Statutes, and amended
to read:
407.041 395.513 Program accountability.—On or before
March 1 of each year, the board shall prepare and transmit to
the Governor and the Legislature a report of hospital cost
containment board program operations and activities for the
preceding year. This report shall include copies of
summaries, compilations, and supplementary reports required by
this chapter part, together with such facts, suggestions, and
policy recommendations as the board deems necessary. The
board shall specifically state its findings and
recommendations on the following issues:
(1) The extent to which cross-subsidization affects
the rates and charges for different types of hospital services

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and an analysis of the reasons for existing levels of cross-
subsidization.

(2) The extent to which third-party reimbursement
mechanisms affect hospital health care costs.

(3) The extent to which public funding policies may be
affecting costs of hospital care.

(4) The extent to which other factors in the hospital
industry may be affecting costs of hospital care, including,
but not limited to, uncompensated care, skilled-employee
shortages, changes in technology, and shifts from
institutional care to ambulatory care.

Section 15. Section 395.5085, Florida Statutes, is
renumbered as section 407.044, Florida Statutes, and amended
to read:

407.044 395.5085 Collection and dissemination of
hospital charges and other hospital-specific information-
Consumer-Information-Network.--

(1) The board, relying on summary-actual-charge data
by-diagnostic-groups-and-other-information collected pursuant
to this chapter s-395.5084,t shall establish a reliable,
timely, and consistent information system. The information
system should be organized such that data are accessible and
useable by other state agencies, the hospital industry, and
other persons who desire access to the board's hospital-
related data.

(2) Semiannually, the board shall identify, by
hospital and by hospital groupings, average charges and
lengths of stay associated with established diagnostic groups.
Charge information shall be cited for at least the following
payer classifications: insurance, not-for-profit insurance,
Medicaid, and Medicare. Combined average charges for all

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payer classifications reported shall be published by the board semiannually for dissemination to the media and the public at large. The publication shall identify charges associated with at least the 10 most frequently occurring diagnostic groups and such other information as the board deems appropriate, published by county or region.

(3) The board shall coordinate the distribution of summary actual charge data by diagnostic groups and special publications through a Consumer Information Network. The membership of this network may include the members of the Senate and the House of Representatives; consumer service offices located within the Department of Insurance; insurance companies licensed to write policies for health insurance in this state; Florida business coalitions on health care; local health councils and the designated state health planning agency; the Board of Medical Examiners; and hospitals. The Board of Medicine Medical Examiners may include the current publication of hospital charges in its mailings related to license renewals. Hospitals are required to make the current publication of hospital charges available to patients or family members for review upon the request of the patient or family member.

†††—The board shall through the Consumer Information Network conduct consumer information seminars at locations throughout the state.

Section 16. Section 395.5042, Florida Statutes, is renumbered as section 407.047, Florida Statutes, and amended to read:

407.047 395.5042—Office of Technical assistance within board.—It is the intent of the Legislature that the board provide to create a single entity to serve as a focal point.

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for-governmental-efforts-and-activities-to-promote-health-care
cost-containment-by-providing-technical-assistance-to-persons,
businesses, and purchaser coalitions interested in containing
the costs of hospital health care. Therefore, there is
created-within-the-Hospital-Cost-Containment-Board-the-Office
of-Technical-Assistance—which-shall-include-such
professional-technical-and-clerical-staff-as-may-be
necessary-to-enable-it-to-carry-out-its-duties.—The-Office-of
Technical-Assistance-shall:
  ††—Assist-employers-in-the-formation-of-health-care
coalitions-around-the-state;
  ‡‡—Develop-model-health-care-benefit-packages-for-use
by-employers-and-providers-in-implementing-health-benefit
plans-which-promote-the-cost-effective-delivery-of-adequate
care;
  †§—Serve-as-a-clearinghouse-for-information
concerning-innovations-in-the-delivery-of-health-care-services
and-the-enhancement-of-competition-in-the-health-care
marketplace;
  †∥—Pursue-the-implementation-of-mechanisms-through
which-state-government-will-lead-by-example-in-the-prudent
purchase-of-adequate-health-services;
  ††—Work-with-existing-health-coalitions-and-local
health-councils-in-carrying-out-their-respective-goals-in-an
efficient-and-effective-manner;

Section 17. Section 395.511, Florida Statutes, is
renumbered as section 407.051, Florida Statutes, and amended
to read:

407.051 395.511 Quality assurance programs.—Each
hospital shall maintain a quality assurance program, which
program must shall include monitoring of the necessity of

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admission, appropriateness of the length of stay, proper
utilization of services, and the evaluation of the quality of
services rendered. Quality assurance plans shall be made
available to the board upon its request.

Section 18. Section 395.515, Florida Statutes, is
renumbered as section 407.054, Florida Statutes, and amended
to read:

407.054 395.515 Prospective payment arrangements.--

(1) The Legislature finds that the traditional
retrospective reimbursement practices of health insurers
provide hospitals with disincentives to contain costs and are
a major contributing factor to the rapidly escalating costs of
hospital care. The Legislature further finds that prospective
payment arrangements designed to provide hospitals with
financial incentives to contain costs will contribute to the
deceleration of hospital-cost increases in the costs of
hospital care while enhancing the adequacy of and access to
care so highly valued by consumers. Furthermore, prospective
payment arrangements that provide fixed payment amounts which
are prospectively set through private-sector negotiation will
provide insurers with a greater degree of investment
stability. Therefore, the Legislature finds that it is the
business of insurance, as well as in the public interest best
interests of the citizens of this state, that insurers, on
behalf of their insureds, should negotiate with hospitals to
establish prospective payment arrangements that provide
financial incentives for the containment of the costs of
hospital care costs.

(2) For the purposes of this section, the term
"prospective payment arrangement" means a financial agreement,
negotiated between a hospital and an insurer, health
maintenance organization, preferred provider organization, or
other third-party payer, which contains, at a minimum, the
elements provided for in subsection (4).

(3) Hospitals, as defined in s. 395.002, and health
insurers, regulated pursuant to parts VI and VII of chapter
627, shall establish by no later than March 17, 1987,
prospective payment arrangements that provide hospitals with
financial incentives to contain costs. Each hospital shall
negotiate with each health insurer which represents 10 percent
or more of the private-pay patients of the hospital to
establish a prospective payment arrangement. Beginning
October 17, 1987, and annually thereafter, Hospitals and health
insurers regulated pursuant to this section shall report, on
October 1 of each year, the results of each specific
prospective payment arrangement adopted by each hospital and
health insurer to the Hospital-Cost-Containment board. If in the event that
a hospital or a health insurer fails to comply with the requirements of this
section, such hospital or health insurer shall have 60 days in
which to justify to the board the reasons for its failure to
comply to the board. The board shall take into account the
failure of the hospital to comply in its approval or
disapproval of the budget of the hospital. In addition, the
board shall report a health insurer's failure to comply to the
Department of Insurance, which shall take into account the
failure by the health insurer to comply in conjunction with
its approval authority under s. 627.410. The board shall
adopt any rules necessary to carry out its responsibilities
required by this section.

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(4) The prospective payment system established pursuant to this section shall include, at a minimum, the following elements:

(a) A maximum allowable payment amount established for individual hospital products, services, patient diagnoses, patient day, patient admission, or per insured, or any combination thereof, which is preset at the beginning of the budget year of the hospital and fixed for the entirety of that budget year, except when extenuating and unusual circumstances acceptable to the board warrant renegotiation;

(b) Timely payment to the hospital by the insurer or the insured, or both, of the maximum allowable payment amount, as so negotiated by the insurer or group of insurers;

(c) Acceptance by the hospital of the maximum payment amount as payment in full, which shall include any deductible or coinsurance provided for in the insurer’s benefit plan;

(d) Utilization reviews for appropriateness of treatment; and

(e) Preadmission screening of nonemergency surgery.

(5) Nothing contained in this section does not prohibit the inclusion of deductibles, coinsurance, or other cost containment provisions in any health insurance policy.

Section 19. Section 395.509, Florida Statutes, is renumbered as section 407.057, Florida Statutes, and is amended to read:

(Substantial rewording of section. See s. 395.509, F.S., for present text.)

407.057 Review of hospital budget.--

(1) The base for hospital budget reviews shall be the hospital's prior year's actual gross revenues per adjusted

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admission inflated forward by the applicable maximum allowable rate of increase or the board-approved gross budgeted revenues per adjusted admission, whichever is higher, unless the board approves a rate of increase below the maximum allowable rate of increase, in which case the board-approved level applies.

(2)(a) Except for a hospital which files a budget pursuant to subsection (3), each hospital, at least 90 days prior to the commencement of its fiscal year, shall file with the board a certified budget letter, acknowledging its applicable maximum allowable rate of increase in gross revenues per adjusted admission and must affirm that the hospital will not exceed such applicable maximum allowable rate of increase. The budget letter, automatically by operation of law, constitutes the budget for the hospital for that fiscal year. However, the board shall have 30 days after receipt of the budget letter to determine if the gross revenues per adjusted admission submitted by the hospital are within the maximum allowable rate of increase for that hospital.

(b) If the budget of a hospital increases at a percentage rate less than the maximum allowable rate of increase applicable to that hospital, the hospital may carry forward the difference and accumulate up to 3 percentage points which may be used in the future. Such accumulated percentage points may be added to the hospital's gross revenues per adjusted admission in future years to increase the hospital's maximum allowable rate of increase or, if a budget amendment is required for the hospital to avoid a penalty, may be used in the current fiscal year. However, the hospital must use its original approved maximum allowable rate of increase as its base. The hospital must specify in the

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budget letter, or in a budget amendment letter submitted before the end of the fiscal year, the number of accumulated percentage points it intends to add to its maximum allowable rate of increase to increase its gross revenues per adjusted admission. A hospital must use its accumulated percentage points before submitting a budget for detailed review or before submitting a request for a budget amendment. The board shall adopt rules which specify procedures for hospitals to accumulate and use any percentage points under this paragraph.

(3) At least 90 days prior to the commencement of its fiscal year, each hospital that requests a rate of increase in gross revenue per adjusted admission in excess of the maximum allowable rate of increase for the hospital's next fiscal year, or each hospital that uses its accumulated percentage points pursuant to paragraph (2)(b) and requests a rate of increase in excess of the maximum allowable rate of increase plus its available accumulated percentage points, is subject to detailed budget review and must file its projected budget with the board for approval. The projected budget filed under s. 407.031(6) shall be deemed approved unless it is disapproved by the board within 90 days after filing. Upon agreement by the board and the hospital, the 90-day period may be waived or extended. As part of the review conducted by the board, the board may approve, disapprove, or disapprove in part the projected budget. A hospital which submits a budget for approval may not operate at a level of expenses or revenues which exceeds the maximum allowable rate of increase, unless a higher rate of increase has been approved by the board. However, a hospital which has accumulated percentage points and which requests a rate of increase which exceeds the maximum allowable rate of increase plus the accumulated

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(4) For purposes of budget review and comparison, the board may, by rule, establish groupings of hospitals according to characteristics, including but not limited to, number of beds, a measure of the nature and range of services provided, teaching hospital status, number of residency programs, resident doctors per bed, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, percentage of Medicaid inpatient days, percentage of charity care days, average daily census, geographical differences, regional referrals, service intensity, and case-mix index. The rule must provide for the establishment of a statistically valid and reliable number of hospital groups. A hospital grouping may not contain fewer than six hospitals.

(5) The board shall review each budget filed pursuant to subsection (3) and amendments filed pursuant to subsection (7) to determine whether the rate of increase contained in the budget or amendment is reasonable and not excessive. In making such determination, the board will consider:

(a) The effect on hospital gross revenues attributable to:

1. The provision of services and care to medically indigent persons.

2. Participation in Medicare, Medicaid, and other governmental programs, including but not limited to, changes in patient days, reimbursement methodologies, and reimbursement rates.

3. Increases in bad debts.
4. Increases in case-mix indexes and severity-of-illness indexes.

5. The provision of new services or facilities, excluding new services or facilities regulated pursuant to s. 381.706 which have not been approved by the designated state agency.

6. For psychiatric hospitals, changes in the average length of stay of patients and changes in admissions to hospital units and to specific services.

(b) Changes in physician practice patterns, skilled medical personnel availability, and insurance rates and other factors beyond the control of the hospital.

(c) Expenses, incurred within the last 3 years, of opening a new hospital or replacing an existing hospital at a new site.

(d) The number of residency programs and resident doctors per bed.

(e) For budgets filed pursuant to subsection (3) and amendments filed pursuant to subsection (7), the board shall first determine a reasonable rate of increase for gross revenues. In determining reasonable rates of increases in budgeted gross revenues, the board shall use the market basket index, increases in the hospital-specific case-mix score, and the criteria in subsection (5). The board shall then determine budgeted gross revenues. In determining reasonable increases in budgeted gross revenues, the board shall include 100 percent of the increase in uncompensated indigent care, 100 percent of the increase in deductions from gross revenues associated with all government payers, and a credit, not to exceed 2 percentage points, for hospitals in the 33rd percentile or lower in gross revenues per adjusted admission.

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for all hospitals for the last year for which audited actual experience is available for all hospitals. The board may not reduce a proposed budget below the maximum allowable rate of increase.

(7)(a) If a hospital intends to amend its budget so that the amended budget does not exceed the maximum allowable rate of increase plus the hospital's accumulated percentage points, the hospital may file with the board a certified budget amendment letter, affirming that its amended budget will not exceed the applicable maximum allowable rate of increase plus its accumulated percentage points. The budget amendment letter is automatically approved by operation of law. However, the board shall have 30 days after receipt of the budget amendment letter to determine if the amended gross revenues per adjusted admission submitted by the hospital are within the maximum allowable rate of increase plus the accumulated percentage points for that hospital.

(b) A request by a hospital to amend its budget to exceed the maximum allowable rate of increase plus its accumulated percentage points, or to exceed its budget as approved by the board, must be filed in writing with supporting documents no later than 90 days before the end of the hospital's fiscal year. The budget amendment letter shall be deemed approved unless it is disapproved or approved as amended by the board within 60 days after such filing. Upon agreement by the board and the hospital, the 60-day period may be waived or extended.

(c) After a hospital files a budget amendment letter, but before the final decision by the board on the budget amendment letter, the board may extend provisional approval to any part of the budget amendment letter. This provisional

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approval shall be superseded by the final decision of the board.

(8) The board shall disapprove, in its entirety or in part, any budget or any budget amendment that contains a rate of increase which the board finds, pursuant to subsection (5), to be unreasonable or excessive. The board may not reduce a proposed budget below the maximum allowable rate of increase as a result of filing a budget request or as a result of filing a request for an amendment. The board may not disapprove all or part of a budget if the hospital chooses to present information and demonstrates to the board that disapproving all or part of the budget would deprive the hospital of its ability to earn a reasonable rate of return or would otherwise jeopardize its ability to meet its financial requirements and obligations. In considering the hospital's financial requirements, obligations, and rate of return, the board shall consider financial indicators including, but not limited to, cash flow to debt, equity financing, long-term debt to equity, operating margin, return on assets, return on equity, average age of plant, and replacement viability.

(9)(a) Upon receipt of a budget letter or a budget amendment letter, the staff of the board shall review the budget, and executive staff members designated by the board shall make preliminary findings and recommend actions in writing as to whether the budget should be approved, disapproved, or disapproved in part. The staff shall send the preliminary findings by certified mail to the hospital. The hospital shall have 14 days after the receipt of the preliminary findings and recommendations to file written objections and request a hearing with the board or to file written objections.

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(b) If a hearing is requested, it shall be conducted by the board or, at the election of the board, by a hearing officer assigned by the Division of Administrative Hearings of the Department of Administration pursuant to s. 120.57. The Division of Administrative Hearings shall assign at least two full-time hearing officers exclusively to hear matters pertaining to this chapter. Hearings must be held within 30 days after the request is filed, unless waived by the board and the hospital. All hearings must be held in Tallahassee, unless the board determines otherwise.

(c) Recommended orders must be issued within 30 days after the close of the hearing, unless waived by all parties. The board shall enter a final order within 90 days after the date of filing of the budget letter or budget amendment letter. It is the intent of the Legislature that the final order shall apply to the entire fiscal year and may not be reduced or prorated for any reason.

(d) Any waiver of the time limits within which to conduct a hearing or to issue a recommended order also constitutes a waiver of the time limit to issue the final order and tolls the automatic approval provision of subsection (3) or paragraph (7)(b). The 90-day period under subsection (3) and the 60-day period under paragraph (7)(b) will be tolled beginning on the date that the waiver is entered and will resume 10 days after the recommended order is submitted to the board. The failure to request a hearing within 14 days after the receipt of the preliminary findings of the staff constitutes a waiver of the right of the hospital to contest the final decision of the board, and the board may enter a final order consistent with the staff's preliminary findings without further proceedings.
(e) During the pendency of any hearing or an appeal of a final order of the board, the hospital may not operate at a level of expenses and revenues which exceeds the maximum allowable rate of increase, unless a higher rate of increase has been approved by the board. However, a hospital that has accumulated percentage points and that requests a rate of increase which exceeds the maximum allowable rate of increase plus the accumulated percentage points may not operate at a level of expenses or revenues in excess of the maximum allowable rate of increase plus the accumulated percentage points.

(10) The board may publish its findings in connection with any review conducted under this section in the newspaper which has the largest circulation in the county in which the hospital is located.

(11) Notwithstanding any other provision of the chapter, hospitals operated by the Department of Health and Rehabilitative Services or the Department of Corrections, comprehensive rehabilitative hospitals, and rural hospitals are exempt from the requirements to file a budget letter, are exempt from budget review and approval for exceeding the maximum allowable rate of increase, and are exempt from any penalties arising therefrom. However, each such hospital is required to submit to the board its audited actual experience, as required by s. 407.031(7).

(12) A hospital which is subject to this section may file with the board, at least 90 days prior to the commencement of its fiscal year, a certified exemption letter exempting the hospital from budget review pursuant to this section. The exemption letter must contain adequate proof that for the previous 2 years payments for 85 percent or more

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of the hospital's patient days have been determined in
advance, either due to government programs, uncompensated
care, or through negotiated arrangements with private
purchasers. The hospital is exempt from the other provisions
of this section unless within 30 days after receipt of the
exemption letter the board determines that the hospital did
not receive payments for 85 percent or more of its patient
days which were determined in advance.

(13) The review and approval of hospital budgets
pursuant to this section shall begin for hospitals with fiscal
years which commence on or after February 1, 1989.
Notwithstanding any other provision in this chapter, any
budget or budget amendment for fiscal years commencing prior
to February 1, 1989, shall be filed and reviewed pursuant to
chapter 84-35, Laws of Florida, and rules adopted by the board
pursuant thereto.

Section 20. Section 395.5094, Florida Statutes, is
renumbered as section 407.061, Florida Statutes, and amended
to read:

407.061 395.5094 Exceeding approved budget or previous
year's actual experience by more than maximum rate of
increase; allowing or authorizing operating revenue or
expenditures to exceed amount in approved budget; penalties.--

(1)(a) The board shall annually compare the audited
actual experience of each hospital to the audited actual
experience of that hospital for the previous year. If the
board determines that the audited actual experience of a
hospital exceeded its previous year's audited actual
experience by more than the maximum allowable rate of increase
or exceeded the projected budget as approved by the board,
whichever is greater, the amount of such excess shall be

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determined by the board, and a penalty shall be levied against
such hospital pursuant to subsection (2) based thereon as
follows:

(b) For hospitals that submit a budget letter, and for
hospitals subject to budget review, the board shall annually
compare each hospital's audited actual experience for net
revenues per adjusted admission to the hospital's audited
actual experience for net revenues per adjusted admission for
the previous year. If the rate of increase in net revenues
per adjusted admission between the previous year and the
current year was less than the market basket index plus 2
percentage points, the hospital may carry forward the
difference and accumulate up to 3 net revenue percentage
points. Such accumulated net revenue percentage points shall
be available to the hospital to offset in any future year
penalties for exceeding the approved budget or the maximum
allowable rate of increase. This paragraph does not justify
the approval of a budget letter or a budget amendment letter
in excess of the maximum allowable rate of increase.

(2) Penalties shall be assessed as follows:

(a) For the first occurrence within a 5-year period,
the board shall either prospectively reduce the current budget
of the hospital or reduce the hospital's next year's budget,
at the option of the hospital, by the amount of the excess up
to 5 percent; and, if such excess is greater than 5 percent
over the maximum allowable rate of increase, any amount in
excess of 5 percent shall be levied by the board as a fine
against such hospital, to be deposited in the Public Medical
Assistance Trust Fund, as created in s. 409.2662.

(b) For the second occurrence within the 5-year period
following the first occurrence as set forth in paragraph (a),
the board shall **either** prospectively reduce the current budget of the hospital or the hospital's next year's budget, at the option of the hospital, by the amount of the excess up to 2 percent; and, if such excess is greater than 2 percent over the maximum allowable rate of increase, any amount in excess of 2 percent shall be levied by the board as a fine against such hospital, to be deposited in the Public Medical Assistance Trust Fund.

(c) For the third occurrence within the 5-year period following the first occurrence as set forth in paragraph (a), the board shall:

1. Levy a fine against the hospital in the total amount of the excess, to be deposited in the Public Medical Assistance Trust Fund.
2. Notify the Department of Health and Rehabilitative Services of the violation, whereupon, the department shall not accept any application for a certificate of need pursuant to ss. 381.701-381.715 from or on behalf of such hospital until such time as the hospital has demonstrated, to the satisfaction of the board, that, following the date the penalty was imposed under subparagraph 1., the hospital has stayed within its projected budget for a period of at least 1 year. However, this subparagraph provision does not apply with respect to a certificate-of-need application filed to satisfy a life or safety code violation.
3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the Department of Health and Rehabilitative Services, whereupon the department shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.
The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital pursuant to s. 409.266(7) or s. 409.2663. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.101 minus the amount of revenues received by the hospital through the operation of s. 409.266(7) or s. 409.2663. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, its entitlement to such reduction. The board shall also reduce the amount of the excess by the percentage increase, converted to an absolute dollar increase using net revenues, in a hospital's actual audited case-mix index, and severity-of-illness index when available, as compared to the previous year's actual audited case-mix index, and severity-of-illness index when available, without any thresholds or limitations. For psychiatric hospitals, the board shall also reduce the amount of the excess by the percentage increase converted to an absolute dollar increase using net revenues in a hospital's actual audited average length of stay as compared to the previous year's actual audited average length of stay without any thresholds or limitations. The board may waive a penalty for a hospital which, because of extraordinary circumstances, exceeds its previous year's audited actual experience by more than the maximum allowable rate of increase or exceeded the projected budget as approved by the board. The board shall consider in making a determination of a penalty waiver a hospital's total and operating margin, its financial viability, changes in mix of cases or service intensity, or

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other extraordinary circumstances, it is the intent of the legislature that the Hospital Cost Containment Board in levying any penalty imposed against a hospital for exceeding its approved budget pursuant to this subsection consider the effect of changes in the case mix of the hospital -- it is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case mix.

(3) If the board finds that any hospital chief executive officer, or any person who is in charge of hospital administration or operations, has knowingly and willfully allowed or authorized actual operating revenues or expenditures that are in excess of projected operating revenues or expenditures in the hospital budget as approved by the board, the board shall order such officer or person to pay an administrative fine not to exceed $5,000.

The board may not reduce the budget of or levy a fine upon any hospital-based on the hospital's audited actual experience for fiscal year 1986 if the hospital treated inmates from the Department of Corrections and if the hospital exceeded its previous year's audited actual experience by more than the maximum allowable rate of increase or exceeded its projected budget as approved by the board for fiscal year 1986 solely as a result of revenue paid to such hospital by the Department of Corrections for treatment of inmates.

Section 21. Section 395.5125, Florida Statutes, is renumbered as section 407.064, Florida Statutes, and amended to read:

407.064 395.5125 Operating costs; nondeductible items.

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

(2) For purposes of determining reasonable costs of
services furnished by hospitals, unrestricted grants, gifts,
and income from endowments may not be deducted from any
operating costs of such hospitals, and, in addition, the
following items may not be deducted from any operating
costs of such hospitals:

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

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

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

Section 22. Section 395.5135, Florida Statutes, is
renumbered as section 407.067, Florida Statutes, and amended
to read:

407.067 395.5135 Burden of proof with respect to
factual determinations by the board.--Notwithstanding any
other provisions of this chapter part, when a hospital alleges
that a factual determination made by the board is incorrect,
the burden of proof shall be on the hospital to demonstrate
that such determination is, in light of the total record, not

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supported by a preponderance of the evidence. The burden of proof remains with the hospital in all cases involving administrative agency action.

Section 23. Section 395.5092, Florida Statutes, is renumbered as section 407.071, Florida Statutes, and amended to read:

407.071 395-5092 Budget review proceedings; duty of Public Counsel.--Notwithstanding any other provisions of this chapter part, it is shall be the duty of the Public Counsel to represent the general public of the state in any proceeding before the board or its advisory panels in any administrative hearing conducted pursuant to s. 120.57 or before any other state or federal agency or court in any issue related to budget review. With respect to any such proceeding, the Public Counsel is subject to the provisions of, and may utilize the powers granted to him by, ss. 350.061-350.0614.

Section 24. Section 395.52, Florida Statutes, is hereby repealed.

Section 25. Hospital Cost Containment Board study; hospital expenditure and revenue study; sunset review criteria.--

(1) The Hospital Cost Containment Board shall contract for a study of the board and hospital expenses and revenues. The study must be completed and a report furnished to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than February 1, 1990. The study shall include the following elements:

(a) Documentation for a multi-year period of the historical expenditures, gross revenues, net revenues, patient revenues by source of revenue, contractual allowances, gross revenues per adjusted admission, net revenues per adjusted

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admission, total operating expenditures, nonoperating revenue, service intensity, case-mix indexes, average length of stay, occupancy rates, staffing, payer mix, and margins of hospitals in this state by type of hospital, geographical location, and type of ownership. The study should include all other factors necessary to understand expenses, revenue, margin, and utilization trends of hospitals in this state.

(b) An historical comparison of rates of increase in gross revenues, contractual allowances, net revenues, and total operating expenses per adjusted admission and patient day, by type of hospital and geographical location. Rates of increases for hospitals in this state should be compared to national hospital market basket indexes.

(c) A determination of the extent to which various factors have affected the rates of increase in gross revenues, net revenues, and total operating expenses per adjusted admission and patient day. Such determination shall include the effect by major factor in dollar and percentage increase by type and location of hospital. Factors considered shall include, but not be limited to, utilization, margins, case-mix indexes, service intensity, nature and scope of services, contractual allowances, changes in technology, changes in payer reimbursement practices, changes in insurance coverages and practices, changes in regulatory practices, inflation, physical plant changes, and changes in medical practice. Such an analysis should include an evaluation of the effect of federal, state, and local statutory or regulatory requirements on costs of and charges for hospital care and changes in statutes or regulations which would provide for more cost-efficient care that is accessible and of acceptable quality.
(d) A determination of the extent to which price and nonprice competition among hospitals in this state has occurred and is occurring and the extent to which such competition has affected hospital revenues, expenses, and margins.

(e) An assessment of productivity improvements by hospitals in this state and voluntary price restraints and cost containment by the hospital industry in this state.

(f) An analysis of the extent to which regulation by the Hospital Cost Containment Board has affected hospital revenues, expenses, and margins. Such analysis should include an assessment of the financial viability of hospitals in this state, using a variety of common financial ratios and indicators.

(g) Recommendations regarding the continuation or modification of the board and its regulatory functions. Such recommendations shall include the number and level of board changes in hospital revenues, the extent of hospital price competition, changes in payer reimbursement practices, or other types of changes which would warrant additional authority or lessen or eliminate the need for such authority.

(h) Methods for accurately assessing increases or decreases in cost shifts between payers and the consequences of such cost shifts.

(i) Recommendations for modifications in the form or method of review and approval of, and imposition of sanctions against, hospital budgets.

(j) An assessment of and recommendations regarding alternative hospital cost containment strategies and mechanisms by which implementation of the policy recommendations would be accomplished.

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(k) A recommendation to the board for a Florida-specific measure of hospital expenses, which shall be adjusted for geographic differences among hospitals in this state. The Florida Hospital Input Price Index shall include, but not be limited to, the components of the National Hospital Input Price Index, weighted for Florida-specific experience, as well as other expenses not currently included in the National Hospital Input Price Index. The study shall indicate expense trends during the past 8 years, as well as unusual expense increases such as for nurses.

(l) Recommendations to the board regarding a methodology and reporting system to measure the impact annually of changes in reimbursement methodologies and changes in reimbursement levels from all government payers and increases in uncompensated care, including bad debts.

(m) Recommendations to the board regarding a statistical measure for the severity-of-illness index.

(2) The report required by subsection (1) shall include results of these studies and recommendations for their implementation. As part of the recommendations, the board shall submit recommendations for the permanent maximum allowable rate of increase. Unless modified by the Legislature, the board shall adopt rules pursuant to chapter 120, Florida Statutes, to implement the recommendations by October 1, 1990.

(3) The Hospital Cost Containment Board shall collect relevant information and data about the hospital industry and board performance criteria as provided in subsection (4). The board shall publish on March 1 of each year a report summarizing board and industry performance. The board shall establish, by rule, any additional hospital financial and

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program reporting requirements necessary to implement the requirements of this subsection.

(4) On or before October 1, 1993, the Legislature shall conduct a review of hospital industry and board performance using the following criteria:

(a) Rates of increase in gross revenues, net revenues, regulated revenues, and total operating expenses per adjusted admission and patient day relative to previous years and national trends.

(b) The extent to which health care purchasers, independent of the board, exercise control over hospital revenues and expenses, including changes in the percent of patient days subject to discounted charges or which are based in some way on hospital costs.

(c) The level and changes in the level of contractual allowances.

(d) The extent to which hospitals have discounted charges for health maintenance organizations, preferred provider organizations, and other payers, and the level of such discounts.

(e) The extent to which charges have increased for self-pay patients and purchasers and insurers who do not benefit from discounts.

(f) The extent of productivity improvements by the industry and voluntary cost containment efforts.

(g) Any evidence of enhanced price competition among hospitals.

(h) Changes in payer reimbursement practices which affect hospital revenues and expenses.

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(1) Actual hospital revenues and expenses relative to budgeted amounts and maximum allowable rates of increase compared to previous years.

(j) The extent of budget reductions mandated and penalties assessed by the board.

(k) The rates of increase in gross revenues, net revenues, total operating expenses, and margins of hospitals which are not subject to detailed budget review compared to those hospitals which are subject to detailed budget review.

(5) The sum of $200,000 is hereby appropriated from the General Revenue Fund to the Hospital Cost Containment Board for the study required by subsection (1) for fiscal year 1988-1989. Any unencumbered balance of such appropriation remaining on June 30, 1989, shall not revert to the General Revenue Fund, but be used for the study in fiscal year 1989-1990.


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by the Legislature prior to that date pursuant to s. 11.61, Florida Statutes.

Section 28. Section 389.301, Florida Statutes, is created to read:

389.301 Short title.--This chapter may be cited as the "Health Planning Act."

Section 29. Section 381.025, Florida Statutes, is renumbered as section 389.304, Florida Statutes, and amended to read:

389.304 Legislative intent; health long-range planning.--

(1) The Legislature finds that the general health and well-being of the public citizens-of-this-state can be improved through more prudent long-range planning by governmental agencies. Many people citizens-of-the-state are denied access to basic health services due to geographic and financial barriers, and alternative delivery systems are needed to replace archaic and ineffective health and social service delivery programs. Furthermore, the Legislature intends that government not only strive to meet existing needs, but develop the ability to anticipate and respond to future needs which may result from population growth, technological advancements, new societal priorities, or other changes.

(2) It is the intent of the Legislature to assure that health care is affordable and accessible to all persons in this state. To further the accomplishment of this goal, the Department of Health and Rehabilitative Services shall serve as a focal point for governmental health planning efforts and activities. The Legislature intends that the statewide health planning responsibilities of the Department of Health and

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Rehabilitative Services shall be expanded. It is the intent of the Legislature that, as the state health planning agency, the Department of Health and Rehabilitative Services shall:

(a) Advise the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding health policy issues; trends in the health care industry, including inflationary trends in health care costs; the health status of Floridians; health care utilization trends; and trends in health care resource supplies;

(b) Identify emerging health care issues and provide relevant analyses to the Governor and the Legislature;

(c) Educate consumers and providers of health care services about health care utilization trends and costs in order to encourage consumer and provider cost consciousness and encourage price competition in the health care market place; and

(d) Recommend to the Governor, the President of the Senate, and the Speaker of the House of Representatives appropriate strategies to ensure affordable and accessible health care in this state.

(3) It is the intent of the Legislature that the Department of Health and Rehabilitative Services strive to improve the delivery of essential health services through greater emphasis on long-range planning and less reliance on crisis intervention. Existing delivery systems shall be evaluated and, where appropriate, such programs shall be enhanced or replaced with alternative delivery systems which emphasize cost efficiency and prevention. Specifically, it is the intent of the Legislature that, as provided within existing appropriations, the Department of Health and Rehabilitative Services:

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(a) Develop a state policy framework for health care and services, including the identification of major health care policy issues and health care priorities to be incorporated in a comprehensive state health plan. Within the policy framework there shall be a review and a redefinition of the role of the department in, and its responsibilities for, environmental health; the development of a contingency plan for emergency response to high-risk public health hazards; and an assessment of the needs of medically underserved persons.

(b) Develop and implement a plan for addressing the public health quality of the drinking water of the state, including a plan for:

1. Water sampling and testing for priority pollutants;
2. Establishment of epidemiological and technical capabilities for human health risk assessments and intervention strategies for toxic contamination; and
3. Performance of a comprehensive assessment of the drinking water of the state in concert with the Department of Environmental Regulation.

(c) Accomplish a reduction in infant mortality by expanding the provision of prenatal care, intensive obstetrical services, family planning services, and follow-up services to high-risk neonates.

(d) Assume the delivery of statutorily prescribed public and personal health services through public health units by entering into contractual arrangements with county governments, and, where feasible, expanding the role of public health units in meeting community needs for primary care and nutrition programs.

(e) Improve the health status of the children of this state through expanding pediatric primary care and dental care

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capabilities and by providing specialized home care services
to families with chronically ill or handicapped children,
determining the need for a statewide medical foster home
program, expanding child protection services, and increasing
the number of children receiving Medicaid screening and
children's medical services programs.

(f) Maximize the use of its health care dollars
through an analysis of all departmental health care services
and funds and by developing policies that will enable the
department to control escalating health care costs and
targeting resources for primary and preventive care in order
to reduce secondary, tertiary, or institutional care. The
department shall make every reasonable effort to serve as a
prudent purchaser of health care services and to lead by
example in stimulating the development of a competitive health
care marketplace.

(g) Plan for the projected rapid growth of the elderly
population of this state by addressing the anticipated acute
and long-term care needs of that subgroup and developing
strategies to replace or delay reliance on institutional care
by maximizing family and community support systems,
alternative residential services, and other more cost-
efficient preventive strategies.

[4] The Legislature intends that the School of
Public Health of the University of South Florida assume a
leadership role within the public health system through the
development of academic programs intended to meet this state's
unique health care, economic, political, and social service
needs. Beyond its roles as educator of public health
professionals in this state and as sponsor of relevant
academic research, the School of Public Health shall be
consulted by the public officials of this state in the management of public health affairs.

§ 389.307 Definitions.--As used in this chapter, the term:

1. "Audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards.

2. "Center" means the State Center for Health Statistics within the Department of Health and Rehabilitative Services.

3. "Certificate of need" means a written statement issued by the department evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.

4. "Data" means items of information made or received by the department which pertain to a condition, status, act, or omission, whether the information is retrievable by manual or other means and whether or not coded, and includes the normal and computer art meanings of the word data.

5. "Department" means the Department of Health and Rehabilitative Services.

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"District" means a service district of the department as established in s. 20.19.

"Financial report" means a report of audited actual experience for nursing homes as required under the uniform system of financial reporting pursuant to s. 389.334.

"Information system" means an interrelated grouping of data for use by the center or other public or private agencies referred to in this section.

"Nursing home" means a facility licensed under s. 400.062, but does not include a facility licensed under chapter 651.

Section 31. Section 389.311, Florida Statutes, is created to read:

389.311 Designation of state health planning agency. -- The department is designated as the state health planning agency. The department is responsible for the planning of all health care services in the state.

Section 32. Section 389.314, Florida Statutes, is created to read:

389.314 Health planning studies; analyses; reports. --

(1) The department shall prepare and furnish a state health plan by December 1 of even-numbered years to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The state health plan shall include, but not be limited to, the health status of the people in this state, health status objectives, recommended strategies to improve the health status of the people in this state, health facility and service inventories and needs, health care manpower requirements and supplies, health care utilization trends, and other analyses of topical health policy issues. The department shall provide for a wide

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distribution of the state health plan to state and local agencies, health care provider associations, consumer organizations, purchaser organizations, and other interested groups. The department may assess a charge for the cost of preparation and publication of the state health plan.

(3) The department shall prepare and furnish an indigent health care plan by December 1 of odd-numbered years to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The indigent health care plan shall include, but not be limited to, identification of medical indigency within the population; analyses of public expenditures related to health care for indigents; an assessment of the effect of public policies on improving the health of indigents and enhancing the access of indigents to health care; strategies to improve the health of indigents and enhance their access to health care services; and analyses of issues related to health care for indigents.

Section 33. Section 389.317, Florida Statutes, is created to read:

389.317 Health care cost containment; duties and responsibilities of the department.--

(1) The department shall prepare and furnish a health care cost containment plan by February 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(2) The annual cost containment plan shall include, but not be limited to, the following components:

(a) Historical analyses of health care costs and charges relative to state and federal inflation indexes.

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(b) The extent of price competition and nonprice competition in the health care marketplace and their effect on health care costs and charges.

(c) Other changes in the health care industry, including productivity improvements and voluntary price restraints, which have contained health care costs and charges.

(d) Changes in third-party payer reimbursement and utilization control practices which have contained health care costs and charges.

(e) Changes in public policies, including reimbursement, utilization control, and service delivery changes of governmental purchasers of health care, which have contained health care costs and charges.

(f) An analysis of changes in the supply and demand for health care services which have contained health care costs and charges. The analysis should include changes in health care manpower, health care facility, and other health care service supplies.

(g) Cost containment planning of the department, including the establishment of cost containment objectives, cost containment initiatives implemented, and the measurement of progress towards the accomplishment of established objectives.

(h) Policy options and recommendations regarding additional cost containment strategies which would lead to improvements in the containment of public and private health care costs.

(3) The department shall collect data and conduct such other analyses relating to health care costs, making maximum use of the local health councils and the Hospital Cost...
Containment Board, in order to advise the Governor and the Legislature on statewide health care cost containment strategies.

Section 34. Section 389.321, Florida Statutes, is created to read:

389.321 Office of Technical Assistance.—It is the intent of the Legislature that a single entity be created to serve as a focal point for governmental efforts and activities to promote health care cost containment. Therefore, the department shall establish an Office of Technical Assistance which provides technical assistance to consumers, purchasers, and providers interested in containing health care costs. The Office of Technical Assistance shall include such professional, technical, and clerical staff as is necessary to enable it to carry out its duties. The Office of Technical Assistance shall:

1. **Assist employers in the formation of health care coalitions in the state.**

2. **Develop model health care benefit packages for use by employers and providers in implementing health benefit plans which promote the cost-effective delivery of adequate care.**

3. **Serve as a clearinghouse for information concerning innovations in the delivery of health care services and the enhancement of competition in the health care marketplace.**

4. **Pursue the implementation of mechanisms through which state government will lead by example in the prudent purchase of adequate health services.**

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(5) Work with existing health coalitions and local health councils in carrying out their respective goals efficiently and effectively.

(6) Develop provider and consumer information and education programs designed to promote provider and consumer cost consciousness.

Section 35. Section 389.324, Florida Statutes, is created to read:

389.324 Legislative intent.--The Legislature finds that there is a lack of accurate, comparable, accessible, and current data on health care costs, health care utilization, health status, quality of care, and other health care concerns. The Legislature finds that without such information it is difficult to properly assess the health status of the state population, assess future resource needs, assess quality of care, determine the accessibility and affordability of health care, assess health practices, assess health-care-related policy issues, devise cost containment strategies, and make and evaluate policy choices. The Legislature finds that neither the public nor private purchasers of health care have sufficient data to enable them to make informed choices among health care providers and that consumers have insufficient information to make informed health care decisions. To remedy this problem, the Legislature finds that it is necessary to create a comprehensive health information system which provides a centralized, uniform health care data collection, analysis, and reporting system. It is the intent of the Legislature that the information compiled by the comprehensive health information system be made available to interested persons to improve the decision-making processes regarding the purchase, price, and use of appropriate health care services.

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It is the intent of the Legislature to require providers and other health-care-related entities to provide the information necessary to operate the comprehensive health information system.

Section 36. Section 389.327, Florida Statutes, is created to read:

389.327 State Center for Health Statistics.--

(1) ESTABLISHMENT.--The department shall establish a State Center for Health Statistics. The center shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics. The center shall be staffed with public health experts, biostatisticians, information system analysts, health policy experts, economists, and other staff necessary to carry out its functions.

(2) STATISTICS.--The comprehensive health information system operated by the State Center for Health Statistics shall collect data on:

(a) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.

(b) The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state.

(c) Environmental, social, and other health hazards.

(d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status.

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(e) Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care, and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities.

(f) Utilization of health care by type of provider.

(g) Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.

(h) Family formation, growth, and dissolution.

(i) The extent of public and private health insurance coverage in this state.

(j) The quality of care provided by various health care providers.

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to produce comparable and uniform health information and statistics, the department shall perform the following functions:

(a) Coordinate the activities of state agencies involved in the design and implementation of the comprehensive health information system.

(b) Undertake research, development, and evaluation respecting the comprehensive health information system.

(c) Review the statistical activities of the department to assure that they are consistent with the comprehensive health information system.

(d) Develop written agreements with local, state, and federal agencies for the sharing of health-care-related data or using the facilities and services of such agencies. State
agencies, local health councils, and other agencies under contract with the department shall assist the center in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred to the center.

(e) The department shall establish by rule the types of data collected, compiled, processed, used, or shared. Decisions regarding center data sets should be made based on consultation with the Comprehensive Health Information System Advisory Council and other public and private users regarding the types of data which should be collected and their uses.

(f) The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the department.

(g) Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-related data. The department shall periodically review ongoing health care data collections of the department and other state agencies to determine if the collections are being conducted in accordance with the established minimum sets of data.

(h) Establish advisory standards to assure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.

(i) Prescribe standards for the publication of health-care-related data reported pursuant to this section which

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ensure the reporting of accurate, valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data reported by or available from the center.

(j) Prescribe standards for the maintenance and preservation of the center's data. This should include methods for archiving data, retrieval of archived data, and data editing and verification.

(k) Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.

(4) TECHNICAL ASSISTANCE.--The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and complied by the center. The center shall also provide the following additional technical assistance services:

(a) Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the methods by which a person may secure data from the center, including procedures governing requests, the ordering of requests, time frames for handling requests, and other procedures necessary to facilitate the use of the center's data. To the extent possible, the center should provide current data timely in response to requests from public or private agencies.

(b) Provide assistance to data sources and users in the areas of data base design, survey design, sampling procedures, statistical interpretation, and data access to promote improved health-care-related data sets.
(c) Identify health care data gaps and seek cooperative agreements with other public or private organizations for meeting documented health care data needs.

(d) Assist other organizations in developing statistical abstracts of their data sets that could be used by the center.

(e) Provide statistical support to state agencies with regard to the use of data bases maintained by the center.

(f) To the extent possible, respond to multiple request for information not currently collected by the center or available from other sources by initiating data collection.

(g) Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center.

(h) Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center.

(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.--The center shall provide for the widespread dissemination of data which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:

(a) The center shall publish and make available periodically to agencies and individuals health statistics publications of general interest, publications providing health statistics on topical health policy issues, publications which provide health status profiles of the people in this state, and other topical health statistics publications.

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(b) The center shall publish, make available, and disseminate, promptly and as widely as practicable, the results of special health surveys, health care research, and health care evaluations conducted or supported under this section. Any publication by the center must include a statement of the limitations on the quality, accuracy, and completeness of the data.

(c) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of health care statistics.

(d) The department shall prepare and furnish a status report on the establishment of the center by April 1, 1989, to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report shall include an inventory of health data available in this state, implementation plans and progress made in implementing the functions assigned to the center, and recommendations for further legislation or resources needed to fulfill legislative intent with regard to the center, particularly with regard to establishing a statewide comprehensive health information system. The center shall thereafter be responsible for publishing and disseminating an annual report on the center's activities.

(e) The center shall be responsible, to the extent resources are available, for conducting a variety of special studies and surveys to expand the health care information and statistics available for health policy analyses, particularly for the review of public policy issues. The center shall develop a process by which users of the center's data are periodically surveyed regarding critical data needs and the results of the survey considered in determining which special

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surveys or studies will be conducted. The center shall select
problems in health care for research, policy analyses, or
special data collections on the basis of their local,
regional, or state importance, the unique potential for
definitive research on the problem, and opportunities for
application of the study findings.

(6) CONFIDENTIALITY.--The center shall adopt, by rule,
procedures necessary to protect the confidentiality of, and
regulate the disclosure of, data and records maintained by the
center. The rule shall prescribe procedures for withholding
and releasing data maintained by the center. In adopting this
rule, the center shall consider individual rights and
reasonable expectations of privacy concerning the use of such
information; the public's interest in free access to
governmental information; protections necessary to encourage
persons to provide information; the public's interest in the
effective use of available data to protect and promote the
health of individuals and the public; and the public's
interest in the effective and efficient management of
governmental activities. The procedures shall specify that
the center's data which is disclosed will not identify a
person by name, address, number, symbol, or any other
identifying information. The procedures shall provide for
periodic monitoring to ensure compliance with this subsection.

A violation of this subsection or the rules adopted by the
department under this subsection is a misdemeanor of the first
degree, punishable as provided in s. 775.082 or s. 775.083.

Any employee of the department who violates this subsection or
the rules adopted by the department under this subsection is
subject to immediate dismissal.
(7) PROVIDER DATA REPORTING.--This section does not confer on the department the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law.

(8) BUDGET; FEES; TRUST FUND.--

(a) The Legislature intends that funding for the State Center for Health Statistics be appropriated from the General Revenue Fund.

(b) The State Center for Health Statistics may apply for and receive and accept grants, gifts, and other payments, including property and services, from any governmental or other public or private entity or person and make arrangements as to the use of same, including the undertaking of special studies and other projects relating to health-care-related topics. Funds obtained pursuant to this paragraph may not be used to offset annual appropriations from the General Revenue Fund.

(c) The center may charge such reasonable fees for services as the department prescribes by rule. The established fees shall not exceed the reasonable cost for such services. Fees collected may not be used to offset annual appropriations from the General Revenue Fund.

(d) By July 1, 1991, each state agency which has a health care program and a health-care-related data program must establish an administrative overhead expense item in its biennial budget for the purpose of funding its use of the State Center for Health Statistics.

(e) The department shall establish a Comprehensive Health Information System Trust Fund as the repository of all funds appropriated to, and fees and grants collected for,
services of the State Center for Health Statistics. Any
funds, other than funds appropriated to the center from the
General Revenue Fund, which are raised or collected by the
department for the operation of the center and which are not
needed to meet the expenses of the center for its current
fiscal year shall be available to the board in succeeding
years.

(9) STATE COMPREHENSIVE HEALTH INFORMATION SYSTEM

ADVISORY COUNCIL.--

(a) There is established in the department the State
Comprehensive Health Information System Advisory Council to
assist the center in reviewing the comprehensive health
information system and to recommend improvements for such
system. The council shall consist of the following members:

1. An employee of the Executive Office of the
Governor, to be appointed by the Governor.

2. An employee of the Department of Insurance, to be
appointed by the Insurance Commissioner.

3. An employee of the Department of Education, to be
appointed by the Commissioner of Education.

4. An employee of the Senate, to be appointed by the
President of the Senate.

5. An employee of the House of Representatives, to be
appointed by the Speaker of the House of Representatives.

6. Ten persons, to be appointed by the Secretary of
the Department of Health and Rehabilitative Services,
representing other state and local agencies, state
universities, the Florida Association of Business/Health
Coalitions, local health councils, professional health-care-
related associations, consumers, and purchasers.

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(b) Each member of the council shall be appointed to serve for a term of 4 years from the date of his appointment, except that a vacancy shall be filled by appointment for the remainder of the term and except that:

1. Three of the members initially appointed by the Secretary of the Department of Health and Rehabilitative Services shall each be appointed for a term of 3 years.

2. Two of the members initially appointed by the Secretary of the Department of Health and Rehabilitative Services shall each be appointed for a term of 2 years.

3. Two of the members initially appointed by the Secretary of the Department of Health and Rehabilitative Services shall each be appointed for a term of 1 year.

(c) The council may meet at the call of its chairman, at the request of the department, or at the request of a majority of its membership, but at least quarterly.

(d) Members shall elect a chairman annually.

(e) A majority of the members constitutes a quorum, and the affirmative vote of a majority of a quorum is necessary to take action.

(f) The council shall maintain minutes of each meeting and shall make such minutes available to any person.

(g) Members of the council shall serve without compensation, but shall be entitled to receive reimbursement for per diem and traveling expenses as provided in s. 112.061.

(h) This subsection is repealed, and the State Comprehensive Health Information System Advisory Council is abolished, on October 1, 1998, and shall be reviewed by the Legislature prior to that date pursuant to s. 11.611.

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Section 37. Section 400.341, Florida Statutes, is renumbered as section 389.331, Florida Statutes, and amended to read:

389.331 Legislative intent; nursing home costs.--The Legislature finds it to be in the best interest of the state that nursing home care be affordable and accessible to all persons requiring these services. Further, the Legislature finds there is a paucity of information on nursing home expenses and revenues and growth in those expenses and revenues, the equity of the burden in providing charity care, and nursing home rates and charges. The potential for growth in nursing home revenues and the effect of such growth on state and local government budgets and on the ability of persons to purchase nursing home care makes it vital that nursing home revenues and expenditures be documented and analyzed. The Legislature finds that the department, through the State Center for Health Statistics, Hospital-Cost Containment-Board is the agency best qualified to collect, analyze, and monitor nursing home financial data and intends that the department board carry out this responsibility in conjunction with the department and the State Nursing Home and Long-Term Care Facility Ombudsman Council and district nursing home and long-term care facility ombudsman councils.

Section 38. Section 400.343, Florida Statutes, is renumbered as section 389.334, Florida Statutes, and amended to read:

389.334 Uniform system of financial reporting for nursing homes.--

(1) The department board shall consult with appropriate professional and governmental advisory bodies, hold public hearings, and consider existing and proposed

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systems of accounting and reporting utilized by nursing homes and then establish by rule a uniform system of financial reporting. Such system shall be based on a uniform chart of accounts developed after considering the American Health Care Association's Uniform Chart of Accounts for Long Term Care Facilities, appropriate audit standards from the American Institute of Certified Public Accountants, and generally accepted accounting principles. Such system shall, to the extent feasible, utilize existing accounting systems and shall make every effort to minimize paperwork to nursing home licensees. In addition, the department board may not require nursing homes to adopt a uniform accounting system. The department board may require the filing of any information relating to the provider's and consumer's cost of services provided in a nursing home, including physicians' compensation.

(2) Within 120 days after the end of its fiscal year, each nursing home shall file with the department board, on forms adopted by the department board and based on the uniform system of financial reporting, its actual audited experience for that fiscal year, including revenues, expenditures, and statistical measures, based on examination by an independent, state-licensed certified public accountant in accordance with generally accepted accounting principles. Each nursing home shall also submit a schedule of the charges in effect at the beginning of the fiscal year and any changes that were made during the fiscal year. A nursing home which is certified under Title XIX of the Social Security Act and files annual Medicaid cost reports may substitute copies of such reports and any Medicaid audits to the department board in lieu of a report and audit required under this subsection. For such CODING: Words stricken are deletions; words underlined are additions.
facilities, the department board may require only information in compliance with ss. 389.331-389.344 this act that is not contained in the Medicaid cost report. Facilities which are certified under Title XVIII but not Title XIX of the Social Security Act must submit a report as developed by the department board. This report will be substantially the same as the Medicaid cost report and shall not require any more information than is contained in the Medicare cost report unless that information is required of all nursing homes. The audit under Title XVIII shall satisfy the audit requirement under this subsection.

(3) In addition to information submitted in accordance with subsection (2), each nursing home shall track and file with the department board, on a form adopted by the department board and designed to protect the anonymity of residents, the following information, where applicable, reported for each resident or reported in the aggregate, if so directed by the department board:

(a) Date of admission;
(b) Location from which admission was made;
(c) Age at the time of admission;
(d) Primary diagnosis at the time of admission;
(e) Source of financial support at the time of admission;
(f) Date of conversion to Medicaid;
(g) Amount spent on nursing home care prior to conversion to Medicaid, by payer source;
(h) Date of discharge;
(i) Reason for discharge; and
(j) Location to which resident is discharged.

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(4) The department board may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of ss. 389.331-389.344 ss. 400.341-400.346. Such requirements shall be established by rule unless the reports are part of a nonrecurring study or unless information is being requested for a single nursing home.

(5) If more than one licensed nursing home facility is operated by the reporting organization, the information required by this section shall be reported for each nursing home and for the organization's home office separately.

(6) All reports filed under ss. 389.331-389.344 ss. 400.341-400.346, except privileged medical information, shall be open to public inspection.

(7) If in-the-event the department board has reason to believe that there is evidence of noncompliance with any of the provisions of ss. 389.331-389.344 this act, the department board may inspect and audit nursing home books and records, including records of individual or corporate ownership, for compliance with ss. 389.331-389.344 this act. Upon presentation to a nursing home of a written request for inspection, the nursing home shall make available to the department board or its staff for inspection, copying, and review all books and records relevant to the determination of whether the nursing home has complied with ss. 389.331-389.344 ss. 400.341-400.346.

Section 39. Section 400.344, Florida Statutes, is renumbered as section 389.337, Florida Statutes, and amended to read:

389.337 400.344 Nursing home revenues and financial analyses, studies, and reports.--

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(1) The department board shall evaluate data from nursing home financial reports beginning with nursing home fiscal years starting January 1, 1985, and shall document and monitor:

(a) Total revenues, annual change in revenues, and revenues by source and classification, including contributions for a patient's care from the patient's resources and from the family and contributions not directed toward any specific patient's care.

(b) Average patient charges by geographic region, payer, and type of facility ownership.

(c) Profit margins by geographic region and type of facility ownership.

(d) Amount of charity care provided by geographic region and type of facility ownership.

(e) Patient days by prior category.

(f) Experience related to Medicaid conversion as reported under s. 389.334(3) s.400-343-37.

(g) Other information pertaining to nursing home revenues and expenditures.

The findings of the department board shall be included in an annual report to the Governor and Legislature by January 1 each year.

(2) The department board shall provide information relating to nursing home charges to the public through pamphlets, brochures, and other appropriate means pursuant to s. 389.321(6) and through its Office of Technical Assistance the Consumer-Information-Network-established-by-s.395-5885.

(3) The department board shall cooperate with and provide pertinent information on nursing home costs and CODING: Words stricken are deletions; words underlined are additions.
charges to the department, local health councils, and the 
State Nursing Home and Long-Term Care Ombudsman Council, and 
district nursing home and long-term care facility ombudsman 
councils.

(4) The department shall also prepare and file such 
summaries and compilations or other supplementary studies and 
reports based on the information analyzed by the department as 
will advance the purposes of ss. 389.331-389.344.

Section 40. Section 400.345, Florida Statutes, is 
renumbered as section 389.341, Florida Statutes, and amended 
to read:

389.341 400.345 Budget, expenses, assessments; nursing 
home financial disclosure program.--

(l)(a) The department board shall include in its 
biennial budget a separate estimate of income and expenditures 
for the administration and operation of the nursing home 
financial disclosure program. Subject to legislative 
approval, expenses of the program shall be financed by 
assessments against each nursing home in an amount set by the 
department of Health and Rehabilitative Services to cover the 
department's board's approved budget for administering and 
operating the nursing home financial disclosure program.

(b) The board shall annually notify the department of 
its approved budget. The department shall calculate the 
amount to be collected per bed, rounded to the nearest whole 
dollar. All license fees collected under this section which 
are due after the date of notification by the department board 
shall be at a rate sufficient to cover the department's 
board's approved budget for administering and operating the 
nursing home financial disclosure program.

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(c) Assessments shall be levied and collected annually by the department. Moneys collected shall be deposited by the department into a separate trust fund trust fund, but such funds shall be maintained in a separate account.

(d) Each new nursing home shall pay its initial assessment upon being licensed, and each nursing home under new ownership shall pay its initial assessment under the new ownership based on its number of beds.

(2) Moneys raised by collection of assessments from nursing homes which are not required to meet the appropriation for the current fiscal year shall be available to the department board in succeeding years.

Section 41. Section 400.346, Florida Statutes, is renumbered as section 389.344, Florida Statutes, and amended to read:

389.344 400.346 Penalty.--Any nursing home which refuses to file a report, fails to timely file a report, files a false report, or files an incomplete report and upon notification fails to timely file a complete report required under ss. 389.331-389.344 400.341-400.346, or which violates any provision of ss. 389.331-389.344 400.341-400.346 or rule adopted thereunder, shall be punished by a fine not exceeding $1,000 per day for each day in violation, to be imposed and collected by the department board.

Section 42. Section 381.703, Florida Statutes, is renumbered as section 389.347, Florida Statutes, and amended to read:

389.347 381.703 Local and state Health planning councils.--

(1) LOCAL HEALTH COUNCILS.--
(a) Local health councils are hereby established as public or private nonprofit agencies serving the counties of a district of the department. The members of each council shall be appointed in an equitable manner by the boards of county commissioners having jurisdiction in the respective district. Each council shall be composed of a number of persons equal to 1 1/2 times the number of counties which compose the district or 12 members, whichever is greater. Each county in a district shall be entitled to at least one member on the council. The balance of the membership of the council shall be allocated among the counties of the district on the basis of population, rounded to the nearest whole number; except that in a district composed of only two counties, no county shall have fewer than four members. The department shall adopt a rule allocating membership of the various counties pursuant to this paragraph which designates the number of initial appointments from each county, the appointees who shall be representatives of health care providers, health care purchasers, and nongovernmental health care consumers, but not excluding elected government officials, and which provides for an orderly rotation of the appointment of the various classifications of members among the counties in each district. The members of the consumer group shall include a representative number of persons over 60 years of age. A majority of council members shall consist of health care purchasers and health care consumers. The members of the local health council shall elect a chairman. Members shall serve for terms of 2 years and may be eligible for reappointment.

(b) Each local health council shall:

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1. Develop a district plan, using uniform methodology as set forth by the department, which shall permit each local health council to develop goals and criteria based on its unique local health needs. The district plan shall be submitted to the department and updated periodically and shall be in a form prescribed by the department. The elements of a district plan which are necessary to the review of certificate-of-need applications for proposed projects within the district shall be adopted by the department as a part of its rules. The district plan shall include, but need not be limited to:

a. The availability, quality of care, efficiency, appropriateness, accessibility, extent of utilization, and adequacy of existing health care facilities and services and hospices in the district.

b. The need, availability, and adequacy of other health care facilities and services and hospices in the district, including outpatient care and ambulatory or home care services, which may serve as less costly alternatives to proposed or available health care facilities and services.

c. The probable economies and improvements in services that may be derived from operation of joint, cooperative, or shared health care and health planning resources.

d. The need in the district for special equipment and services which are not reasonably and economically accessible in adjoining areas.

e. The need for research and educational facilities, including, but not limited to, institutional and community training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels, and for other health care practitioners.

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2. Stimulate the development of cooperative arrangements relating to the health manpower training efforts of educational institutions and service institutions and the health manpower recruitment and retention efforts of medically underserved communities.

3. Identify and encourage community resources and mechanisms to facilitate consumer choice and market competition in health care by providing data, information, and analysis on charges, resource availability, and certification.

4. Advise the district administrator of the department on health care resource allocations, including federal block grant funds, and work with the district administrator, the district alcohol, drug abuse, and mental health planning councils, and the areawide agency on aging in developing and carrying out a health resources allocation plan.

5. Implement activities to increase public awareness of community health needs and emphasize advantages of preventive health activities and cost-effective health service selection.

6. Assist the department in carrying out data collection activities that relate to the functions set forth in this chapter subsection.

7. Monitor the onsite construction progress, if any, of certificate-of-need projects and report their findings to the department on forms provided by the department.

8. Advise and assist regional planning councils and local governments within each respective district on the development of optional plan elements to address the health goals and policies in the State Comprehensive Plan.

9. Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of state funds

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distributed to meet the medical needs of indigents, the medically-indigent. A report on medically-indigent care of indigents shall be prepared by each local health council and submitted to the Statewide Health Council no later than January 1 of each year. At a minimum, the report shall include the following elements:

a. An inventory of services within the district providing health care to Medicaid and medically indigent clients.

b. An assessment of the use of those services by Medicaid and medically indigent clients.

c. An evaluation of the population need within the district for indigent health care services for indigents and a determination of whether or not that need is being met.

d. A summary presentation of public opinion in communities throughout the district on the medical needs of indigents the-medically-indigent and the services provided to meet these needs.

e. Recommendations for improving health care services for indigents the-medically-indigent.

(c) Local health councils may conduct public hearings pursuant to s. 381.709(3)(b).

(d) Local health councils may employ personnel to carry out the council's purposes. Such personnel shall possess qualifications and be paid salaries commensurate with comparable positions in the Career Service System. However, such personnel shall not be deemed to be state employees.

(e) Each local health council is authorized to accept and receive, in furtherance of its health planning functions, funds, grants, and services from governmental agencies and from private or civic sources, and to perform studies related
to local health planning in exchange for such funds, grants, or services. Each local health council shall, no later than January 30 of each year, render an accounting of the receipt and disbursement of such funds received by it to the department. The department shall consolidate all such reports and submit such consolidated report to the Legislature no later than March 1 of each year. Funds received by a local health council pursuant to this paragraph shall not be deemed to be a substitute for, or an offset against, any funding provided pursuant to subsection (3).

(2) STATEWIDE HEALTH COUNCIL.--The Statewide Health Council is hereby established as a state-level comprehensive health council which is advisory to the department. The Statewide Health Council shall be composed of the 11 chairmen of the local health councils, two members appointed by the Governor, two members appointed by the President of the Senate, and two members appointed by the Speaker of the House of Representatives. At least one of the two members appointed by the Governor, the President of the Senate, and the Speaker of the House of Representatives, respectively, must be a health care consumer or a health care purchaser. Appointed members of the council shall be appointed to serve for a 2-year term commencing on January 1 of each odd-numbered year.

The Statewide Health Council shall:

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

(b) Promote public awareness of state health care issues;

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

(d) Review district health plans for consistency with state health goals and policies;

(e) Prepare and submit to the department an annual a state report, in a manner and form prescribed by the department, which includes the evaluations by each local health council for its respective district, on the adequacy, appropriateness, and effectiveness of state funds distributed to meet the medical needs of indigents the medically indigent;

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

(g) Conduct any other functions or studies and analyses falling under the purview of the mission, goals, and objectives prescribed in this subsection above.

(3) FUNDING.--

(a) The Legislature intends that the cost of local health councils and the Statewide Health Council be borne by application fees for certificates of need and by assessments on health care facilities subject to facility licensure by the department, including abortion clinics, adult congregate living facilities, adult day care centers, ambulatory surgical centers, birthing centers, clinical laboratories, crisis stabilization units, home health agencies, hospices.

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hospitals, intermediate care facilities for the mentally
retarded, nursing homes, and multiphasic testing centers.

(b) A hospital licensed under chapter 395, a nursing
home licensed under chapter 400, and a home health agency
licensed under chapter 400 shall be assessed an annual fee of
$500. All other facilities listed in paragraph (a) shall each
be assessed an annual fee of $150. Facilities operated by the
Department of Health and Rehabilitative Services or the
Department of Corrections are exempt from the fee required in
this subsection.

(c) The department shall, by rule, establish a
facility billing and collection process for the billing and
collection of the health facility fees authorized by this
subsection.

(d) A health facility which is assessed a fee under
this subsection is subject to a fine of $100 per day for each
day in which the facility is late in submitting its annual fee
up to a maximum of the annual fee owed by the facility. A
facility which refuses to pay the fee or fine is subject to
the forfeiture of its license.

(e) There is created in the State Treasury the
Local and State Health Trust Fund. Moneys in the fund shall
be appropriated only to the department for the purposes of
this section.

(f) The department shall, on an ongoing basis,
deposit 90 percent of all certificate-of-need application fees
in the Local and State Health Trust Fund.

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The department shall develop and maintain a comprehensive health-care data base for the purpose of health planning and for certificate of need determinations. The department or its contractor is authorized to require the submission of information from health facilities, health service providers, and licensed health professionals which is determined by the department through rule to be necessary for meeting the department's responsibilities as established in this section.

The department shall provide funding for the Statewide Health Council and local health councils according to an allocation plan. All contract funds shall be distributed according to an allocation plan developed by the department that provides for a minimum and equal funding base for each local health council. Any remaining funds shall be distributed based on adjustments for workload. The department may also make grants to or reimburse local health councils from federal funds provided to the state for activities related to those functions set forth in this section.

Section 3. Section 389.351, Florida Statutes, is created to read:

389.351 Legislative intent.--The Legislature finds that a significant portion of the residents of this state do not have reasonably available private health insurance coverage of the costs of necessary basic health care services. This lack of basic health coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state. The Legislature concludes...

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that there is insufficient information regarding the extent of
uninsurance and underinsurance in this state, the
characteristics of the uninsured and underinsured populations,
employer characteristics, practices and trends regarding the
offering of group health insurance coverage, current sources
of and utilization of care by the uninsured and underinsured
residents of this state and their levels of access to care,
and strategies for promoting the affordability and
availability of private health insurance coverage.

Section 44. Study on health care coverage for
uninsured persons.--
(1) The Department of Health and Rehabilitative
Services shall conduct a study of health care coverage for
uninsured persons.

(2)(a) The final report of the Department of Health
and Rehabilitative Services shall include, but not be limited
to, analyses and recommendations based on an historical
analysis of the health insurance system in this state,
including, but not limited to, the structure, coverage,
benefits, and dynamics of the health insurance system in this
state.

1. The department shall collect data on the extent and
characteristics of the uninsured and underinsured populations
in this state, including data by geographic location;
demographic characteristics, including age, race, gender,
family composition, education, and income; employment status;
type of employment; length of employment; length of time
without insurance; availability and affordability of group
health insurance; reasons for the lack of group health
insurance coverage; health status; health care utilization;
and other factors.

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2. The department shall conduct an analysis of the state's mandated benefit laws and determine the effect such laws have had on insurance practices, the availability of group health insurance, establishment of self-insured plans by employers, health care insurance costs, and health care costs. The department should make recommendations regarding legislative processes which should be used to determine the feasibility of additional mandated benefits, including the use of mandatory cost-benefit analyses prior to the legislation of additional mandated benefits. The department should also recommend any changes to current mandated benefits which would make private group or individual health insurance plans more available and more affordable.

3. The department should determine if there are any statutory barriers to the formation of group health insurance plans by large groups, other than employers and private insurers, and develop strategies for the formation of alternative forms of group health insurance plans, including multiple employer trust and nonemployer and noninsurer group health insurance plans.

(b) The final report of the department should include a variety of policy options and recommendations regarding strategies to improve the private health insurance coverage of uninsured and underinsured persons. The department report shall include, but not be limited to, policy options and recommendations in the following areas:

1. A policy conceptual framework, target populations, and the role of public and private financing.

2. Strategies designed to increase employer group health insurance coverage, including, but not limited to, mandated employer coverage, employer-funded and state-funded

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health insurance pools, other forms of state-subsidized or state-administered health insurance pools or health plans, and health insurance continuation options. The department should identify any local, state, or federal statutes or regulations which discourage employer-sponsored group health insurance coverage and make recommendations for eliminating such disincentives.

3. Strategies designed to contain health insurance costs, including, but not limited to, changes in mandated benefits and coverages, regulatory controls, alternative market strategies, consumer education and information strategies, strategies designed to increase consumer and provider cost consciousness, and alternative, innovative benefit plans.

4. Strategies designed to provide ongoing insurance options for former Medicaid recipients.

5. Strategies designed to increase the availability of affordable private long-term care insurance.

6. Strategies designed to increase the availability of health insurance coverage, private or public, of persons with catastrophic illnesses who are unable to obtain or afford private health insurance coverage.

7. The department's report shall include financing and implementation strategies for the policy options and recommendations contained in the final report. The department report shall also include details regarding any proposed demonstration projects which are designed to test various strategies to increase private or employer-based health insurance coverages.

(3) The Department of Health and Rehabilitative Services may contract with one or more public or private

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organizations or individuals to perform such functions as are in keeping with the intent of this section.

(4) The sum of $100,000 is hereby appropriated from the Public Medical Assistance Trust Fund to the Department of Health and Rehabilitative Services for this study for fiscal year 1988-1989. Any unencumbered balance of such appropriation remaining on June 30, 1989, shall not revert, but may be used for the study in fiscal year 1989-1990.

(5) The Department of Health and Rehabilitative Services shall prepare and submit a final report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1990. An interim report on the progress of the department's work shall be submitted to the Governor and the Legislature by February 1, 1989.

Section 45. Section 381.704, Florida Statutes, is amended to read:

381.704 Duties and responsibilities of department; rules.--

(1) The department is designated as the single state agency to issue, revoke, or deny certificates of need and to issue, revoke, or deny exemptions from certificate-of-need review in accordance with the district plans prepared pursuant to s. 389.347, the statewide health plan, and present and future federal and state statutes. The department is designated as the state health planning agency for purposes of federal law.

(2) In the exercise of its authority to issue licenses to health care facilities and health service providers, as provided under chapters 393, 395, and 400, and to hospices, the department shall not issue a license to any health care...
facility, health service provider, hospice, or part of a
health care facility which fails to receive a certificate of
need for the licensed facility or service.

(3) The department shall establish, by rule, uniform
need methodologies for health services and health facilities.
In developing uniform need methodologies, the department
shall, at a minimum, consider the demographic characteristics
of the population, the health status of the population,
service use patterns, standards and trends, and market
economics.

(4) The department may adopt rules necessary to
implement ss. 381.701-381.715.

(5) The elements of the district local health plan,
prepared pursuant to s. 389.347, which are necessary to the
review of certificate-of-need applications for proposed
projects within the district shall be adopted by the
department as a part of its rules.

Section 46. Section 409.2665, Florida Statutes, is
created to read:

409.2665 Medicaid selective contracting.—The
department shall prepare a plan for the implementation of a
selective contracting program for the contracting of hospital
inpatient and outpatient services provided to Medicaid
recipients. The department shall consult with hospital
providers and provider associations in the development of the
plan. The plan shall include the methodology to be used in
setting or negotiating rates under the selective contracting
program; provider bidding and eligibility requirements;
provider and recipient education requirements; methods for
contracting with teaching hospitals; methods for assuring
sufficient access to inpatient and outpatient care, statutory

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and administrative requirements to implement the selective contracting program; estimates of cost savings; a summary of provider reaction and recommendations regarding a selective contracting program; and other components of the proposed program. The plan shall include implementation strategies and time frames. The department shall furnish the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1989.

Section 47. Section 400.342, Florida Statutes, is hereby repealed.

Section 48. Paragraph (n) of subsection (3) of section 119.07, Florida Statutes, is amended to read:

119.07 Inspection and examination of records;

exemptions.--

(3)

(n) A patient record obtained by the Hospital Cost Containment Board established under s. 407.011 ss.395.509,

which record contains the name, residence or business address, telephone number, social security or other identifying number, or photograph of any person or the spouse, relative, or guardian of such person or which record is patient-specific or otherwise identifies the patient, either directly or indirectly, is exempt from the provisions of paragraph (l)(a).

Section 49. Subsection (18) of section 215.22, Florida Statutes, is amended to read:

215.22 Certain moneys and certain trust funds enumerated.--The following described moneys and income of a revenue nature deposited in the following described trust funds, by whatever name designated, shall be those from which the deductions authorized by s. 215.20 shall be made:

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The Hospital Cost Containment Trust Fund

established pursuant to s. 407.027 ss.395.51,

The enumeration of the above moneys or trust funds shall not prohibit the applicability thereto of s. 215.24 should the Governor determine that for the reasons mentioned in s. 215.24 the money or trust fund should be exempt herefrom, as it is the purpose of this law to exempt all trust funds from its force and effect when, by the operation of this law, federal matching funds or contributions to any trust fund would be lost to the state.

Section 50. Paragraph (a) of subsection (6) and subsection (10) of section 381.601, Florida Statutes, are amended to read:

381.601 Blood transfusions.--

(6) UNIFORM SYSTEM OF FINANCIAL REPORTING.--

(a) The department shall, in consultation with the Florida Hospital Cost Containment Board, develop a uniform system of financial reporting consistent with the reporting system for hospital blood service departments under s. 407.031 ss.395.507. Existing reporting systems and data developed by the Florida Hospital Cost Containment Board shall be utilized by the department whenever applicable in carrying out the provisions of this section. Appropriate professional advisory bodies, existing proposed systems of accounting and reporting utilized by hospital and community blood banks and other blood service operations may be considered, but every attempt should be made to develop a reporting system consistent with that developed under s. 407.031 ss.395.507. No system of financial reporting required under this section shall require the filing of reports which duplicate existing cost containment reporting

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requirements. The system shall be based on a uniform chart of accounts and generally accepted accounting principles for all facilities in the state which collect, store, process, or transfuse blood. Information relating to the consumer and provider, the costs, the percentage of profits, the fees obtained from nonreplacement assessments, the quantity of blood replaced under the individual responsibility concept, the recruitment costs, and other appropriate information may be included within the system as provided in s. 407.031.

(10) LIMITATION.—Nothing in this section shall require hospitals to file reports or make disclosures beyond those required by s. 407.031.

Section 51. Paragraph (a) of subsection (2) of section 381.710, Florida Statutes, is amended to read:

381.710 Conditions and monitoring.—

(2)(a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 1 year after the date of issuance. The department may extend the period of validity of the certificate for an additional period of up to 6 months, upon a showing of good cause, as defined by rule, by the applicant for the extension. The department shall monitor the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application with the assistance of the local health council as specified in s. 389.347(1)(b), and may revoke the certificate of need, if the holder of the

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Section 52. Paragraph (d) of subsection (1) of section 395.101, Florida Statutes, is amended to read:

395.101 Annual assessments on net operating revenues to fund public medical assistance; administrative fines for failure to pay assessments when due.--

(1) For the purposes of this section, the term:

(d) "Hospital Cost Containment Board" or "board" means the Hospital Cost Containment Board created by s. 407.011.

Section 53. Subsection (2) of section 400.609, Florida Statutes, is amended to read:

400.609 Components of hospice programs of care.--Each hospice program shall consist of three components or modes of care which afford the terminally ill individual and the family of the terminally ill individual a range of service delivery which can be tailored to specific needs and preferences of the patient and family at any point in time. These three components are:

(2) INPATIENT HOSPICE CARE.--The inpatient component of care is an adjunct to hospice home care and shall primarily be used only for short-term stays. The facility or rooms within a facility used for the hospice inpatient component of care shall be arranged, administered, and managed in such a manner to provide privacy, dignity, comfort, warmth, and safety for the terminally ill patient and the family. Every possible accommodation shall be made to create as homelike an atmosphere as practicable. To facilitate overnight family visitation within the facility, rooms shall be limited to no more than double occupancy; and, whenever possible, both

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occupants shall be hospice patients. There shall be a
continuum of care and a continuity of care givers between the
hospice home program and the inpatient aspect of care to the
extent practicable and compatible with the preferences of the
patient and his family. Fees charged for inpatient hospice
care, whether provided directly by the hospice or through
contract, shall be made available upon request to the Hospital
Cost Containment Board created in s. 407.011 s-395-503. The
hours for daily operation and the location of the place where
the services are provided shall be determined, to the extent
practicable, by the accessibility of such services to the
patients and families served by the hospice program.

Section 54. Paragraph (d) of subsection (2) and
subsection (4) of section 409.2663, Florida Statutes, are
amended to read:

409.2663 Redistribution of funds in the Public Medical
Assistance Trust Fund.--

(2) DEFINITIONS.--As used in this section:
(d) "Board" means the Hospital Cost Containment Board
as established in s. 407.011 s-395-503.

(4) Funds distributed to a hospital pursuant to this
section shall not be considered as net revenues of such
hospital in determining whether an excess has occurred
pursuant to s. 407.061 s-395-5094. However, if an excess
occurs, such funds shall be included in determining the
reduction of the amount of the excess for the amount of the
assessment paid by the hospital pursuant to s. 395.101 minus
the amount of revenues received by the hospital pursuant to
this section or s. 409.266(7).

Section 55. Subsection (3) of section 627.9175,
Florida Statutes, is amended to read:

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627.9175 Reports of information on health insurance.--

(3) Each health insurer shall annually submit to the department available information related to physician charges. The department shall provide by rule a uniform format for the submission of this information in order to allow for meaningful comparisons of physician charge data. The department, in conjunction with the health insurance industry and the Hospital Cost Containment Board, shall make an initial report to the 1985 regular session of the Legislature as to the feasibility of subdividing total physician charges by specialty and subdividing the most commonly used procedures by location in this state. The department shall provide information collected under this subsection to the Hospital Cost Containment Board for dissemination under the provisions of s. 407.014(9) of the Hospital Cost Containment Board.

Section 56. Subsection (6) of section 768.81, Florida Statutes, as amended by section 79 of chapter 88-1, Laws of Florida, is amended to read:

768.81 Comparative fault.--

(6) Notwithstanding anything in law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, when an apportionment of damages pursuant to this section is attributed to a teaching hospital as defined in s. 407.004, the court shall enter judgment against each party liable on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability.

Section 57. Except as otherwise expressly provided in this act, this act shall take effect October 1, 1988.
STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR
Senate Bill 904

The committee substitute:


-- Retains current law providing for an 11 member board, but revises composition of board to include three providers, three purchasers, four consumers, and the Deputy Assistant Secretary for Regulation and Health Facilities of HRS.

-- Changes the definition of maximum allowable rate of increase (MARI) by allowing hospitals to increase charges by the market basket index, (National Hospital Input Price Index "NHIPI") plus two points as the base; and then allows for a hospital specific index addressing the hospital's shortfalls. Gives 50 percent credit for Medicare, 100 percent credit for charity care and 100 percent credit for Medicaid.

-- Subjects all hospitals (except DHRS and DOC hospitals, Shriner's Hospital, comprehensive rehabilitation hospitals, rural hospitals with less than 85 beds, and hospitals where, for the previous 2 years payments for 85 percent or more of the hospital's patient days have been determined in advance) to budget review, but only if the hospital wishes to exceed the MARI.

-- Requires only hospitals wishing to exceed the MARI need file detailed budgets.

-- Requires all hospitals requesting increases below the MARI submit a "budget letter" which indicates what the hospital's expected GR/AA will be for its next fiscal year, and a statement affirming it intends to stay within the MARI.

-- Allows hospitals to accumulate percentage points up to a cumulative maximum of three points to be used in future years.

-- Gives hospitals the option, when a penalty is assessed, to have its current budget prospectively reduced or have the next year's budget reduced.

-- Allows hospitals to accumulate up to 3 net revenue percentage points to offset penalties in future years.

-- Allows board to waive a penalty when extraordinary circumstances exist.

-- Provides for a HCCB study to include, among other things, development of a Florida Hospital Input Price Index (FHIPI), severity of illness, and government shortfall impact.

-- Provides for a mandated legislative review of hospital industry and board performance on or before October 1, 1993.

-- Creates ch. 389, F.S., the "Health Planning Act of 1988."

-- Designates DHRS as the state health planning agency.
--Requires DHRS to furnish a biennial state health plan, a biennial indigent health care plan, and an annual health care cost containment plan.

--Transfers the Office of Technical Assistance currently within the HCCB to DHRS.

--Requires DHRS to establish a State Center for Health Statistics.

--Establishes within DHRS a State Comprehensive Health Information System Advisory Council consisting of 15 members.

--Transfers the responsibility for collection and dissemination of information relating to nursing home charges from HCCB to DHRS.

--Provides for renumbering of local health councils and Statewide Health Council to ch. 389, F.S.

--Provides for a DHRS study of health care coverage for the uninsured.

--Provides for DHRS to prepare a plan for the implementation of a selective contracting program for the contracting of hospital inpatient and outpatient services provided to Medicaid recipients.

In addition, the committee substitute makes technical and clarifying changes.
A bill to be entitled

An act relating to health care; creating the
Health Care Cost Containment Act; creating
chapter 407, F.S.; amending and transferring
part II of chapter 395, F.S., relating to the
Health Care Cost Containment Act of 1979, to
chapter 407, F.S.; providing a short title;
providing definitions; prescribing the maximum
allowable rate of increase in hospital rates;
providing legislative intent; establishing
administrative authority; revising composition
of the Hospital Cost Containment Board;
deleting obsolete language; revising board
procedures; revising powers and duties of the
board; requiring a threshold by which budgets
are subject to board review; providing immunity
to hospitals for releasing certain data;
prescribing law governing hospital budgets and
budget amendments, revising the uniform system
of financial reporting for hospitals and
providing procedures for grouping hospitals;
requiring all hospitals exceeding certain
thresholds to submit budgets; providing
penalties relating to required reports and
information; providing for analyses, studies,
and reports by the board; requiring accessible
data base, abolishing the Office of Technical
Assistance, deleting certain technical
assistance responsibilities; revising
procedures establishing prospective payment
arrangements; requiring hospitals not exceeding

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maximum allowable rate of increase to file
budget letters with board instead of detailed
budget; establishing detailed budget review
threshold; allowing hospitals to accumulate
percentage points for use in future, providing
rulemaking authority; revising board budget
review and approval review processes; requiring
hospitals requesting increases above the
maximum allowable rate of increase to file
budgets; establishing hospital groupings;
providing for budget review; providing for
budget amendment; establishing criteria for
budget review; providing for preliminary
findings; providing for objections; providing
for hearings; providing for exceptions;
providing exemptions for certain hospitals from
detailed budget review; providing an effective
date for revised budget review and approval
procedures; modifying penalty provisions;
providing for accumulation of net revenue
percentage points to offset penalties;
providing for waiver of penalty; specifying
duties of Public Counsel; repealing s. 395.52,
F.S., relating to information or physician
charges; providing for studies and reports by
the board; providing an appropriation;
providing for a hospital expenditure and
revenue study; providing for rules; revising
and readopting provisions of part II of chapter
395, F.S., as amended and transferred,

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Regulatory Sunset Act; providing for future review and repeal of such provisions; creating chapter 389, F.S.; amending and transferring ss. 381.025, 381.703, 400.341, 400.343-400.346, F.S., to chapter 389, F.S.; creating the "Health Planning Act"; providing legislative intent; providing definitions; designating the state health planning agency; authorizing health planning studies, analyses, and reports; providing for biennial health care plans; providing departmental cost containment responsibilities; providing for an annual health care cost containment plan; creating an Office of Technical Assistance within the department; establishing technical assistance responsibilities; establishing a state center for health statistics; providing for a comprehensive health information system; establishing center functions; providing for center technical assistance; providing for center publications, reports, and special studies; providing for data confidentiality; providing a penalty; limiting provider reporting; providing for center budget, fees, and trust fund; providing an appropriation; establishing a Comprehensive Health Information System Advisory Council; providing for appointments; providing for staggering of terms; providing for meetings; providing for uniform system of financial reporting to the department by nursing homes; providing for

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monitoring of certificate-of-need projects;
providing for assessments on certain health
care facilities; providing a fine for
noncompliance; providing a penalty; providing
for a study on health care coverage for the
uninsured; providing for interim and final
reports; providing an appropriation; amending
s. 381.704, F.S.; revising duties and
responsibilities of department; creating s.
409.2665, F.S.; providing for a Medicaid
selective contracting plan; repealing s.
400.342, F.S., relating to definitions;
amending ss. 119.07, 215.22, 381.601, 381.710,
395.101, 400.609, 409.2663, 627.9175, 768.81,
F.S.; conforming cross-references; providing an
effective date.

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

Section 1. This act may be cited as the "Health Care
Cost Containment Act."

Section 2. Section 395.501, Florida Statutes, is
renumbered as section 407.001, Florida Statutes, and amended
to read:

407.001 [395.501] Short title.--This chapter part-shall
be-known-and may be cited as the "Hospital Health-Care Cost
Containment Board Act of-1979."

Section 3. Section 395.502, Florida Statutes, is
renumbered as section 407.004, Florida Statutes, and amended
to read:

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407.004 395T502 Definitions.—As used in this chapter, the term:

1. "Adjusted admission" means the sum of acute admissions and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

2. "Audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards.

3. "Board" means the Hospital Cost Containment Board created by s. 407.011 395T509.

4. "Budget" means the projections by the hospital, for a specified future time period, of expenses expenditures and revenues, with supporting statistical indicators.

5. "Case-mix index" means a measurable calculated index for each hospital based on financial accounting and case-mix data which shows collection-as-set forth in s. 395T504—reflecting the relative costliness of the mix of cases of a that hospital compared to itself in prior years or compared to a state or national mix of cases.


7. "Comprehensive rehabilitative hospital" means a hospital licensed by the Department of Health and Rehabilitative Services as a specialty hospital, as that term is defined in s. 395.002(14); provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the

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hospital are classified as "comprehensive rehabilitative beds" pursuant to s. 395.003(4), and are not classified as "general beds."

(8) "Consumer" means any person other than a person who administers health activities, provides health services, has a fiduciary interest in a health facility or other health agency, or has a material financial interest in the rendering of health services.

(9) "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing such service as to offset some of the costs of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.

(10) "Department" means the Department of Health and Rehabilitative Services insurance.

(11) "Florida Price Level Index" is the index developed by the Executive Office of the Governor to measure the differences from county to county in the cost of purchasing a specific market basket of goods and services at a particular time.

(12) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue. Gross revenues do not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors.

(13) "Hospital" means a health care institution as defined in s. 395.002(6).

(14) "Hospital-specific case-mix score" means the increase, without a threshold or limitation, in the case-mix
index and severity-of-illness index between the previous year's audited actual case-mix index and severity-of-illness index and the projected case-mix index and severity-of-illness index for the ensuing budget year.

[15] "Local health council" means an agency created under s. 389.347 defined in s. 389.347.

[16] "Major health care purchaser" means 1 of the 10 largest private employers in the state, a commercial health insurer, or a health care services plan certificated under chapter 641.

[17] "Maximum allowable rate of increase" or "MAR" means the maximum rate at which a hospital is expected to increase its average gross revenues per adjusted admission for a given period. The maximum allowable rate of increase is composed of two parts: the market basket index and plus points, which are defined as follows:

[18] "Market basket index" means the revised market basket index used to measure the inflation in hospital input prices as employed on January 1, 1988, by the Secretary of the United States Department of Health and Human Services for Medicare reimbursement. If the measure ceases to be calculated in this manner, the inflation index shall be the index approved by rule adopted promulgated by the board. The method used in determining the index approved by rule shall be substantially the same as the method employed on January 1, 1988, for determining the inflation in hospital input prices by the Secretary of the United States Department of Health and Human Services for purposes of Medicare reimbursement.

[19] "Plus-points" means additional percentage points added to the market basket index to adjust for the Florida
specific experience. The points to be added to the market-basket-index shall be 5 percent for calendar-year 1985; 4 percent for calendar-year 1986; and 3 percent for each year thereafter.

(18) "Maximum allowable rate of increase" means the maximum rate at which a hospital is normally expected to increase its average gross revenues per adjusted admission for a given period. The board, using the most recent audited actual experience for each hospital, shall calculate the maximum allowable rate of increase for each hospital as follows. The projected rate of increase in the market basket index shall be divided by a number which is determined by subtracting the sum of one half of the proportion of Medicare days plus the proportion of Medicaid days and the proportion of charity care days from the number one. Two percentage points shall be added to this quotient. The formula to be employed by the board to calculate the maximum allowable rate of increase shall take the following form:

\[
MARI = \frac{\text{NHIPI}}{1 - [(\text{Me } \times .5) + \text{Md} + \text{Cc}]} + 2
\]

where:

(a) \(MARI\) = maximum allowable rate of increase applied to gross revenue.

(b) \(\text{NHIPI}\) = national hospital input price index, which shall be the projected rate of change in the market basket index.

(c) \(\text{Me}\) = proportion of Medicare days, including, when available and reported to the board, Medicare HMO days to total days.

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(d) \( Md = \frac{\text{proportion of Medicaid days, including, when available and reported to the board, Medicaid HMO days to total days}}{} \)

(e) \( Cc = \frac{\text{proportion of charity care days to total days with a 50 percent offset for restricted grants for charity care and unrestricted grants from local governments}}{} \)

(19) "Medically indigent person" means a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources required to meet his basic needs for shelter, food, and clothing.

(20) "Net revenue" means gross revenue minus deductions from revenue.

(21) "Operating expenses" or "operating expenditures" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses, and other operating expenses, excluding income taxes.

(22) "Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.

(23) "Rate of return" means the financial indicators which the board uses to determine reasonableness of the financial requirements of a hospital and which may include, but not be limited to, return on assets, return on equity, total margin, and debt service coverage.

(24) "Rural hospital" means an acute care hospital which is licensed under chapter 395, which has 85 or fewer beds, and which is:

(a) The sole provider within a county that has a population density of no greater than 100 persons per square mile;

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(b) An acute care hospital within a county that has a population density of no greater than 100 persons per square mile and is at least 30 minutes of travel time, on normally travelled roads under normal traffic conditions, from another acute care hospital within the same county; or

c) A provider supported by a hospital tax district the boundaries of which encompass a population of 100 or fewer persons per square mile.

(25) "Severity-of-illness index" means a measurable index for each hospital based on financial accounting data which shows the differential levels of resource consumption of treating patients within the same mix of cases.

(26) "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the board in meeting its responsibilities pursuant to this chapter part.

"State-health-planning-agency" means the agency designated by the Governor to perform the health planning and development functions prescribed by 35 U.S. Code §1401-4 and 647—the National Health Planning and Resources Development Act of 1974.

(27) "Teaching hospital" means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as indicated reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

(28) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy

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discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care to medically indigent persons.

Section 4. Section 395.5025, Florida Statutes, is renumbered as section 407.007, Florida Statutes, and amended to read:

407.007 395.5025 Legislative intent to assure affordable hospital health care.—It is the intent of the Legislature to assure that adequate hospital health care is affordable and accessible to all the people citizens of this state. To further the accomplishment of this goal, the Hospital Cost Containment Board is created to advise the Governor, the President of the Senate, and the Speaker of the House of Representatives legislature regarding health-care costs of hospital care; inflationary trends in health-care costs of hospital care; the impact of health-care costs of hospital care on the state budget, the impact of hospital charges and third-party reimbursement mechanisms on health care costs of hospital care; and the education of consumers and providers of hospital health-care services in order to encourage price competition in the hospital industry health care-marketplace. The Legislature finds and declares that rising hospital costs of hospital care and cost shifting are of vital concern to the people of this state because of the danger that hospital services are becoming unaffordable and thus inaccessible to residents of the state. It is further declared that costs of hospital care costs should be contained through improved competition between hospitals and improved competition between insurers, through financial incentives which foster efficiency instead of inefficiency, and through sincere initiatives on behalf of providers, insurers, and

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consumers to contain costs. **However, as a safety net, it is**
the intent of the Legislature to establish a program of
prospective budget review and approval which will contain
hospital revenues which exceed certain thresholds where in-the
event—that competition-oriented methods do not adequately
contain costs and to ensure the access of Floridians to
adequate hospital care which could become jeopardized
because of unaffordable costs. **The Legislature further finds**
that there is insufficient information regarding the extent to
which various factors affect the rates of increase in costs of
and charges for hospital care and the effect of prospective
budget review and approval on the containment of costs of and
charges for hospital care.

Section 5. Section 395.503, Florida Statutes, is
renumbered as section 407.011, Florida Statutes, and amended
to read:

407.011 395.503 Hospital Cost Containment Board.—
(1)(a) There is created the Hospital Cost Containment
Board. The board shall be administratively located within the
office of the secretary of the department of Health and
Rehabilitative Services and shall be composed of eleven
members. Ten members shall be appointed by the Governor,
subject to confirmation and confirmation by the Senate. Three
members must be providers of hospital health care,
including two representatives of the hospital industry and one
representative of the nursing-home industry; three members
must be major purchasers of health care; and four members must
be consumers with no direct involvement in health care. The
Deputy Assistant Secretary for Regulation and Health
Facilities of the department shall be a member of the board.
All members of the board must be permanent residents of the

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state, and at least one member of the board must be 60 years of age or older.

(b) Except for the Deputy Assistant Secretary for
Regulation and Health Care Facilities of the department, each appointment to the board shall be for a 3-year term—except that the initial appointment of the provider member added by chapter 87-927, Laws of Florida, shall be for a term ending December 31, 1989, and the initial appointment of the consumer member added by chapter 87-927, Laws of Florida, shall be for a term ending December 31, 1988. Except for the Deputy Assistant Secretary for Regulation and Health Facilities of the department, no member is eligible for appointment for more than two consecutive terms, regardless of the length of any one term. A vacancy on the board shall be filled within 60 days from the date on which the vacancy occurs, which appointment shall be made for the remainder of the unexpired term.

(c) The Governor may remove from office any member who
he appointed and who would no longer be eligible to serve on the board by virtue of the requirement that he be a provider, purchaser, consumer, or resident of the state or—who becomes disqualified for neglect of any duty required by law—who misses more than four meetings in any one year.

(2)(a) The members of the board shall biennially elect a chairperson and a vice-chairperson from its membership. The board shall meet from time to time to fulfill its responsibilities. Meetings may be called by the chairperson or any five members and, except in the event of an emergency, shall be called by written notice. Meetings shall be called in advance and be open to the public. Six voting members of the board constitute a quorum.
(b) Board members shall be remunerated at-the-rate-of $50-per-day while on official board business and shall be entitled to be reimbursed for their expenses while on official business for the board in accordance with the provisions of § 112.061.

(3)(a) The board shall appoint an executive director who shall serve at the pleasure of the board and who must have had experience in the organization, financing, or delivery of health care. The executive director shall perform the duties delegated to him by the board. The executive director, with the concurrence of the board, shall appoint, and may terminate, a general counsel, a chief financial analyst who has had at least 5 years' experience in hospital financial management, a director of public information, and a director of research and may appoint, with the consent of the board, such other staff and staff attorneys as the board deems necessary. The board may contract with persons outside the board for services necessary to carry out its activities when this will promote efficiency, avoid duplication of effort, and make the best use of available expertise.

(b) The board may apply for and receive and accept grants, gifts, and other payments, including property and service from any governmental or other public or private entity or person, and make arrangements as to the use of same, including the undertaking of special studies and other projects relating to health-care costs of hospital care.

(4) The board may create committees from its membership and may create such ad hoc advisory committees to advise the board and its staff in specialized fields related to the functions of hospitals as it deems necessary. The members of any ad hoc advisory committee shall be entitled to

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reimbursement for expenses incurred, including travel expenses.

Section 6. Section 395.504, Florida Statutes, as amended by section 7 of chapter 88-1, Laws of Florida, is renumbered as section 407.014, Florida Statutes, and amended to read:

407.014 395-504 Powers and duties of board.--To properly carry out its authority, the board:

(1) Shall require the submission by hospitals of such case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups as the board deems necessary in order to have available the statistical information necessary to properly conduct financial analyses and budget review and approval and to carry out its public information and education functions as contained in s. 407.044.

(a) Such requirement shall be adopted promulgated by rule if the submission of case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups is being required of all hospitals or of any group thereof; however, rules are not required for the submission of data for a special study or when information is being requested for a single hospital.

(b) Such data may include, but are not limited to: leases, contracts, itemized patient bills, medical record abstracts, and related diagnostic information necessary to evaluate the case-mix index of a hospital and to identify actual charges and lengths of stay associated with specific diagnostic groups; necessary operating expenses; appropriate expenses incurred for rendering services to patients who cannot or do not pay; all properly incurred

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interest charges; and reasonable depreciation expenses based on the expected useful life of the property and equipment involved.

(2) Shall approve, disapprove approve-as-amended-by the-board, or disapprove in part the budget of each hospital which requests increases above the maximum allowable rate of increase, including its projected expenses expenditures and projected revenues.

(3) May contract with local health councils to disseminate information to the public on hospital health care costs.

(4) Shall cooperate with the comprehensive-Health Planning Office of the Regulation and Health Facilities of the department of Health-and-Rehabilitative-Services in the development of a biennial work plan defining the roles and responsibilities of the board and the comprehensive-Health Planning Office of Regulation and Health Facilities in the establishment of the State Center for Health Statistics an integrated-health-care-data-base and shall consult with and make recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives board and the secretary of the department Health-and-Rehabilitative Services with respect to analyses and studies of hospital health care costs, capital expenditures by hospitals and their relationship to health care costs, and related matters which may be undertaken by the board.

(5) May inspect and audit hospital books and records, including records of individual or corporate ownership, for compliance with this chapter part. Upon presentation of a written request for inspection to a hospital by the board or its staff, the hospital shall make available to the board or

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its staff for inspection, copying, and review all books and
records relevant to the determination of whether the hospital
has complied with this chapter part.

(6) Shall publish and make available to the public a
toll-free telephone number for the purpose of handling
consumer complaints regarding hospital charges and shall serve
as a liaison between consumer entities and other private
entities and governmental entities for the disposition of
billing problems identified by consumers of hospital care.

(7) Shall monitor and report on the effects of
prospective payment arrangements preferred-provider
organizations and changes in reimbursement methodologies for
Medicare on cost shifting.

(8) Shall designate executive staff members to issue
preliminary findings pursuant to s. 407.057(7).

(9) May investigate consumer complaints relating to
problems with hospital billing practices and issue reports to
be made public in any cases that the board determines the
hospital has engaged in erroneous billing practices. Shall
publish, based on information provided by the Department of
insurance under s. 627.9175, an annual report containing
premium and benefit comparisons, or the equivalent thereof,
for policies of individual health insurance and shall
disseminate the report in the manner provided in s. 395.5085.
The report shall also indicate, as applicable, the extent to
which the premiums charged by a given entity have increased
over the prior premium year.

(10) Shall publish, based on information provided by
the Department of Insurance under s. 627.9175, an annual
report containing available physician charge comparisons.

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profiles-and-related-information-and-shall-disseminate-the
report-in-the-manner-provided-in-s--395.5085--

Section 7. Section 407.017, Florida Statutes, is
created to read:

407.017 Reporting and use of data; immunity.--A
hospital or other reporting entity or its employees or agents
are not subject to criminal penalties, or liable to any
consumer or purchaser for civil damages, as a result of
disclosure by someone other than such entity of patient data
reported by such entity to the board as required under this
chapter.

Section 8. Section 395.505, Florida Statutes, is
renumbered as section 407.021, Florida Statutes, and amended
to read:

407.021 395-505 Rules; public hearings;
investigations; subpoena power.--In addition to the powers
granted to the board elsewhere in this chapter part, the board
may be authorized to:

(1) Adopt, amend, and repeal rules respecting the
exercise of the powers conferred by this chapter part which
are applicable to the adoption promulgation of rules.

(2) Hold public hearings, conduct investigations, and
subpoena witnesses, papers, records, and documents in
connection therewith. The board may administer oaths or
affirmations in any hearing or investigation.

(3) Exercise, subject to the limitations and
restrictions herein imposed in this chapter, all other powers
which are reasonably necessary or essential to carry out the
expressed objects and purposes of this chapter part.

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Section 9. Section 395.5051, Florida Statutes, is renumbered as section 407.024, Florida Statutes, and amended to read:

407.024 395.5051 Effect of ch.-84-35-haws-of-Florida on existing rules.--Nothing contained in this chapter chapter 84-35-laws-of-Florida is intended to repeal or modify any of the existing rules of the Hospital Cost Containment Board, as created to implement chapter 84-35, Laws of Florida in-395.503, unless such rule or part thereof is in direct conflict with the provisions of this chapter 84-35. However, any budget or budget amendment for fiscal years beginning prior to February 1, 1989, must be filed and reviewed pursuant to chapter 84-35, Laws of Florida, and rules adopted by the board pursuant thereto.

Section 10. Section 395.512, Florida Statutes, is renumbered as section 407.027, Florida Statutes, and amended to read:

407.027 395.512 Budget; expenses; assessments; hospital cost containment program account.--

(1) The board shall biennially prepare a budget which shall include an estimate of income and expenditures for administration and operation of the hospital cost containment program for the biennium, to be submitted to the Governor for transmittal to the Legislature for approval. Subject to the approval of the Legislature, expenses of the program shall be financed by assessments against hospitals in an amount to be determined biennially by the board, but not to exceed 0.04 percent of the gross operating costs of each hospital for the provision of hospital services for its last fiscal year. Each new hospital shall pay its initial assessment upon being licensed by the state and shall base its assessment payment CODING: Words stricken are deletions; words underlined are additions.
during the first year of operation upon its projections for
gross operating costs for that year. Each hospital under new
ownership shall pay its initial assessment for the first year
of operation under new ownership based on its gross operating
costs for the last fiscal year under previous ownership. The
assessments shall be levied and collected quarterly. All
moneys collected are to be deposited by the Treasurer into the
Hospital Cost Containment Trust Fund in-the-general-fund,
which-account-is-heretofore-created. The Hospital Cost
Containment Trust Fund shall be subject to the service charge
imposed pursuant to chapter 215.

(2) Any amounts raised by the collection of
assessments from hospitals provided for in this section which
are not required to meet appropriations in the budget act for
the current fiscal year shall be available to the board in
succeeding years.

(3) Hospitals operated by the Department of Health and
Rehabilitative Services or the Department of Corrections are
exempt from the assessments required under this section.

Section 11. Section 395.507, Florida Statutes, is
renumbered as section 407.031, Florida Statutes, and amended
to read:

407.031 395.507 Uniform system of financial
reporting.—

(1) The board shall, by rule, after consulting with
appropriate professional and governmental advisory bodies and
holding public hearings, and considering existing and proposed
systems of accounting and reporting utilized by hospitals,
specify a uniform system of financial reporting based on a
uniform chart of accounts developed after considering the
American Hospital Association Chart of Accounts, the American

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Institute of Certified Public Accountants Hospital Audit Guide, and generally accepted accounting principles. However, this subsection does not authorize the board to require hospitals to adopt a uniform accounting system. As a part of such system of financial reporting, the board may require the filing of any information relating to the cost, to both the provider and the consumer, of any service provided in such hospital except the cost of a physician's services which is billed independently of the hospital.

(2) For the purposes of this chapter part, and in order to allow meaningful comparisons, the board shall, by rule, group hospitals into statistically valid and reliable groups according to characteristics, including, but not limited to, a measure of the nature and range of services provided, teaching hospital status, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, average daily census, geographical differences, service intensity, resident doctors per bed, average length of stay, wage index, Medicaid inpatient days, charity care days, and case-mix index. The board shall provide for the establishment of general groups and for the establishment of additional specialty groups as needed; however, no group shall contain fewer than six hospitals.

(3) In establishing such uniform reporting procedures, the board shall, among other issues, take into consideration the need for financial data which reflects the average bill per day and the average bill per stay billed by the hospital and the degree of cross-subsidization by cost center.

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(4) When appropriate, the reporting system shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred in connection with educational research and other non-patient-related activities, including, but not limited to, charitable activities of such hospitals.

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

(6) At least 90 days prior to the commencement of its next fiscal year, each hospital requesting approval of a rate of increase in gross revenues per adjusted admission in excess of the maximum allowable rate of increase for such next fiscal year must file with the board, on forms adopted by the board and based on the uniform system of financial reporting:

(a) Its budget for the next fiscal year, including projected expenditures, projected revenues, and statistical measures necessary for the board to evaluate these projections. Any hospital the final budget of which requires public review and approval may submit its budget prior to public review and approval and must subsequently file any amendments adopted during the public review process at least 45 days prior to the beginning of the fiscal year of the hospital.

(b) Its actual experience for the first 6 months of its current fiscal year, including actual expenditures, actual revenues, and statistical measures necessary for the board to evaluate the actual experience.

(c) Its estimated experience for the last 6 months of its current fiscal year, including estimated expenditures,
estimated revenues, and statistical measures necessary for the
board to evaluate these estimates.

(d) Information necessary for the board to evaluate
the effectiveness of current services and the justification of
the hospital for increased costs to continue current services,
improve existing services, and provide new services.

(e) Its schedule of projected rates which will be
implemented to generate projected revenues.

(7) Within 120 days after its fiscal year ends, each
hospital shall file with the board, on forms adopted by the
board and based on the uniform system of financial reporting,
its actual audited experience for that fiscal year, including
expenditures, revenues, and statistical measures.

(8) The board may require other reports based on the
uniform system of financial reporting necessary to accomplish
the purposes of this chapter part.

(9) The Shriners Hospital for Crippled Children,
located in Tampa, is exempt from the financial reporting
requirements of this chapter part until such time as it first
receives revenues from or on behalf of any individual patient.

Section 12. Section 395.514, Florida Statutes, is
renumbered as section 407.034, Florida Statutes, and amended
to read:

407.034 395.514 Violation of chapter part or rule;
penalties.--Refusal Any hospital which refuses to file,
failure fails to timely file, or filing files false or
incomplete reports or other information required to be filed
under the provisions of this chapter part, or violation of
which violates any other provision of this chapter part or
rule adopted under this chapter part, is punishable shall be
punished by a fine not exceeding $1,000 a day for each day the

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In violation occurs, to be fixed, imposed, and collected by
the board. Each day the violation continues shall be
considered a separate offense. The violation of any provision
of this chapter part or of a rule adopted under this chapter,
part, or the knowing and willful falsification of a report
required under this chapter part, is a ground for the
imposition of an administrative fine not to exceed $20,000, to
be fixed, imposed, and collected by the department of Health
and-Rehabilitative-Services.

Section 13. Section 395.508, Florida Statutes, is
renumbered as section 407.037, Florida Statutes, and amended
to read:

407.037 Hospital costs and finances; analyses, studies, and reports.--

(1) The board shall: shall-from-time-to-time-undertake
(a) Collect data and conduct analyses and studies
relating to hospital health care costs, making maximum use of
local health councils and the department designated-state
health-planning-agency whenever appropriate; possibly-and
(b) Conduct analyses and research relating to the
financial status of any hospital or hospitals subject to the
provisions of this chapter; part--The-board-and-the
department-shall

(c) Jointly develop with the department and the
Department of Insurance, criteria to analyze and study the
continuous effect upon hospital health care costs of third-
party reimbursement mechanisms, including the effects of
Medicare, Medicaid, uncompensated care, and other governmental
reimbursement mechanisms. The board shall incorporate into
its reports the findings of the department and the Department
of Insurance relating to the effect upon hospital health care

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costs of third-party reimbursement mechanisms, including
health insurance as defined in ss. 624.603 and 627.652, health
care service plans as defined in s. 641.01, and health
maintenance organizations as defined in s. 641.19(6)

(d) Conduct analyses and research relating to the
effects of uncompensated charity care on hospital budgets, and

(e) The board may publish and disseminate such
information as the board deems desirable and in the public
interest, including information which will assist consumers
and purchasers to understand the impact government-funded
programs and third-party reimbursement mechanisms may have on
hospital finances.

(2) The board shall also prepare and file such
summaries and compilations or other supplementary reports
based on the information analyzed by the board hereunder as
will advance the purposes of this chapter part.

Section 14. Section 395.513, Florida Statutes, is
renumbered as section 407.041, Florida Statutes, and amended
to read:

407.041 395.513 Program accountability.--On or before
March 1 of each year, the board shall prepare and transmit to
the Governor and the Legislature a report of hospital cost
containment board program operations and activities for the
preceding year. This report shall include copies of
summaries, compilations, and supplementary reports required by
this chapter part, together with such facts, suggestions, and
policy recommendations as the board deems necessary. The
board shall specifically state its findings and
recommendations on the following issues:

(1) The extent to which cross-subsidization affects
the rates and charges for different types of hospital services
and an analysis of the reasons for existing levels of cross-
subsidization.

(2) The extent to which third-party reimbursement
mechanisms affect hospital health care costs.

(3) The extent to which public funding policies may be
affecting costs of hospital care.

(4) The extent to which other factors in the hospital
industry may be affecting costs of hospital care, including,
but not limited to, uncompensated care, skilled-employee
shortages, changes in technology, and shifts from
institutional care to ambulatory care.

Section 15. Section 395.5085, Florida Statutes, is
renumbered as section 407.044, Florida Statutes, and amended
to read:

407.044 395.5085 Collection and dissemination of
hospital charges and other hospital-specific information;
Consumer-information-Network.--

(1) The board, relying on summary-actual-charge data
by-diagnostic-groups-and-other-information collected pursuant
to this chapter s-395-5084t1, shall establish a reliable,
timely, and consistent information system. The information
system should be organized such that data are accessible and
useable by other state agencies, the hospital industry, and
other persons who desire access to the board's hospital-
related data.

(2) Semiannually, the board shall identify, by
hospital and by hospital groupings, average charges and
lengths of stay associated with established diagnostic groups.
Charge information shall be cited for at least the following
payer classifications: insurance, not-for-profit insurance,
Medicaid, and Medicare. Combined average charges for all
payer classifications reported shall be published by the board semiannually for dissemination to the media and the public at large. The publication shall identify charges associated with at least the 10 most frequently occurring diagnostic groups and such other information as the board deems appropriate, published by county or region.

(3) The board shall coordinate the distribution of summary-actual-charge-data-by-diagnostic-groups-and-special publications through a Consumer Information Network. The membership of this network may include the members of the Senate and the House of Representatives; consumer service offices located within the Department of Insurance; insurance companies licensed to write policies for health insurance in this state; Florida business coalitions on health care; local health councils and the designated state health planning agency; the Board of Medical Examiners; and hospitals. The Board of Medicine Medical Examiners may include the current publication of hospital charges in its mailings related to license renewals. Hospitals are required to make the current publication of hospital charges available to patients or family members for review upon the request of the patient or family member.

407.047(4) The board shall through the Consumer Information Network conduct consumer information seminars at locations throughout the state.

Section 16. Section 395.5042, Florida Statutes, is renumbered as section 407.047, Florida Statutes, and amended to read:

407.047 395.5042—Office of Technical assistance within board. It is the intent of the Legislature that the board provide to create a single entity to serve as a focal point.

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for-governmental-efforts-and-activities-to-promote-health-care
cost-containment-by-providing-technical-assistance-to-persons,
businesses, and purchaser coalitions interested in containing
the costs of hospital health care. Therefore there is
created-within-the-Hospital-Cost-Containment-Board-the-Office
of-Technical-Assistance-which-shall-include-such
professional-technical-and-clerical-staff-as-may-be
necessary-to-enable-it-to-carry-out-its-duties-The-Office-of
Technical-Assistance-shall:
††—Assist-employers-in-the-formation-of-health-care
coalitions-around-the-state
††—Develop-model-health-care-benefit-packages-for-use
by-employers-and-providers-in-implementing-health-benefit
plans-which-promote-the-cost-effective-delivery-of-adequate
care:
††—Serve-as-a-clearinghouse-for-information
concerning-innovations-in-the-delivery-of-health-care-services
and-the-enhancement-of-competition-in-the-health-care
marketplace
††—Pursue-the-implementation-of-mechanisms-through
which-state-government-will-lead-by-example-in-the-prudent
purchase-of-adequate-health-services;
††—Work-with-existing-health-coalitions-and-local
health-councils-in-carrying-out-their-respective-goals-in-an
efficient-and-effective-manner;
Section 17. Section 395.511, Florida Statutes, is
renumbered as section 407.051, Florida Statutes, and amended
to read:

407.051 395.511 Quality assurance programs.—Each
hospital shall maintain a quality assurance program, which
program must shall include monitoring of the necessity of

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admission, appropriateness of the length of stay, proper
utilization of services, and the evaluation of the quality of
services rendered. Quality assurance plans shall be made
available to the board upon its request.

Section 18. Section 395.515, Florida Statutes, is
renumbered as section 407.054, Florida Statutes, and amended
to read:

407.054 395.515 Prospective payment arrangements.--
(1) The Legislature finds that the traditional
retrospective reimbursement practices of health insurers
provide hospitals with disincentives to contain costs and are
a major contributing factor to the rapidly escalating costs of
hospital care. The Legislature further finds that prospective
payment arrangements designed to provide hospitals with
financial incentives to contain costs will contribute to the
deceleration of hospital-cost increases in the costs of
hospital care while enhancing the adequacy of and access to
care so highly valued by consumers. Furthermore, prospective
payment arrangements that provide fixed payment amounts which
are prospectively set through private-sector negotiation will
provide insurers with a greater degree of investment
stability. Therefore, the Legislature finds that it is the
business of insurance, as well as in the public interest best
interests-of-the-citizens-of-this-state, that insurers, on
behalf of their insureds, should negotiate with hospitals to
establish prospective payment arrangements that provide
financial incentives for the containment of the costs of
hospital care costs.

(2) For the purposes of this section, the term
"prospective payment arrangement" means a financial agreement,
negotiated between a hospital and an insurer, health
maintenance organization, preferred provider organization, or other third-party payer, which contains, at a minimum, the elements provided for in subsection (4).

(3) Hospitals, as defined in s. 395.002, and health insurers, regulated pursuant to parts VI and VII of chapter 627, shall establish by no later than March 1, 1997 prospective payment arrangements that provide hospitals with financial incentives to contain costs. Each hospital shall negotiate with each health insurer which represents 10 percent or more of the private-pay patients of the hospital to establish a prospective payment arrangement. Beginning October 1, 1997, and annually thereafter, hospitals and health insurers regulated pursuant to this section shall report, on October 1 of each year, the results of each specific prospective payment arrangement adopted by each hospital and health insurer to the Hospital-Cost-Containment board, hereafter referred to as the "board." If in the event that a hospital or a health insurer fails to comply has not complied by March 1, 1997 with the requirements of this section, such hospital or health insurer shall have 60 days in which to justify to the board the reasons for its failure to comply-to-the-board. The board shall take into account the failure of the hospital to comply in its approval or disapproval of the budget of the hospital. In addition, the board shall report a health insurer's failure to comply to the Department of Insurance, which shall take into account the failure by the health insurer to comply in conjunction with its approval authority under s. 627.410. The board shall adopt any rules necessary to carry out its responsibilities required by this section.

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(4) The prospective payment system established pursuant to this section shall include, at a minimum, the following elements:

(a) A maximum allowable payment amount established for individual hospital products, services, patient diagnoses, patient day, patient admission, or per insured, or any combination thereof, which is preset at the beginning of the budget year of the hospital and fixed for the entirety of that budget year, except when extenuating and unusual circumstances acceptable to the board warrant renegotiation;

(b) Timely payment to the hospital by the insurer or the insured, or both, of the maximum allowable payment amount, as so negotiated by the insurer or group of insurers;

(c) Acceptance by the hospital of the maximum payment amount as payment in full, which shall include any deductible or coinsurance provided for in the insurer's benefit plan;

(d) Utilization reviews for appropriateness of treatment; and

(e) Preadmission screening of nonemergency surgery.

(5) Nothing contained in this section does not prohibit the inclusion of deductibles, coinsurance, or other cost containment provisions in any health insurance policy.

Section 19. Section 395.509, Florida Statutes, is renumbered as section 407.057, Florida Statutes, and is amended to read:

(Substantial rewording of section. See s. 395.509, F.S., for present text.)

407.057 Review of hospital budget.--

(1) The base for hospital budget reviews shall be the hospital's prior year's actual gross revenues per adjusted

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admission inflated forward by the applicable maximum allowable rate of increase or the board-approved gross budgeted revenues per adjusted admission, whichever is higher, unless the board approves a rate of increase below the maximum allowable rate of increase, in which case the board-approved level applies.

(2)(a) Except for a hospital which files a budget pursuant to subsection (3), each hospital, at least 90 days prior to the commencement of its fiscal year, shall file with the board a certified budget letter, acknowledging its applicable maximum allowable rate of increase in gross revenues per adjusted admission and must affirm that the hospital will not exceed such applicable maximum allowable rate of increase. The budget letter, automatically by operation of law, constitutes the budget for the hospital for that fiscal year. However, the board shall have 30 days after receipt of the budget letter to determine if the gross revenues per adjusted admission submitted by the hospital are within the maximum allowable rate of increase for that hospital.

(b) If the budget of a hospital increases at a percentage rate less than the maximum allowable rate of increase applicable to that hospital, the hospital may carry forward the difference and accumulate up to 3 percentage points which may be used in the future. Such accumulated percentage points may be added to the hospital's gross revenues per adjusted admission in future years to increase the hospital's maximum allowable rate of increase or, if a budget amendment is required for the hospital to avoid a penalty, may be used in the current fiscal year. However, the hospital must use its original approved maximum allowable rate of increase as its base. The hospital must specify in the

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budget letter, or in a budget amendment letter submitted before the end of the fiscal year, the number of accumulated percentage points it intends to add to its maximum allowable rate of increase to increase its gross revenues per adjusted admission. A hospital must use its accumulated percentage points before submitting a budget for detailed review or before submitting a request for a budget amendment. The board shall adopt rules which specify procedures for hospitals to accumulate and use any percentage points under this paragraph.

(3) At least 90 days prior to the commencement of its fiscal year, each hospital that requests a rate of increase in gross revenue per adjusted admission in excess of the maximum allowable rate of increase for the hospital's next fiscal year, or each hospital that uses its accumulated percentage points pursuant to paragraph (2)(b) and requests a rate of increase in excess of the maximum allowable rate of increase plus its available accumulated percentage points, is subject to detailed budget review and must file its projected budget with the board for approval. The projected budget filed under s. 407.031(6) shall be deemed approved unless it is disapproved by the board within 90 days after filing. Upon agreement by the board and the hospital, the 90-day period may be waived or extended. As part of the review conducted by the board, the board may approve, disapprove, or disapprove in part the projected budget. A hospital which submits a budget for approval may not operate at a level of expenses or revenues which exceeds the maximum allowable rate of increase, unless a higher rate of increase has been approved by the board. However, a hospital which has accumulated percentage points and which requests a rate of increase which exceeds the maximum allowable rate of increase plus the accumulated

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percentage points may not operate at a level of expenses or
revenues in excess of the maximum allowable rate of increase
plus its accumulated percentage points.

(4) For purposes of budget review and comparison, the
board may, by rule, establish groupings of hospitals according
to characteristics, including, but not limited to, number of
beds, a measure of the nature and range of services provided,
teaching hospital status, number of residency programs,
resident doctors per bed, number of medical specialties
represented on the hospital staff, percentage of Medicare
inpatient days, percentage of Medicaid inpatient days,
percentage of charity care days, average daily census,
geographical differences, regional referrals, service
intensity, and case-mix index. The rule must provide for the
establishment of a statistically valid and reliable number of
hospital groups. A hospital grouping may not contain fewer
than six hospitals.

(5) The board shall review each budget filed pursuant
to subsection (3) and amendments filed pursuant to subsection
(7) to determine whether the rate of increase contained in the
budget or amendment is reasonable and not excessive. In
making such determination, the board shall consider:

   (a) The effect on hospital gross revenues attributable
to:

      1. The provision of services and care to medically
indigent persons.

      2. Participation in Medicare, Medicaid, and other
governmental programs, including but not limited to, changes
in patient days, reimbursement methodologies, and
reimbursement rates.

      3. Increases in bad debts.
4. Increases in case-mix indexes and severity-of-illness indexes.

5. The provision of new services or facilities, excluding new services or facilities regulated pursuant to s. 381.706 which have not been approved by the designated state agency.

6. For psychiatric hospitals, changes in the average length of stay of patients and changes in admissions to hospital units and to specific services.

   (b) Changes in physician practice patterns, skilled medical personnel availability, and insurance rates and other factors beyond the control of the hospital.

   (c) Expenses, incurred within the last 3 years, of opening a new hospital or replacing an existing hospital at a new site.

   (d) The number of residency programs and resident doctors per bed.

   (6) For budgets filed pursuant to subsection (3) and amendments filed pursuant to subsection (7), the board shall first determine a reasonable rate of increase for gross revenues. In determining reasonable rates of increases in budgeted gross revenues, the board shall use the market basket index, increases in the hospital-specific case-mix score, and the criteria in subsection (5). The board shall then determine budgeted gross revenues. In determining reasonable increases in budgeted gross revenues, the board shall include 100 percent of the increase in uncompensated indigent care, 100 percent of the increase in deductions from gross revenues associated with all government payers, and a credit, not to exceed 2 percentage points, for hospitals in the 33rd percentile or lower in gross revenues per adjusted admission.

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for all hospitals for the last year for which audited actual experience is available for all hospitals. The board may not reduce a proposed budget below the maximum allowable rate of increase.

(7)(a) If a hospital intends to amend its budget so that the amended budget does not exceed the maximum allowable rate of increase plus the hospital's accumulated percentage points, the hospital may file with the board a certified budget amendment letter, affirming that its amended budget will not exceed the applicable maximum allowable rate of increase plus its accumulated percentage points. The budget amendment letter is automatically approved by operation of law. However, the board shall have 30 days after receipt of the budget amendment letter to determine if the amended gross revenues per adjusted admission submitted by the hospital are within the maximum allowable rate of increase plus the accumulated percentage points for that hospital.

(b) A request by a hospital to amend its budget to exceed the maximum allowable rate of increase plus its accumulated percentage points, or to exceed its budget as approved by the board, must be filed in writing with supporting documents no later than 90 days before the end of the hospital's fiscal year. The budget amendment letter shall be deemed approved unless it is disapproved or approved as amended by the board within 60 days after such filing. Upon agreement by the board and the hospital, the 60-day period may be waived or extended.

(c) After a hospital files a budget amendment letter, but before the final decision by the board on the budget amendment letter, the board may extend provisional approval to any part of the budget amendment letter. This provisional
(8) The board shall disapprove, in its entirety or in part, any budget or any budget amendment that contains a rate of increase which the board finds, pursuant to subsection (5), to be unreasonable or excessive. The board may not reduce a proposed budget below the maximum allowable rate of increase as a result of filing a budget request or as a result of filing a request for an amendment. The board may not disapprove all or part of a budget if the hospital chooses to present information and demonstrates to the board that disapproving all or part of the budget would deprive the hospital of its ability to earn a reasonable rate of return or would otherwise jeopardize its ability to meet its financial requirements and obligations. In considering the hospital's financial requirements, obligations, and rate of return, the board shall consider financial indicators including, but not limited to, cash flow to debt, equity financing, long-term debt to equity, operating margin, return on assets, return on equity, average age of plant, and replacement viability.

(9)(a) Upon receipt of a budget letter or a budget amendment letter, the staff of the board shall review the budget, and executive staff members designated by the board shall make preliminary findings and recommend actions in writing as to whether the budget should be approved, disapproved, or disapproved in part. The staff shall send the preliminary findings by certified mail to the hospital. The hospital shall have 14 days after the receipt of the preliminary findings and recommendations to file written objections and request a hearing with the board or to file written objections.
(b) If a hearing is requested, it shall be conducted by the board or, at the election of the board, by a hearing officer assigned by the Division of Administrative Hearings of the Department of Administration pursuant to s. 120.57. The Division of Administrative Hearings shall assign at least two full-time hearing officers exclusively to hear matters pertaining to this chapter. Hearings must be held within 30 days after the request is filed, unless waived by the board and the hospital. All hearings must be held in Tallahassee, unless the board determines otherwise.

(c) Recommended orders must be issued within 30 days after the close of the hearing, unless waived by all parties. The board shall enter a final order within 90 days after the date of filing of the budget letter or budget amendment letter. It is the intent of the Legislature that the final order shall apply to the entire fiscal year and may not be reduced or prorated for any reason.

(d) Any waiver of the time limits within which to conduct a hearing or to issue a recommended order also constitutes a waiver of the time limit to issue the final order and tolls the automatic approval provision of subsection (3) or paragraph (7)(b). The 90-day period under subsection (3) and the 60-day period under paragraph (7)(b) will be tolled beginning on the date that the waiver is entered and will resume 10 days after the recommended order is submitted to the board. The failure to request a hearing within 14 days after the receipt of the preliminary findings of the staff constitutes a waiver of the right of the hospital to contest the final decision of the board, and the board may enter a final order consistent with the staff's preliminary findings without further proceedings.

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(e) During the pendency of any hearing or an appeal of a final order of the board, the hospital may not operate at a level of expenses and revenues which exceeds the maximum allowable rate of increase, unless a higher rate of increase has been approved by the board. However, a hospital that has accumulated percentage points and that requests a rate of increase which exceeds the maximum allowable rate of increase plus the accumulated percentage points may not operate at a level of expenses or revenues in excess of the maximum allowable rate of increase plus the accumulated percentage points.

(10) The board may publish its findings in connection with any review conducted under this section in the newspaper which has the largest circulation in the county in which the hospital is located.

(11) Notwithstanding any other provision of the chapter, hospitals operated by the Department of Health and Rehabilitative Services or the Department of Corrections, comprehensive rehabilitative hospitals, and rural hospitals are exempt from the requirements to file a budget letter, are exempt from budget review and approval for exceeding the maximum allowable rate of increase, and are exempt from any penalties arising therefrom. However, each such hospital is required to submit to the board its audited actual experience, as required by s. 407.031(7).

(12) A hospital which is subject to this section may file with the board, at least 90 days prior to the commencement of its fiscal year, a certified exemption letter exempting the hospital from budget review pursuant to this section. The exemption letter must contain adequate proof that for the previous 2 years payments for 85 percent or more...
of the hospital's patient days have been determined in advance, either due to government programs, uncompensated care, or through negotiated arrangements with private purchasers. The hospital is exempt from the other provisions of this section unless within 30 days after receipt of the exemption letter the board determines that the hospital did not receive payments for 85 percent or more of its patient days which were determined in advance.

(13) The review and approval of hospital budgets pursuant to this section shall begin for hospitals with fiscal years which commence on or after February 1, 1989. Notwithstanding any other provision in this chapter, any budget or budget amendment for fiscal years commencing prior to February 1, 1989, shall be filed and reviewed pursuant to chapter 84-35, Laws of Florida, and rules adopted by the board pursuant thereto.

Section 20. Section 395.5094, Florida Statutes, is renumbered as section 407.061, Florida Statutes, and amended to read:

407.061 395.5094 Exceeding approved budget or previous year's actual experience by more than maximum rate of increase; allowing or authorizing operating revenue or expenditures to exceed amount in approved budget; penalties.--

(1)(a) The board shall annually compare the audited actual experience of each hospital to the audited actual experience of that hospital for the previous year. If the board determines that the audited actual experience of a hospital exceeded its previous year's audited actual experience by more than the maximum allowable rate of increase or exceeded the projected budget as approved by the board, whichever is greater, the amount of such excess shall be
determined by the board, and a penalty shall be levied against
such hospital pursuant to subsection (2), as follows:

(b) For hospitals that submit a budget letter, and for
hospitals subject to budget review, the board shall annually
compare each hospital's audited actual experience for net
revenues per adjusted admission to the hospital's audited
actual experience for net revenues per adjusted admission for
the previous year. If the rate of increase in net revenues
per adjusted admission between the previous year and the
current year was less than the market basket index plus 2
percentage points, the hospital may carry forward the
difference and accumulate up to 3 net revenue percentage
points. Such accumulated net revenue percentage points shall
be available to the hospital to offset in any future year
penalties for exceeding the approved budget or the maximum
allowable rate of increase. This paragraph does not justify
the approval of a budget letter or a budget amendment letter
in excess of the maximum allowable rate of increase.

(2) Penalties shall be assessed as follows:

(a) For the first occurrence within a 5-year period,
the board shall either prospectively reduce the current budget
of the hospital or reduce the hospital's next year's budget,
at the option of the hospital, by the amount of the excess up
to 5 percent; and, if such excess is greater than 5 percent
over the maximum allowable rate of increase, any amount in
excess of 5 percent shall be levied by the board as a fine
against such hospital, to be deposited in the Public Medical
Assistance Trust Fund, as created in s. 409.2662.

(b) For the second occurrence within the 5-year period
following the first occurrence as set forth in paragraph (a),

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the board shall either prospectively reduce the current budget
of the hospital or the hospital's next year's budget, at the
option of the hospital, by the amount of the excess up to 2
percent; and, if such excess is greater than 2 percent over
the maximum allowable rate of increase, any amount in excess
of 2 percent shall be levied by the board as a fine against
such hospital, to be deposited in the Public Medical
Assistance Trust Fund.

(c) For the third occurrence within the 5-year period
following the first occurrence as set forth in paragraph (a),
the board shall:

1. Levy a fine against the hospital in the total
amount of the excess, to be deposited in the Public Medical
Assistance Trust Fund.

2. Notify the Department of Health and Rehabilitative
Services of the violation, whereupon, the department shall not
accept any application for a certificate of need pursuant to
ss. 381.701-381.715 from or on behalf of such hospital until
such time as the hospital has demonstrated, to the
satisfaction of the board, that, following the date the
penalty was imposed under subparagraph 1., the hospital has
stayed within its projected budget for a period of at least 1
year. However, this subparagraph provision does not apply
with respect to a certificate-of-need application filed to
satisfy a life or safety code violation.

3. Upon a determination that the hospital knowingly
and willfully generated such excess, notify the Department of
Health and Rehabilitative Services, whereupon the department
shall initiate disciplinary proceedings to deny, modify,
suspend, or revoke the license of such hospital or impose an
administrative fine on such hospital not to exceed $20,000.

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The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital pursuant to s. 409.266(7) or s. 409.2663. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.101 minus the amount of revenues received by the hospital through the operation of s. 409.266(7) or s. 409.2663. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, its entitlement to such reduction. The board shall also reduce the amount of the excess by the percentage increase, converted to an absolute dollar increase using net revenues, in a hospital's actual audited case-mix index, and severity-of-illness index when available, as compared to the previous year's actual audited case-mix index, and severity-of-illness index when available, without any thresholds or limitations. For psychiatric hospitals, the board shall also reduce the amount of the excess by the percentage increase converted to an absolute dollar increase using net revenues in a hospital's actual audited average length of stay as compared to the previous year's actual audited average length of stay without any thresholds or limitations. The board may waive a penalty for a hospital which, because of extraordinary circumstances, exceeds its previous year's audited actual experience by more than the maximum allowable rate of increase or exceeded the projected budget as approved by the board. The board shall consider in making a determination of a penalty waiver a hospital's total and operating margin, its financial viability, changes in mix of cases or service intensity, or

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other extraordinary circumstances. It is the intent of the legislature that the hospital cost-containment board in levying any penalty imposed against a hospital for exceeding its approved budget pursuant to this subsection consider the effect of changes in the case-mix of the hospital. It is the responsibility of the hospital to demonstrate to the satisfaction of the board any change in its case-mix.

(3) If the board finds that any hospital chief executive officer, or any person who is in charge of hospital administration or operations, has knowingly and willfully allowed or authorized actual operating revenues or expenditures that are in excess of projected operating revenues or expenditures in the hospital budget as approved by the board, the board shall order such officer or person to pay an administrative fine not to exceed $5,000.

The board may not reduce the budget of or levy a fine upon any hospital based on the hospital's audited actual experience for fiscal year 1986 if the hospital treated inmates from the Department of Corrections and if the hospital exceeded its previous year's audited actual experience by more than the maximum allowable rate of increase or exceeded its projected budget as approved by the board for fiscal year 1986 solely as the result of revenue paid to such hospital by the Department of Corrections for treatment of inmates.

Section 21. Section 395.5125, Florida Statutes, is renumbered as section 407.064, Florida Statutes, and amended to read:

407.064 395.5125 Operating costs; nondeductible items.--

(1) It is the policy of this state that philanthropic support for health care should be encouraged and expanded,

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especially in support of experimental and innovative efforts to improve the health care delivery system.

(2) For purposes of determining reasonable costs of services furnished by hospitals, unrestricted grants, gifts, and income from endowments may not be deducted from any operating costs of such hospitals, and, in addition, the following items may not be deducted from any operating costs of such hospitals:

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

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

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

Section 22. Section 395.5135, Florida Statutes, is renumbered as section 407.067, Florida Statutes, and amended to read:

407.067 395.5135 Burden of proof with respect to factual determinations by the board.--Notwithstanding any other provisions of this chapter part, when a hospital alleges that a factual determination made by the board is incorrect, the burden of proof shall be on the hospital to demonstrate that such determination is, in light of the total record, not

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supported by a preponderance of the evidence. The burden of proof remains with the hospital in all cases involving administrative agency action.

Section 23. Section 395.5092, Florida Statutes, is renumbered as section 407.071, Florida Statutes, and amended to read:

407.071 395.5092 Budget review proceedings; duty of Public Counsel.--Notwithstanding any other provisions of this chapter, it is the duty of the Public Counsel to represent the general public of the state in any proceeding before the board or its advisory panels in any administrative hearing conducted pursuant to s. 120.57 or before any other state or federal agency or court in any issue related to budget review. With respect to any such proceeding, the Public Counsel is subject to the provisions of, and may utilize the powers granted to him by, ss. 350.061-350.0614.

Section 24. Section 395.52, Florida Statutes, is hereby repealed.

Section 25. Hospital Cost Containment Board study; hospital expenditure and revenue study; sunset review criteria.--

(1) The Hospital Cost Containment Board shall contract for a study of the board and hospital expenses and revenues. The study must be completed and a report furnished to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than February 1, 1990. The study shall include the following elements:

(a) Documentation for a multi-year period of the historical expenditures, gross revenues, net revenues, patient revenues by source of revenue, contractual allowances, gross revenues per adjusted admission, net revenues per adjusted...
admission, total operating expenditures, nonoperating revenue, service intensity, case-mix indexes, average length of stay, occupancy rates, staffing, payer mix, and margins of hospitals in this state by type of hospital, geographical location, and type of ownership. The study should include all other factors necessary to understand expenses, revenue, margin, and utilization trends of hospitals in this state.

(b) An historical comparison of rates of increase in gross revenues, contractual allowances, net revenues, and total operating expenses per adjusted admission and patient day, by type of hospital and geographical location. Rates of increases for hospitals in this state should be compared to national hospital market basket indexes.

(c) A determination of the extent to which various factors have affected the rates of increase in gross revenues, net revenues, and total operating expenses per adjusted admission and patient day. Such determination shall include the effect by major factor in dollar and percentage increase by type and location of hospital. Factors considered shall include, but not be limited to, utilization, margins, case-mix indexes, service intensity, nature and scope of services, contractual allowances, changes in technology, changes in payer reimbursement practices, changes in insurance coverages and practices, changes in regulatory practices, inflation, physical plant changes, and changes in medical practice. Such an analysis should include an evaluation of the effect of federal, state, and local statutory or regulatory requirements on costs of and charges for hospital care and changes in statutes or regulations which would provide for more cost-efficient care that is accessible and of acceptable quality.
(d) A determination of the extent to which price and nonprice competition among hospitals in this state has occurred and is occurring and the extent to which such competition has affected hospital revenues, expenses, and margins.

(e) An assessment of productivity improvements by hospitals in this state and voluntary price restraints and cost containment by the hospital industry in this state.

(f) An analysis of the extent to which regulation by the Hospital Cost Containment Board has affected hospital revenues, expenses, and margins. Such analysis should include an assessment of the financial viability of hospitals in this state, using a variety of common financial ratios and indicators.

(g) Recommendations regarding the continuation or modification of the board and its regulatory functions. Such recommendations shall include the number and level of board changes in hospital revenues, the extent of hospital price competition, changes in payer reimbursement practices, or other types of changes which would warrant additional authority or lessen or eliminate the need for such authority.

(h) Methods for accurately assessing increases or decreases in cost shifts between payers and the consequences of such cost shifts.

(i) Recommendations for modifications in the form or method of review and approval of, and imposition of sanctions against, hospital budgets.

(j) An assessment of and recommendations regarding alternative hospital cost containment strategies and mechanisms by which implementation of the policy recommendations would be accomplished.
(k) A recommendation to the board for a Florida-specific measure of hospital expenses, which shall be adjusted for geographic differences among hospitals in this state. The Florida Hospital Input Price Index shall include, but not be limited to, the components of the National Hospital Input Price Index, weighted for Florida-specific experience, as well as other expenses not currently included in the National Hospital Input Price Index. The study shall indicate expense trends during the past 8 years, as well as unusual expense increases such as for nurses.

(l) Recommendations to the board regarding a methodology and reporting system to measure the impact annually of changes in reimbursement methodologies and changes in reimbursement levels from all government payers and increases in uncompensated care, including bad debts.

(m) Recommendations to the board regarding a statistical measure for the severity-of-illness index.

(2) The report required by subsection (1) shall include results of these studies and recommendations for their implementation. As part of the recommendations, the board shall submit recommendations for the permanent maximum allowable rate of increase. Unless modified by the Legislature, the board shall adopt rules pursuant to chapter 120, Florida Statutes, to implement the recommendations by October 1, 1990.

(3) The Hospital Cost Containment Board shall collect relevant information and data about the hospital industry and board performance criteria as provided in subsection (4). The board shall publish on March 1 of each year a report summarizing board and industry performance. The board shall establish, by rule, any additional hospital financial and

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(4) On or before October 1, 1993, the Legislature shall conduct a review of hospital industry and board performance using the following criteria:

(a) Rates of increase in gross revenues, net revenues, regulated revenues, and total operating expenses per adjusted admission and patient day relative to previous years and national trends.

(b) The extent to which health care purchasers, independent of the board, exercise control over hospital revenues and expenses, including changes in the percent of patient days subject to discounted charges or which are based in some way on hospital costs.

(c) The level and changes in the level of contractual allowances.

(d) The extent to which hospitals have discounted charges for health maintenance organizations, preferred provider organizations, and other payers, and the level of such discounts.

(e) The extent to which charges have increased for self-pay patients and purchasers and insurers who do not benefit from discounts.

(f) The extent of productivity improvements by the industry and voluntary cost containment efforts.

(g) Any evidence of enhanced price competition among hospitals.

(h) Changes in payer reimbursement practices which affect hospital revenues and expenses.

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(1) Actual hospital revenues and expenses relative to
budgeted amounts and maximum allowable rates of increase
compared to previous years.

(j) The extent of budget reductions mandated and
penalties assessed by the board.

(k) The rates of increase in gross revenues, net
revenues, total operating expenses, and margins of hospitals
which are not subject to detailed budget review compared to
those hospitals which are subject to detailed budget review.

(5) The sum of $200,000 is hereby appropriated from
the General Revenue Fund to the Hospital Cost Containment
Board for the study required by subsection (1) for fiscal year

Section 26. Notwithstanding section 24 of chapter 82-
182, Laws of Florida, or section 30 of chapter 84-35, Laws of
Florida, sections 395.501, 395.502, 395.5025, 395.503,
395.504, 395.505, 395.507, 395.508, 395.5085, 395.509,
395.5092, 395.5094, 395.511, 395.512, 395.5125, 395.513,
395.5135, 395.514, and 395.515, Florida Statutes, shall not
stand repealed October 1, 1988, as scheduled by said acts, but
said sections, as amended, transferred, and renumbered, are
hereby revived and readopted.

Section 27. Sections 407.001, 407.004, 407.007,
407.011, 407.014, 407.017, 407.021, 407.024, 407.027, 407.031,
407.034, 407.037, 407.041, 407.044, 407.047, 407.051, 407.054,
407.057, 407.061, 407.064, 407.067, and 407.071, Florida
Statutes, are repealed October 1, 1998, and shall be reviewed
by the Legislature prior to that date pursuant to s. 11.61,
Florida Statutes.

Section 28. Section 389.301, Florida Statutes, is
created to read:

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389.301 Short title.--This chapter may be cited as the "Health Planning Act."

Section 29. Section 381.025, Florida Statutes, is renumbered as section 389.304, Florida Statutes, and amended to read:

389.304 Legislative intent; long-range planning.--

(1) The Legislature finds that the general health and well-being of the public citizens-of-the-state can be improved through more prudent long-range planning by governmental agencies. Many people citizens-of-the-state are denied access to basic health services due to geographic and financial barriers, and alternative delivery systems are needed to replace archaic and ineffective health and social service delivery programs. Furthermore, the Legislature intends that government not only strive to meet existing needs, but develop the ability to anticipate and respond to future needs which may result from population growth, technological advancements, new societal priorities, or other changes.

(2) It is the intent of the Legislature to assure that health care is affordable and accessible to all persons in this state. To further the accomplishment of this goal, the Department of Health and Rehabilitative Services shall serve as a focal point for governmental health planning efforts and activities. The Legislature intends that the statewide health planning responsibilities of the Department of Health and Rehabilitative Services shall be expanded. It is the intent of the Legislature that, as the state health planning agency, the Department of Health and Rehabilitative Services shall.

CODING: Words struck are deletions; words underlined are additions.
(a) Advise the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding health policy issues; trends in the health care industry, including inflationary trends in health care costs; the health status of Floridians; health care utilization trends; and trends in health care resource supplies;

(b) Identify emerging health care issues and provide relevant analyses to the Governor and the Legislature;

(c) Educate consumers and providers of health care services about health care utilization trends and costs in order to encourage consumer and provider cost consciousness and encourage price competition in the health care market; and

(d) Recommend to the Governor, the President of the Senate, and the Speaker of the House of Representatives appropriate strategies to ensure affordable and accessible health care in this state.

It is the intent of the Legislature that the Department of Health and Rehabilitative Services strive to improve the delivery of essential health services through greater emphasis on long-range planning and less reliance on crisis intervention. Existing delivery systems shall be evaluated and, where appropriate, such programs shall be enhanced or replaced with alternative delivery systems which emphasize cost efficiency and prevention. Specifically, it is the intent of the Legislature that, as provided within existing appropriations, the Department of Health and Rehabilitative Services:

(a) Develop a state policy framework for health care and services, including the identification of major health care policy issues and health care priorities to be

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incorporated in a comprehensive state health plan. Within the
policy framework there shall be a review and a redefinition of
the role of the department in, and its responsibilities for,
environmental health; the development of a contingency plan
for emergency response to high-risk public health hazards; and
an assessment of the needs of medically underserved persons.

(b) Develop and implement a plan for addressing the
public health quality of the drinking water of the state,
including a plan for:

1. Water sampling and testing for priority pollutants,
2. Establishment of epidemiological and technical
   capabilities for human health risk assessments and
   intervention strategies for toxic contamination; and
3. Performance of a comprehensive assessment of the
drinking water of the state in concert with the Department of
   Environmental Regulation.

(c) Accomplish a reduction in infant mortality by
expanding the provision of prenatal care, intensive
obstetrical services, family planning services, and follow-up
services to high-risk neonates.

(d) Assume the delivery of statutorily prescribed
public and personal health services through public health
units by entering into contractual arrangements with county
governments, and, where feasible, expanding the role of public
health units in meeting community needs for primary care and
nutrition programs.

(e) Improve the health status of the children of this
state through expanding pediatric primary care and dental care
capabilities and by providing specialized home care services
to families with chronically ill or handicapped children,
determining the need for a statewide medical foster home
program, expanding child protection services, and increasing
the number of children receiving Medicaid screening and
children's medical services programs.

(f) Maximize the use of its health care dollars
through an analysis of all departmental health care services
and funds and by developing policies that will enable the
department to control escalating health care costs and
targeting resources for primary and preventive care in order
to reduce secondary, tertiary, or institutional care. The
department shall make every reasonable effort to serve as a
prudent purchaser of health care services and to lead by
example in stimulating the development of a competitive health
care marketplace.

(g) Plan for the projected rapid growth of the elderly
population of this state by addressing the anticipated acute
and long-term care needs of that subgroup and developing
strategies to replace or delay reliance on institutional care
by maximizing family and community support systems,
alternative residential services, and other more cost-
efficient preventive strategies.

(4) The Legislature intends that the School of
Public Health of the University of South Florida assume a
leadership role within the public health system through the
development of academic programs intended to meet this state's
unique health care, economic, political, and social service
needs. Beyond its roles as educator of public health
professionals in this state and as sponsor of relevant
academic research, the School of Public Health shall be
consulted by the public officials of this state in the
management of public health affairs.
It is the intent of the Legislature that the medical schools in this state develop in their curricula an emphasis on cost consciousness and cost containment, so that physicians in training will be made aware of the financial consequences to the patient of the physician's clinical decisions.

Section 30. Section 389.307, Florida Statutes, is created to read:

389.307 Definitions.—As used in this chapter, the term:

1. "Audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards.

2. "Center" means the State Center for Health Statistics within the Department of Health and Rehabilitative Services.

3. "Certificate of need" means a written statement issued by the department evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility, health service, or hospice.

4. "Data" means items of information made or received by the department which pertain to a condition, status, act, or omission, whether the information is retrievable by manual or other means and whether or not coded, and includes the normal and computer art meanings of the word data.

5. "Department" means the Department of Health and Rehabilitative Services.

6. "District" means a service district of the department as established in s. 20.19.
"Financial report" means a report of audited actual experience for nursing homes as required under the uniform system of financial reporting pursuant to § 389.334.

"Information system" means an interrelated grouping of data for use by the center or other public or private agencies referred to in this section.

"Nursing home" means a facility licensed under § 400.062, but does not include a facility licensed under chapter 651.

Section 31. Section 389.311, Florida Statutes, is created to read:

389.311 Designation of state health planning agency.-- The department is designated as the state health planning agency. The department is responsible for the planning of all health care services in the state.

Section 32. Section 389.314, Florida Statutes, is created to read:

389.314 Health planning studies: analyses: reports.--

(1) The department shall prepare and furnish a state health plan by December 1 of even-numbered years to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The state health plan shall include, but not be limited to, the health status of the people in this state, health status objectives, recommended strategies to improve the health status of the people in this state, health facility and service inventories and needs, health care manpower requirements and supplies, health care utilization trends, and other analyses of topical health policy issues. The department shall provide for a wide distribution of the state health plan to state and local agencies, health care provider associations, consumer...
organizations, purchaser organizations, and other interested groups. The department may assess a charge for the cost of preparation and publication of the state health plan.

(3) The department shall prepare and furnish an indigent health care plan by December 1 of odd-numbered years to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The indigent health care plan shall include, but not be limited to, identification of medical indigency within the population; analyses of public expenditures related to health care for indigents; an assessment of the effect of public policies on improving the health of indigents and enhancing the access of indigents to health care; strategies to improve the health of indigents and enhance their access to health care services; and analyses of issues related to health care for indigents.

Section 33. Section 389.317, Florida Statutes, is created to read:

389.317 Health care cost containment; duties and responsibilities of the department.--

(1) The department shall prepare and furnish a health care cost containment plan by February 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(2) The annual cost containment plan shall include, but not be limited to, the following components:

(a) Historical analyses of health care costs and charges relative to state and federal inflation indexes.

(b) The extent of price competition and nonprice competition in the health care marketplace and their effect on health care costs and charges.

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(c) Other changes in the health care industry, including productivity improvements and voluntary price restraints, which have contained health care costs and charges.

(d) Changes in third-party payer reimbursement and utilization control practices which have contained health care costs and charges.

(e) Changes in public policies, including reimbursement, utilization control, and service delivery changes of governmental purchasers of health care, which have contained health care costs and charges.

(f) An analysis of changes in the supply and demand for health care services which have contained health care costs and charges. The analysis should include changes in health care manpower, health care facility, and other health care service supplies.

(g) Cost containment planning of the department, including the establishment of cost containment objectives, cost containment initiatives implemented, and the measurement of progress towards the accomplishment of established objectives.

(h) Policy options and recommendations regarding additional cost containment strategies which would lead to improvements in the containment of public and private health care costs.

(3) The department shall collect data and conduct such other analyses relating to health care costs, making maximum use of the local health councils and the Hospital Cost Containment Board, in order to advise the Governor and the Legislature on statewide health care cost containment strategies.
Section 34. Section 389.321, Florida Statutes, is
created to read:

389.321 Office of Technical Assistance.--

(1) It is the intent of the Legislature that a single
entity be created to serve as a focal point for governmental
efforts and activities to promote health care cost
containment. Therefore, the department shall establish an
Office of Technical Assistance which provides technical
assistance to consumers, purchasers, and providers interested
in containing health care costs. The Office of Technical
Assistance shall include such professional, technical, and
clerical staff as is necessary to enable it to carry out its
duties. The Office of Technical Assistance shall:

(a) Assist employers in the formation of health care
coalitions in the state.

(b) Develop model health care benefit packages for use
by employers and providers in implementing health benefit
plans which promote the cost-effective delivery of adequate
care.

(c) Serve as a clearinghouse for information
concerning innovations in the delivery of health care services
and the enhancement of competition in the health care
marketplace.

(d) Pursue the implementation of mechanisms through
which state government will lead by example in the prudent
purchase of adequate health services.

(e) Work with existing health coalitions and local
health councils in carrying out their respective goals
efficiently and effectively.

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(f) Develop provider and consumer information and education programs designed to promote provider and consumer cost consciousness.

(2) The department shall biennially prepare a separate estimate of expenditures for the administration and operation of the Office of Technical Assistance. Subject to legislative approval, the expense of the Office of Technical Assistance shall be financed by assessments, assessed pursuant to s. 407.027, against hospitals. The Hospital Cost Containment Board, established pursuant to chapter 407, shall ensure that sufficient hospital assessments are transferred to the department to fund the cost of the Office of Technical Assistance. The Hospital Cost Containment Board shall transfer resources, including staff, contained in its continuation appropriation for fiscal year 1988-1989, to the department by October 1, 1988, for the operation of the Office of Technical Assistance.

Section 35. Section 389.324, Florida Statutes, is created to read:

389.324 Legislative intent.--The Legislature finds that there is a lack of accurate, comparable, accessible, and current data on health care costs, health care utilization, health status, quality of care, and other health care concerns. The Legislature finds that without such information it is difficult to properly assess the health status of the state population, assess future resource needs, assess quality of care, determine the accessibility and affordability of health care, assess health practices, assess health-care-related policy issues, devise cost containment strategies, and make and evaluate policy choices. The Legislature finds that neither the public nor private purchasers of health care have

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sufficient data to enable them to make informed choices among health care providers and that consumers have insufficient information to make informed health care decisions. To remedy this problem, the Legislature finds that it is necessary to create a comprehensive health information system which provides a centralized uniform health care data collection, analysis, and reporting system. It is the intent of the Legislature that the information compiled by the comprehensive health information system be made available to interested persons to improve the decision-making processes regarding the purchase, price, and use of appropriate health care services. It is the intent of the Legislature to require providers and other health-care-related entities to provide the information necessary to operate the comprehensive health information system.

Section 36. Section 389.327, Florida Statutes, is created to read:

389.327 State Center for Health Statistics.--

(1) ESTABLISHMENT.--The department shall establish a State Center for Health Statistics. The center shall establish a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics. The center shall be staffed with public health experts, biostatisticians, information system analysts, health policy experts, economists, and other staff necessary to carry out its functions.

(2) STATISTICS.--The comprehensive health information system operated by the State Center for Health Statistics shall collect data on:

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(a) The extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and infant and maternal morbidity and mortality.

(b) The impact of illness and disability of the state population on the state economy and on other aspects of the well-being of the people in this state.

(c) Environmental, social, and other health hazards.

(d) Health knowledge and practices of the people in this state and determinants of health and nutritional practices and status.

(e) Health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care, and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities.

(f) Utilization of health care by type of provider.

(g) Health care costs and financing, including trends in health care prices and costs, the sources of payment for health care services, and federal, state, and local expenditures for health care.

(h) Family formation, growth, and dissolution.

(i) The extent of public and private health insurance coverage in this state.

(j) The quality of care provided by various health care providers.

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.--In order to produce comparable and uniform health information and statistics, the department shall perform the following functions:
(a) Coordinate the activities of state agencies involved in the design and implementation of the comprehensive health information system.

(b) Undertake research, development, and evaluation respecting the comprehensive health information system.

(c) Review the statistical activities of the department to assure that they are consistent with the comprehensive health information system.

(d) Develop written agreements with local, state, and federal agencies for the sharing of health-care-related data or using the facilities and services of such agencies. State agencies, local health councils, and other agencies under contract with the department shall assist the center in obtaining, compiling, and transferring health-care-related data maintained by state and local agencies. Written agreements must specify the types, methods, and periodicity of data exchanges and specify the types of data that will be transferred to the center.

(e) The department shall establish by rule the types of data collected, compiled, processed, used, or shared. Decisions regarding center data sets should be made based on consultation with the Comprehensive Health Information System Advisory Council and other public and private users regarding the types of data which should be collected and their uses.

(f) The center shall establish standardized means for collecting health information and statistics under laws and rules administered by the department.

(g) Establish minimum health-care-related data sets which are necessary on a continuing basis to fulfill the collection requirements of the center and which shall be used by state agencies in collecting and compiling health-care-
related data. The department shall periodically review ongoing health care data collections of the department and other state agencies to determine if the collections are being conducted in accordance with the established minimum sets of data.

(h) Establish advisory standards to assure the quality of health statistical and epidemiological data collection, processing, and analysis by local, state, and private organizations.

(i) Prescribe standards for the publication of health-care-related data reported pursuant to this section which ensure the reporting of accurate, valid, reliable, complete, and comparable data. Such standards should include advisory warnings to users of the data regarding the status and quality of any data reported by or available from the center.

(j) Prescribe standards for the maintenance and preservation of the center's data. This should include methods for archiving data, retrieval of archived data, and data editing and verification.

(k) Ensure that strict quality control measures are maintained for the dissemination of data through publications, studies, or user requests.

(4) TECHNICAL ASSISTANCE.--The center shall provide technical assistance to persons or organizations engaged in health planning activities in the effective use of statistics collected and compiled by the center. The center shall also provide the following additional technical assistance services:

(a) Establish procedures identifying the circumstances under which, the places at which, the persons from whom, and the methods by which a person may secure data from the center,
including procedures governing requests, the ordering of requests, time frames for handling requests, and other procedures necessary to facilitate the use of the center's data. To the extent possible, the center should provide current data timely in response to requests from public or private agencies.

(b) Provide assistance to data sources and users in the areas of data base design, survey design, sampling procedures, statistical interpretation, and data access to promote improved health-care-related data sets.

(c) Identify health care data gaps and seek cooperative agreements with other public or private organizations for meeting documented health care data needs.

(d) Assist other organizations in developing statistical abstracts of their data sets that could be used by the center.

(e) Provide statistical support to state agencies with regard to the use of data bases maintained by the center.

(f) To the extent possible, respond to multiple request for information not currently collected by the center or available from other sources by initiating data collection.

(g) Maintain detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center.

(h) Respond to requests for data which are not available in published form by initiating special computer runs on data sets available to the center.

(5) PUBLICATIONS; REPORTS; SPECIAL STUDIES.--The center shall provide for the widespread dissemination of data.

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which it collects and analyzes. The center shall have the following publication, reporting, and special study functions:

(a) The center shall publish and make available periodically to agencies and individuals health statistics publications of general interest, publications providing health statistics on topical health policy issues, publications which provide health status profiles of the people in this state, and other topical health statistics publications.

(b) The center shall publish, make available, and disseminate, promptly and as widely as practicable, the results of special health surveys, health care research, and health care evaluations conducted or supported under this section. Any publication by the center must include a statement of the limitations on the quality, accuracy, and completeness of the data.

(c) The center shall provide indexing, abstracting, translation, publication, and other services leading to a more effective and timely dissemination of health care statistics.

(d) The department shall prepare and furnish a status report on the establishment of the center by April 1, 1989, to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report shall include an inventory of health data available in this state, implementation plans and progress made in implementing the functions assigned to the center, and recommendations for further legislation or resources needed to fulfill legislative intent with regard to the center, particularly with regard to establishing a statewide comprehensive health information system. The center shall thereafter be responsible for
publishing and disseminating an annual report on the center's activities.

(e) The center shall be responsible, to the extent resources are available, for conducting a variety of special studies and surveys to expand the health care information and statistics available for health policy analyses, particularly for the review of public policy issues. The center shall develop a process by which users of the center's data are periodically surveyed regarding critical data needs and the results of the survey considered in determining which special surveys or studies will be conducted. The center shall select problems in health care for research, policy analyses, or special data collections on the basis of their local, regional, or state importance, the unique potential for definitive research on the problem, and opportunities for application of the study findings.

(6) CONFIDENTIALITY.--The center shall adopt, by rule, procedures necessary to protect the confidentiality of, and regulate the disclosure of, data and records maintained by the center. The rule shall prescribe procedures for withholding and releasing data maintained by the center. In adopting this rule, the center shall consider individual rights and reasonable expectations of privacy concerning the use of such information; the public's interest in free access to governmental information; protections necessary to encourage persons to provide information; the public's interest in the effective use of available data to protect and promote the health of individuals and the public; and the public's interest in the effective and efficient management of governmental activities. The procedures shall specify that the center's data which is disclosed will not identify a
person by name, address, number, symbol, or any other identifying information. The procedures shall provide for periodic monitoring to ensure compliance with this subsection. A violation of this subsection or the rules adopted by the department under this subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. Any employee of the department who violates this subsection or the rules adopted by the department under this subsection is subject to immediate dismissal.

(7) PROVIDER DATA REPORTING.--This section does not confer on the department the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law.

(8) BUDGET; FEES; TRUST FUND.--

(a) The Legislature intends that funding for the State Center for Health Statistics be appropriated from the General Revenue Fund.

(b) The State Center for Health Statistics may apply for and receive and accept grants, gifts, and other payments, including property and services, from any governmental or other public or private entity or person and make arrangements as to the use of same, including the undertaking of special studies and other projects relating to health-care-related topics. Funds obtained pursuant to this paragraph may not be used to offset annual appropriations from the General Revenue Fund.

(c) The center may charge such reasonable fees for services as the department prescribes by rule. The established fees shall not exceed the reasonable cost for such...
services. Fees collected may not be used to offset annual appropriations from the General Revenue Fund.

(d) By July 1, 1991, each state agency which has a health care program and a health-care-related data program must establish an administrative overhead expense item in its biennial budget for the purpose of funding its use of the State Center for Health Statistics.

(e) The department shall establish a Comprehensive Health Information System Trust Fund as the repository of all funds appropriated to, and fees and grants collected for, services of the State Center for Health Statistics. Any funds, other than funds appropriated to the center from the General Revenue Fund, which are raised or collected by the department for the operation of the center and which are not needed to meet the expenses of the center for its current fiscal year shall be available to the board in succeeding years.

(9) STATE COMPREHENSIVE HEALTH INFORMATION SYSTEM ADVISORY COUNCIL.--

(a) There is established in the department the State Comprehensive Health Information System Advisory Council to assist the center in reviewing the comprehensive health information system and to recommend improvements for such system. The council shall consist of the following members:

1. An employee of the Executive Office of the Governor, to be appointed by the Governor.

2. An employee of the Department of Insurance, to be appointed by the Insurance Commissioner.

3. An employee of the Department of Education, to be appointed by the Commissioner of Education.
4. Ten persons, to be appointed by the Secretary of the Department of Health and Rehabilitative Services, representing other state and local agencies, state universities, the Florida Association of Business/Health Coalitions, local health councils, professional health-care-related associations, consumers, and purchasers.

(b) Each member of the council shall be appointed to serve for a term of 4 years from the date of his appointment, except that a vacancy shall be filled by appointment for the remainder of the term and except that:

1. Three of the members initially appointed by the Secretary of the Department of Health and Rehabilitative Services shall each be appointed for a term of 3 years.

2. Two of the members initially appointed by the Secretary of the Department of Health and Rehabilitative Services shall each be appointed for a term of 2 years.

3. Two of the members initially appointed by the Secretary of the Department of Health and Rehabilitative Services shall each be appointed for a term of 1 year.

(c) The council may meet at the call of its chairman, at the request of the department, or at the request of a majority of its membership, but at least quarterly.

(d) Members shall elect a chairman annually.

(e) A majority of the members constitutes a quorum, and the affirmative vote of a majority of a quorum is necessary to take action.

(f) The council shall maintain minutes of each meeting and shall make such minutes available to any person.

(g) Members of the council shall served without compensation, but shall be entitled to receive reimbursement

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for per diem and traveling expenses as provided in s. 112.061.

(h) This subsection is repealed, and the State Comprehensive Health Information System Advisory Council is abolished, on October 1, 1998, and shall be reviewed by the Legislature prior to that date pursuant to s. 11.611.

Section 37. Section 400.341, Florida Statutes, is renumbered as section 389.331, Florida Statutes, and amended to read:

389.331 Legislative intent; nursing home costs.--The Legislature finds it to be in the best interest of the state that nursing home care be affordable and accessible to all persons requiring these services. Further, the Legislature finds there is a paucity of information on nursing home expenses and revenues and growth in those expenses and revenues, the equity of the burden in providing charity care, and nursing home rates and charges. The potential for growth in nursing home revenues and the effect of such growth on state and local government budgets and on the ability of persons to purchase nursing home care makes it vital that nursing home revenues and expenditures be documented and analyzed. The Legislature finds that the department, through the State Center for Health Statistics, is the agency best qualified to collect, analyze, and monitor nursing home financial data and intends that the department board carry out this responsibility in conjunction with the State Nursing Home and Long-Term Care Facility Ombudsman Council and district nursing home and long-term care facility ombudsman councils.

Section 38. Section 400.343, Florida Statutes, is renumbered as section 389.334, Florida Statutes, and amended to read:

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389.334 400-343 Uniform system of financial reporting

(1) The department board shall consult with appropriate professional and governmental advisory bodies, hold public hearings, and consider existing and proposed systems of accounting and reporting utilized by nursing homes and then establish by rule a uniform system of financial reporting. Such system shall be based on a uniform chart of accounts developed after considering the American Health Care Association's Uniform Chart of Accounts for Long Term Care Facilities, appropriate audit standards from the American Institute of Certified Public Accountants, and generally accepted accounting principles. Such system shall, to the extent feasible, utilize existing accounting systems and shall make every effort to minimize paperwork to nursing home licensees. In addition, the department board may not require nursing homes to adopt a uniform accounting system. The department board may require the filing of any information relating to the provider's and consumer's cost of services provided in a nursing home, including physicians' compensation.

(2) Within 120 days after the end of its fiscal year, each nursing home shall file with the department board, on forms adopted by the department board and based on the uniform system of financial reporting, its actual audited experience for that fiscal year, including revenues, expenditures, and statistical measures, based on examination by an independent, state-licensed certified public accountant in accordance with generally accepted accounting principles. Each nursing home shall also submit a schedule of the charges in effect at the beginning of the fiscal year and any changes that were made.

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during the fiscal year. A nursing home which is certified
under Title XIX of the Social Security Act and files annual
Medicaid cost reports may substitute copies of such reports
and any Medicaid audits to the department board in lieu of a
report and audit required under this subsection. For such
facilities, the department board may require only information
in compliance with ss. 389.331-389.344 this act that is not
contained in the Medicaid cost report. Facilities which are
certified under Title XVIII but not Title XIX of the Social
Security Act must submit a report as developed by the
department board. This report will be substantially the same
as the Medicaid cost report and shall not require any more
information than is contained in the Medicare cost report
unless that information is required of all nursing homes. The
audit under Title XVIII shall satisfy the audit requirement
under this subsection.

(3) In addition to information submitted in accordance
with subsection (2), each nursing home shall track and file
with the department board, on a form adopted by the department
board and designed to protect the anonymity of residents, the
following information, where applicable, reported for each
resident or reported in the aggregate, if so directed by the
department board:

(a) Date of admission;
(b) Location from which admission was made;
(c) Age at the time of admission;
(d) Primary diagnosis at the time of admission;
(e) Source of financial support at the time of
admission;
(f) Date of conversion to Medicaid;

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(g) Amount spent on nursing home care prior to conversion to Medicaid, by payor source;

(h) Date of discharge;

(i) Reason for discharge; and

(j) Location to which resident is discharged.

(4) The department board may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of ss. 389.331-389.344 and 488T34i-488T346. Such requirements shall be established by rule unless the reports are part of a nonrecurring study or unless information is being requested for a single nursing home.

(5) If more than one licensed nursing home facility is operated by the reporting organization, the information required by this section shall be reported for each nursing home and for the organization's home office separately.

(6) All reports filed under ss. 389.331-389.344 and 488T34i-488T346, except privileged medical information, shall be open to public inspection.

(7) If in-the-event the department board has reason to believe that there is evidence of noncompliance with any of the provisions of ss. 389.331-389.344 this act, the department board may inspect and audit nursing home books and records, including records of individual or corporate ownership, for compliance with ss. 389.331-389.344 this act. Upon presentation to a nursing home of a written request for inspection, the nursing home shall make available to the department board or its staff for inspection, copying, and review all books and records relevant to the determination of whether the nursing home has complied with ss. 389.331-389.344 and 488T34i-488T346.
Section 39. Section 400.344, Florida Statutes, is renumbered as section 389.337, Florida Statutes, and amended to read:

389.337 Nursing home revenues and financial analyses. (1) The department board shall evaluate data from nursing home financial reports beginning with nursing home fiscal years starting January 1, 1985, and shall document and monitor:

(a) Total revenues, annual change in revenues, and revenues by source and classification, including contributions for a patient's care from the patient's resources and from the family and contributions not directed toward any specific patient's care.

(b) Average patient charges by geographic region, payer, and type of facility ownership.

(c) Profit margins by geographic region and type of facility ownership.

(d) Amount of charity care provided by geographic region and type of facility ownership.

(e) Patient days by prior category.

(f) Experience related to Medicaid conversion as reported under s. 389.334(3).

(g) Other information pertaining to nursing home revenues and expenditures.

The findings of the department board shall be included in an annual report to the Governor and Legislature by January 1 each year.

(2) The department board shall provide information relating to nursing home charges to the public through
pamphlets, brochures, and other appropriate means pursuant to
s. 389.321(6) and through its Office of Technical Assistance
the-Consumer-Information-Network-established-by-s-395-5085.

(3) The department board shall cooperate with and
provide pertinent information on nursing home costs and
charges to the department's local health councils, and the
State Nursing Home and Long-Term Care Ombudsman Council, and
district nursing home and long-term care facility ombudsman
councils.

(4) The department shall also prepare and file such
summaries and compilations or other supplementary studies and
reports based on the information analyzed by the department as
will advance the purposes of ss. 389.331-389.344.

Section 40. Section 400.345, Florida Statutes, is
renumbered as section 389.341, Florida Statutes, and amended
to read:

389.341 400-345 Budget, expenses, assessments; nursing
home financial disclosure program.--

(1)(a) The department board shall include in its
biennial budget a separate estimate of income and expenditures
for the administration and operation of the nursing home
financial disclosure program. Subject to legislative
approval, expenses of the program shall be financed by
assessments against each nursing home in an amount set by the
department of Health and Rehabilitative Services to cover the
department's board's approved budget for administering and
operating the nursing home financial disclosure program.

(b) The board shall annually notify the department of
its approved budget. The department shall calculate the
amount to be collected per bed, rounded to the nearest whole
dollar. All license fees collected under this section which

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are due after the date of notification by the department board shall be at a rate sufficient to cover the department's board's approved budget for administering and operating the nursing home financial disclosure program.

(c) Assessments shall be levied and collected annually by the department. Moneys collected shall be deposited by the department into a separate trust fund the Hospital-Containment-Board-Trust-Fund-as-collected-but-such-funds shall-be-maintained-in-a-separate-account.

(d) Each new nursing home shall pay its initial assessment upon being licensed, and each nursing home under new ownership shall pay its initial assessment under the new ownership based on its number of beds.

(2) Moneys raised by collection of assessments from nursing homes which are not required to meet the appropriation for the current fiscal year shall be available to the department board in succeeding years.

Section 41. Section 400.346, Florida Statutes, is renumbered as section 389.344, Florida Statutes, and amended to read:

389.344 400+346 Penalty.--Any nursing home which refuses to file a report, fails to timely file a report, files a false report, or files an incomplete report and upon notification fails to timely file a complete report required under ss. 389.331-389.344 ss-400+346-400+346, or which violates any provision of ss. 389.331-389.344 ss-400+346-400+346 or rule adopted thereunder, shall be punished by a fine not exceeding $1,000 per day for each day in violation, to be imposed and collected by the department board.

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Section 42. Section 381.703, Florida Statutes, is renumbered as section 389.347, Florida Statutes, and amended to read:

389.347 Local health councils. --

(1) LOCAL HEALTH COUNCILS. --

(a) Local health councils are hereby established as public or private nonprofit agencies serving the counties of a district of the department. The members of each council shall be appointed in an equitable manner by the boards of county commissioners having jurisdiction in the respective district. Each council shall be composed of a number of persons equal to 1 1/2 times the number of counties which compose the district or 12 members, whichever is greater. Each county in a district shall be entitled to at least one member on the council. The balance of the membership of the council shall be allocated among the counties of the district on the basis of population, rounded to the nearest whole number; except that in a district composed of only two counties, no county shall have fewer than four members. The department shall adopt a rule allocating membership of the various counties pursuant to this paragraph which designates the number of initial appointments from each county, the appointees who shall be representatives of health care providers, health care purchasers, and nongovernmental health care consumers, but not excluding elected government officials, and which provides for an orderly rotation of the appointment of the various classifications of members among the counties in each district. The members of the consumer group shall include a representative number of persons over 60 years of age. A majority of council members shall consist of...
health care purchasers and health care consumers. The members
of the local health council shall elect a chairman. Members
shall serve for terms of 2 years and may be eligible for
reappointment.

(b) Each local health council shall:

1. Develop a district plan, using uniform methodology
as set forth by the department, which shall permit each local
health council to develop goals and criteria based on its
unique local health needs. The district plan shall be
submitted to the department and updated periodically and shall
be in a form prescribed by the department. The elements of a
district plan which are necessary to the review of
certificate-of-need applications for proposed projects within
the district shall be adopted by the department as a part of
its rules. The district plan shall include, but need not be
limited to:

a. The availability, quality of care, efficiency,
appropriateness, accessibility, extent of utilization, and
adequacy of existing health care facilities and services and
hospices in the district.

b. The need, availability, and adequacy of other
health care facilities and services and hospices in the
district, including outpatient care and ambulatory or home
care services, which may serve as less costly alternatives to
proposed or available health care facilities and services.

c. The probable economies and improvements in services
that may be derived from operation of joint, cooperative, or
shared health care and health planning resources.

d. The need in the district for special equipment and
services which are not reasonably and economically accessible
in adjoining areas.

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e. The need for research and educational facilities, including, but not limited to, institutional and community training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels, and for other health care practitioners.

2. Stimulate the development of cooperative arrangements relating to the health manpower training efforts of educational institutions and service institutions and the health manpower recruitment and retention efforts of medically underserved communities.

3. Identify and encourage community resources and mechanisms to facilitate consumer choice and market competition in health care by providing data, information, and analysis on charges, resource availability, and certification.

4. Advise the district administrator of the department on health care resource allocations, including federal block grant funds, and work with the district administrator, the district alcohol, drug abuse, and mental health planning councils, and the areawide agency on aging in developing and carrying out a health resources allocation plan.

5. Implement activities to increase public awareness of community health needs and emphasize advantages of preventive health activities and cost-effective health service selection.

6. Assist the department in carrying out data collection activities that relate to the functions set forth in this chapter subsection.

7. Monitor the onsite construction progress, if any, of certificate-of-need projects and report their findings to the department on forms provided by the department.

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8. Advise and assist regional planning councils and local governments within each respective district on the development of optional plan elements to address the health goals and policies in the State Comprehensive Plan.

9. Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of state funds distributed to meet the medical needs of indigents the medically-indigent. A report on medical indigent care of indigents shall be prepared by each local health council and submitted to the Statewide Health Council no later than January 1 of each year. At a minimum, the report shall include the following elements:

   a. An inventory of services within the district providing health care to Medicaid and medically indigent clients.

   b. An assessment of the use of those services by Medicaid and medically indigent clients.

   c. An evaluation of the population need within the district for indigent health care services for indigents and a determination of whether or not that need is being met.

   d. A summary presentation of public opinion in communities throughout the district on the medical needs of indigents the-medically-indigent and the services provided to meet these needs.

   e. Recommendations for improving health care services for indigents the-medically-indigent.

   (c) Local health councils may conduct public hearings pursuant to s. 381.709(3)(b).

   (d) Local health councils may employ personnel to carry out the councils' purposes. Such personnel shall possess qualifications and be paid salaries commensurate with

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comparable positions in the Career Service System. However, such personnel shall not be deemed to be state employees.

(e) Each local health council is authorized to accept and receive, in furtherance of its health planning functions, funds, grants, and services from governmental agencies and from private or civic sources, and to perform studies related to local health planning in exchange for such funds, grants, or services. Each local health council shall, no later than January 30 of each year, render an accounting of the receipt and disbursement of such funds received by it to the department. The department shall consolidate all such reports and submit such consolidated report to the Legislature no later than March 1 of each year. Funds received by a local health council pursuant to this paragraph shall not be deemed to be a substitute for, or an offset against, any funding provided pursuant to subsection (3).

(2) STATEWIDE HEALTH COUNCIL.—The Statewide Health Council is hereby established as a state-level comprehensive health council which is advisory to the department. The Statewide Health Council shall be composed of the 11 chairmen of the local health councils, two members appointed by the Governor, two members appointed by the President of the Senate, and two members appointed by the Speaker of the House of Representatives. At least one of the two members appointed by the Governor, the President of the Senate, and the Speaker of the House of Representatives, respectively, must be a health care consumer or a health care purchaser. Appointed members of the council shall be appointed to serve for a 2-year term commencing on January 1 of each odd-numbered year. The Statewide Health Council shall:

CODING: Words strucken are deletions; words underlined are additions.
(a) Advise the Governor, the Legislature, and the department on state health policy issues, state and local health planning activities, and state health regulation programs;

(b) Promote public awareness of state health care issues;

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

(d) Review district health plans for consistency with state health goals and policies;

(e) Prepare and submit to the department an annual a state report, in a manner and form prescribed by the department, which includes the evaluations by each local health council for its respective district, on the adequacy, appropriateness, and effectiveness of state funds distributed to meet the medical needs of indigents the-medically-indigent;

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

(g) Conduct any other functions or studies and analyses falling under the purview of the mission, goals, and objectives prescribed in this subsection above.

(3) FUNDING.--

(a) The Legislature intends that the cost of local health councils and the Statewide Health Council be borne by application fees for certificates of need and by assessments

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on health care facilities subject to facility licensure by the
department, including abortion clinics, adult congregate
living facilities, adult day care centers, ambulatory surgical
centers, birthing centers, clinical laboratories, crisis
stabilization units, home health agencies, hospices,
hospitals, intermediate care facilities for the mentally
retarded, nursing homes, and multiphasic testing centers.

(b) A hospital licensed under chapter 395, a nursing
home licensed under chapter 400, and a home health agency
licensed under chapter 400 shall be assessed an annual fee of
$500. All other facilities listed in paragraph (a) shall each
be assessed an annual fee of $150. Facilities operated by the
Department of Health and Rehabilitative Services or the
Department of Corrections are exempt from the fee required in
this subsection.

(c) The department shall, by rule, establish a
facility billing and collection process for the billing and
collection of the health facility fees authorized by this
subsection.

(d) A health facility which is assessed a fee under
this subsection is subject to a fine of $100 per day for each
day in which the facility is late in submitting its annual fee
up to a maximum of the annual fee owed by the facility. A
facility which refuses to pay the fee or fine is subject to
the forfeiture of its license.

(e) There is created in the State Treasury the
Local and State Health Trust Fund. Moneys in the fund shall
be appropriated only to the department for the purposes of
this section.

(f) The department shall, on an ongoing basis,
deposit 90 percent of all certificate-of-need application fees
and 100 percent of health care facility assessments, assessed pursuant to s. 389.347(3), in the Local and State Health Trust Fund.

+DUTIES-AND-RESPONSIBILITIES-OF-THE-DEPARTMENT+-
+The-department-is-responsible-for-the-planning-of
+all-health-care-services-in-the-state-and-for-the-preparation
+of-the-state-health-plan.
+The-department-shall-develop-and-maintain-a
+comprehensive-health-care-data-base-for-the-purpose-of-health
planning-and-for-certificate-of-need-determinations.--The
department-or-its-contractor-is-authorized-to-require-the
submission-of-information-from-health-facilities--health
service-providers--and-licensed-health-professionals--which-is
determined-by-the-department--through-rule--to-be-necessary
for-meeting-the-department's-responsibilities-as-established
in-this-section.

The department shall provide funding for the
Statewide Health Council and local health councils according
to an allocation plan. All contract funds shall be
distributed according to an allocation plan developed by the
department that provides for a minimum and equal funding base
for each local health council. Any remaining funds shall be
distributed based on adjustments for workload. The department
may also make grants to or reimburse local health councils
from federal funds provided to the state for activities
related to those functions set forth in this section.

Section 43. Section 389.351, Florida Statutes, is
created to read:

389.351 Legislative intent.--The Legislature finds
that a significant portion of the residents of this state do
not have reasonably available private health insurance

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coverage of the costs of necessary basic health care services. This lack of basic health coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state. The Legislature concludes that there is insufficient information regarding the extent of uninsurance and underinsurance in this state, the characteristics of the uninsured and underinsured populations, employer characteristics, practices and trends regarding the offering of group health insurance coverage, current sources of and utilization of care by the uninsured and underinsured residents of this state and their levels of access to care, and strategies for promoting the affordability and availability of private health insurance coverage.

Section 44. Study on health care coverage for uninsured persons.--

(1) The Department of Health and Rehabilitative Services shall conduct a study of health care coverage for uninsured persons.

(2)(a) The final report of the Department of Health and Rehabilitative Services shall include, but not be limited to, analyses and recommendations based on an historical analysis of the health insurance system in this state, including, but not limited to, the structure, coverage, benefits, and dynamics of the health insurance system in this state.

1. The department shall collect data on the extent and characteristics of the uninsured and underinsured populations in this state, including data by geographic location;
demographic characteristics, including age, race, gender,
family composition, education, and income; employment status;
type of employment; length of employment; length of time
without insurance; availability and affordability of group
health insurance; reasons for the lack of group health
insurance coverage; health status; health care utilization;
and other factors.

2. The department shall conduct an analysis of the
state's mandated benefit laws and determine the effect such
laws have had on insurance practices, the availability of
group health insurance, establishment of self-insured plans by
employers, health care insurance costs, and health care costs.
The department should make recommendations regarding
legislative processes which should be used to determine the
feasibility of additional mandated benefits, including the use
of mandatory cost-benefit analyses prior to the legislation of
additional mandated benefits. The department should also
recommend any changes to current mandated benefits which would
make private group or individual health insurance plans more
available and more affordable.

3. The department should determine if there are any
statutory barriers to the formation of group health insurance
plans by large groups, other than employers and private
insurers, and develop strategies for the formation of
alternative forms of group health insurance plans, including
multiple employer trust and nonemployer and noninsurer group
health insurance plans.

(b) The final report of the department should include
a variety of policy options and recommendations regarding
strategies to improve the private health insurance coverage of
uninsured and underinsured persons. The department report
shall include, but not be limited to, policy options and
recommendations in the following areas:

1. A policy conceptual framework, target populations, and the role of public and private financing.

2. Strategies designed to increase employer group health insurance coverage, including, but not limited to, mandated employer coverage, employer-funded and state-funded health insurance pools, other forms of state-subsidized or state-administered health insurance pools or health plans, and health insurance continuation options. The department should identify any local, state, or federal statutes or regulations which discourage employer-sponsored group health insurance coverage and make recommendations for eliminating such disincentives.

3. Strategies designed to contain health insurance costs, including, but not limited to, changes in mandated benefits and coverages, regulatory controls, alternative market strategies, consumer education and information strategies, strategies designed to increase consumer and provider cost consciousness, and alternative, innovative benefit plans.

4. Strategies designed to provide ongoing insurance options for former Medicaid recipients.

5. Strategies designed to increase the availability of affordable private long-term care insurance.

6. Strategies designed to increase the availability of health insurance coverage, private or public, of persons with catastrophic illnesses who are unable to obtain or afford private health insurance coverage.

7. The department's report shall include financing and implementation strategies for the policy options and

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recommendations contained in the final report. The department report shall also include details regarding any proposed demonstration projects which are designed to test various strategies to increase private or employer-based health insurance coverages.

(3) The Department of Health and Rehabilitative Services may contract with one or more public or private organizations or individuals to perform such functions as are in keeping with the intent of this section.

(4) The sum of $100,000 is hereby appropriated from the Public Medical Assistance Trust Fund to the Department of Health and Rehabilitative Services for this study for fiscal year 1988-1989.

(5) The Department of Health and Rehabilitative Services shall prepare and submit a final report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1990. An interim report on the progress of the department's work shall be submitted to the Governor and the Legislature by February 1, 1989.

Section 45. Section 381.704, Florida Statutes, is amended to read:

381.704 Duties and responsibilities of department; rules.--

(1) The department is designated as the single state agency to issue, revoke, or deny certificates of need and to issue, revoke, or deny exemptions from certificate-of-need review in accordance with the district plans prepared pursuant to s. 389.347, the statewide health plan, and present and future federal and state statutes. The department is

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designated-as-the-state-health-planning-agency-for-purposes-of
federal-law

(2) In the exercise of its authority to issue licenses
to health care facilities and health service providers, as
provided under chapters 393, 395, and 400, and to hospices,
the department shall not issue a license to any health care
facility, health service provider, hospice, or part of a
health care facility which fails to receive a certificate of
need for the licensed facility or service.

(3) The department shall establish, by rule, uniform
need methodologies for health services and health facilities.
In developing uniform need methodologies, the department
shall, at a minimum, consider the demographic characteristics
of the population, the health status of the population,
service use patterns, standards and trends, and market
economics.

(4) The department may adopt rules necessary to
implement ss. 381.701-381.715.

(5) The elements of the district local health plan,
personal to s. 389.347, which are necessary to the
review of certificate-of-need applications for proposed
projects within the district shall be adopted by the
department as a part of its rules.

Section 46. Section 409.2665, Florida Statutes, is
created to read:

409.2665 Medicaid selective contracting.—The
department shall prepare a plan for the implementation of a
selective contracting program for the contracting of hospital
inpatient and outpatient services provided to Medicaid
recipients. The department shall consult with hospital
producers and provider associations in the development of the

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The plan shall include the methodology to be used in setting or negotiating rates under the selective contracting program; provider bidding and eligibility requirements; provider and recipient education requirements; methods for contracting with teaching hospitals; methods for assuring sufficient access to inpatient and outpatient care; statutory and administrative requirements to implement the selective contracting program; estimates of cost savings; a summary of provider reaction and recommendations regarding a selective contracting program; and other components of the proposed program. The plan shall include implementation strategies and time frames. The department shall furnish the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by February 1, 1989.

Section 47. Section 400.342, Florida Statutes, is hereby repealed.

Section 48. Paragraph (n) of subsection (3) of section 119.07, Florida Statutes, is amended to read:

119.07 Inspection and examination of records; exemptions.--

(3)

(n) A patient record obtained by the Hospital Cost Containment Board established under s. 407.011 ss-395-503, which record contains the name, residence or business address, telephone number, social security or other identifying number, or photograph of any person or the spouse, relative, or guardian of such person or which record is patient-specific or otherwise identifies the patient, either directly or indirectly, is exempt from the provisions of paragraph (1)(a).

Section 49. Subsection (18) of section 215.22, Florida Statutes, is amended to read:

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215.22 Certain moneys and certain trust funds
enumerated.--The following described moneys and income of a
revenue nature deposited in the following described trust
funds, by whatever name designated, shall be those from which
the deductions authorized by s. 215.20 shall be made:

(18) The Hospital Cost Containment Trust Fund
established pursuant to s. 407.027 ss. 395.515.

The enumeration of the above moneys or trust funds shall not
prohibit the applicability thereto of s. 215.24 should the
Governor determine that for the reasons mentioned in s. 215.24
the money or trust fund should be exempt herefrom, as it is
the purpose of this law to exempt all trust funds from its
force and effect when, by the operation of this law, federal
matching funds or contributions to any trust fund would be
lost to the state.

Section 50. Paragraph (a) of subsection (6) and
subsection (10) of section 381.601, Florida Statutes, are
amended to read:

381.601 Blood transfusions.--
(6) UNIFORM SYSTEM OF FINANCIAL REPORTING.--
(a) The department shall, in consultation with the
Florida Hospital Cost Containment Board, develop a uniform
system of financial reporting consistent with the reporting
system for hospital blood service departments under s. 407.031
ss. 395.597. Existing reporting systems and data developed by
the Florida Hospital Cost Containment Board shall be utilized
by the department whenever applicable in carrying out the
provisions of this section. Appropriate professional advisory
bodies, existing proposed systems of accounting and reporting
utilized by hospital and community blood banks and other blood
service operations may be considered, but every attempt should be made to develop a reporting system consistent with that developed under s. 407.031 ST-395T507. No system of financial reporting required under this section shall require the filing of reports which duplicate existing cost containment reporting requirements. The system shall be based on a uniform chart of accounts and generally accepted accounting principles for all facilities in the state which collect, store, process, or transfuse blood. Information relating to the consumer and provider, the costs, the percentage of profits, the fees obtained from nonreplacement assessments, the quantity of blood replaced under the individual responsibility concept, the recruitment costs, and other appropriate information may be included within the system as provided in s. 407.031 ST-395T507.

(10) LIMITATION.--Nothing in this section shall require hospitals to file reports or make disclosures beyond those required by s. 407.031 ST-395T507.

Section 51. Paragraph (a) of subsection (2) of section 381.710, Florida Statutes, is amended to read:

381.710 Conditions and monitoring.—

(2)(a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 1 year after the date of issuance. The department may extend the period of validity of the certificate for an additional period of up to 6 months, upon a showing of good cause, as defined by rule, by the applicant for the extension. The department shall monitor the

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progress of the holder of the certificate of need in meeting
the timetable for project development specified in the
application with the assistance of the local health council as
specified in s. 389.347(1)(b). and may
revoke the certificate of need, if the holder of the
certificate is not meeting such timetable and is not making a
good faith effort, as defined by rule, to meet it.

Section 52. Paragraph (d) of subsection (1) of section
395.101, Florida Statutes, is amended to read:

395.101 Annual assessments on net operating revenues
to fund public medical assistance; administrative fines for
failure to pay assessments when due.--

(1) For the purposes of this section, the term:

(d) "Hospital Cost Containment Board" or "board" means

the Hospital Cost Containment Board created by s. 407.011.

Section 53. Subsection (2) of section 400.609, Florida
Statutes, is amended to read:

400.609 Components of hospice programs of care.--Each
hospice program shall consist of three components or modes of
care which afford the terminally ill individual and the family
of the terminally ill individual a range of service delivery
which can be tailored to specific needs and preferences of the
patient and family at any point in time. These three
components are:

(2) INPATIENT HOSPICE CARE.--The inpatient component
of care is an adjunct to hospice home care and shall primarily
be used only for short-term stays. The facility or rooms
within a facility used for the hospice inpatient component of
care shall be arranged, administered, and managed in such a
manner to provide privacy, dignity, comfort, warmth, and

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safety for the terminally ill patient and the family. Every possible accommodation shall be made to create as homelike an atmosphere as practicable. To facilitate overnight family visitation within the facility, rooms shall be limited to no more than double occupancy; and, whenever possible, both occupants shall be hospice patients. There shall be a continuum of care and a continuity of care givers between the hospice home program and the inpatient aspect of care to the extent practicable and compatible with the preferences of the patient and his family. Fees charged for inpatient hospice care, whether provided directly by the hospice or through contract, shall be made available upon request to the Hospital Cost Containment Board created in s. 407.011 ss. 395-593. The hours for daily operation and the location of the place where the services are provided shall be determined, to the extent practicable, by the accessibility of such services to the patients and families served by the hospice program.

Section 54. Paragraph (d) of subsection (2) and subsection (4) of section 409.2663, Florida Statutes, are amended to read:

409.2663 Redistribution of funds in the Public Medical Assistance Trust Fund.--

(2) DEFINITIONS.--As used in this section:

(d) "Board" means the Hospital Cost Containment Board as established in s. 407.011 ss. 395-593.

(4) Funds distributed to a hospital pursuant to this section shall not be considered as net revenues of such hospital in determining whether an excess has occurred pursuant to s. 407.061 ss. 395-594. However, if an excess occurs, such funds shall be included in determining the reduction of the amount of the excess for the amount of the excess.
Section 55. Subsection (3) of section 627.9175, Florida Statutes, is amended to read:

627.9175 Reports of information on health insurance --

(3) Each health insurer shall annually submit to the department available information related to physician charges. The department shall provide by rule a uniform format for the submission of this information in order to allow for meaningful comparisons of physician charge data. The department, in conjunction with the health insurance industry and the Hospital Cost Containment Board, shall make an initial report to the 1985 regular session of the Legislature as to the feasibility of subdividing total physician charges by specialty and subdividing the most commonly used procedures by location in this state. The department shall provide information collected under this subsection to the Hospital Cost Containment Board for dissemination under the provisions of s. 407.014(9). The department shall provide information collected under this subsection to the Hospital Cost Containment Board for dissemination under the provisions of s. 407.014(9).

Section 56. Subsection (6) of section 768.81, Florida Statutes, as amended by section 79 of chapter 88-1, Laws of Florida, is amended to read:

768.81 Comparative fault.--

(6) Notwithstanding anything in law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, when an apportionment of damages pursuant to this section is attributed to a teaching hospital as defined in s. 407.004, the court shall enter judgment against each party liable on the basis of such party's percentage of damages.
fault and not on the basis of the doctrine of joint and
several liability.

Section 57. Except as otherwise expressly provided in
this act, this act shall take effect October 1, 1988.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR COMMITTEE SUBSTITUTE
Senate Bill 904

CS/CS/SB 904 contains relatively minor changes to CS/SB 904
which accomplish the following:

-- Brings the bill in line with the provisions of Chapter
216, P.S., with regard to reversion of appropriated
funds;

-- Corrects an oversight to allow the Office of Technical
Assistance to continue to be funded from Hospital Cost
Containment Trust Fund receipts after the office is
transferred to HRS;

-- Corrects an oversight by identifying the depository trust
fund for the new health care facility assessments which
are to help fund the State and Local Health Councils;

-- Removes language which would require legislative
employees to be appointed to serve on the State
Comprehensive Health Information System Advisory Council.

CODING: Words struck are deletions; words underlined are additions.
A bill to be entitled
An act relating to health care; creating the
"Affordable Health Care Assurance Act of 1988";
amending s. 154.01, F.S.; authorizing counties
to relinquish public health facilities and
equipment; amending s. 154.011, F.S.; modifying
provisions relating to a system of primary care
programs; amending s. 154.331, F.S.; providing
for establishment of independent health care
special districts, with authority to levy ad
valorem taxes; providing for appointment and
powers and functions of governing boards;
providing procedures and restrictions with
respect to millage rates; providing for
dissolution of districts; providing for
compliance with statutory requirements;
amending s. 200.001, F.S.; providing certain
authority to independent health care special
districts in described home rule charter
counties; amending s. 381.702, F.S.; defining
"multifacility project"; amending ss. 381.705,
381.706, 381.709, and 381.710, F.S.; providing
additional projects subject to certificate-of-
need review; providing review criteria;
modifying review process; extending validity
period for certain certificates of need;
creating chapter 407, F.S., relating to health
care cost containment; renumbering ss. 395.5125
and 395.5135, F.S., and amending and
renumbering ss. 395.501, 395.502, 395.5025,
395.503, 395.504, 395.5042, 395.505, 395.5051,
395.507, 395.508, 395.5085, 395.509, 395.5092, 395.5094, 395.511, 395.512, 395.513, 395.514, 395.515, and 395.52, F.S., formerly constituting part II of chapter 395, F.S.; changing short title; providing and changing definitions; providing legislative intent with respect to the Health Care Cost Containment Board, formerly the Hospital Cost Containment Board; revising administration and membership; modifying powers and duties; providing for effect of existing board rules; providing for submission of the board's final legislative budget request; requiring certain hospitals to submit budget information to the board; providing for additional research and analysis relating to health care costs; modifying contents of a report to the Legislature; revising provisions relating to consumer information; eliminating the Consumer Information Network; providing additional responsibilities of the Office of Technical Assistance; providing for quality assurance monitoring; revising provisions relating to review of hospital budgets; requiring hospitals not exceeding maximum allowable rate of increase to file a budget letter, rather than a detailed budget; allowing banking of percentage points for future use; providing review criteria; providing for budget amendment; providing for objections and hearing; providing exemptions for certain hospitals; providing a

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penalty; clarifying duty of the Public Counsel
with respect to budget proceedings; providing
an exemption for information relating to
charges by certain physicians; requiring an
annual report by health insurers relating to
physician charges; conforming terminology;
deleting obsolete language; creating s.
407.025, F.S.; providing immunity from
liability for certain report or release of
patient data; creating s. 407.10, F.S.;
creating the consumer information and advisory
council; amending and renumbering ss. 400.341,
400.343, 400.344, 400.345, and 400.346, F.S.;
directing the board to make certain nursing
home financial information available;
correcting cross-references; conforming
language; directing the board to contract with
the University of Florida for certain studies;
amending s. 409.266, F.S.; authorizing certain
use of moneys in the Public Medical Assistance
Trust Fund; expanding Medicaid eligibility to
certain persons; requiring a report; providing
for increases in physician reimbursement;
extending the length of stay for certain
hospital services; amending s. 409.2661, F.S.;
providing for additional primary care health
training demonstration projects; increasing
funding; amending s. 409.2663, F.S.; revising
provisions for redistribution of surplus public
medical assistance funds; providing for an
accounting of funds; providing a methodology to

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qualify for funds; providing a timetable; amending s. 627.9175, F.S.; requiring certain reports by health insurers; creating the "Rural Hospital Act of 1988"; providing legislative intent and definitions; amending s. 154.011, F.S.; requiring certain primary care programs to utilize and coordinate with rural hospitals for outpatient services; providing an appropriation to increase primary care physicians and nurses in rural areas; amending s. 409.266, F.S.; extending Medicaid funding to certain patients in rural areas; amending s. 410.016, F.S.; requiring the Department of Health and Rehabilitative Services to utilize rural hospitals in providing services to the aged; providing for a study of personnel shortages in rural hospitals; requiring a report; providing certain rulemaking authority; postponing Sunset repeal of s. 409.266(7)(k), F.S., relating to the Medicaid medically needy program; saving part II of chapter 395, F.S., from Sunset repeal; providing for future review and repeal; repealing s. 400.342, F.S., which provides definitions relating to nursing homes; providing a directive to statute editors; providing effective dates.

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

Section 1. This act may be cited as the "Affordable Health Care Assurance Act of 1988."

CODING: Words stricken are deletions; words underlined are additions.
Section 2. Subsection (4) of section 154.01, Florida Statutes, is amended to read:

154.01 Public health unit delivery system.—

(4) The use and maintenance of public health unit facilities and equipment shall be subject to the provisions of the contract between the Department of Health and Rehabilitative Services and each county. However, the counties may retain ownership of such facilities and equipment and the right to use such facilities and equipment as the need arises, to the extent that such use would not impose an unwarranted interference with the operation of the public health unit pursuant to the provisions of the contract. In all cases, such facilities shall be used primarily for purposes related to public health. Ownership of public health unit facilities and equipment may be relinquished by a county to the Department of Health and Rehabilitative Services by mutual consent of the parties in the contract.

Section 3. Subsections (1), (3), and (4) of section 154.011, Florida Statutes, are amended to read:

154.011 State/county primary care system services.—

(1) It is the intent of the Legislature that all 67 counties offer primary care services through a system of primary care programs organized through contracts, as required by s. 154.01(3), for Medicaid recipients and other qualified low-income persons. Therefore, beginning July 1, 1987, the Department of Health and Rehabilitative Services is directed, to the extent that funds are appropriated, to develop a plan to implement a primary care program in cooperation with each county. The department shall coordinate with the county's primary care panel, as created by s. 154.013, or with the county's governing body if no primary care panel is appointed.

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Such primary care system programs shall be phased-in and made operational as additional resources are appropriated pursuant to s. 409.266(7)(6)(c), and shall be subject to the following:

(a) The department shall enter into contracts with the county governing body for the purpose of expanding primary care coverage. The county governing body shall have the option of organizing the primary care programs through county public health units or through county public hospitals owned and operated directly by the county. The department shall, as its first priority, maximize the number of counties participating in the primary care system programs under this section, but shall establish priorities for funding based on need and the willingness of counties to participate. The department shall select counties for program funding programs through a formal request-for-proposal process that requires compliance with program standards for cost-effective quality care and seeks to maximize access throughout the county.

(b) Each county's primary care program may utilize the following options of providing services:

- offering services directly through the county public health units;
- by contracting with individual or group practitioners for all or part of the services; or by developing service delivery models which are organized through the county public health units, but which utilize other service or delivery systems available, such as federal primary care programs or prepaid health plans. In addition, counties shall have the option of pooling resources and joining with neighboring counties in order to fulfill the intent of this section.

(c) Each primary care program shall conform to the requirements and specifications of the department, and shall at a minimum:

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1. Adopt a minimum eligibility standard of at least 100 percent of the federal nonfarm poverty level.

2. Provide a comprehensive mix of preventive, personal, and noninstitutional acute illness care services.

3. Be family oriented and be easily accessible regardless of income, physical status, or geographical location.

4. Ensure 24-hour telephone access and offer evening and weekend clinic services.

5. Offer continuity of care over time.

6. Make maximum use of existing providers and closely coordinate its services and funding with existing federal primary care programs, especially in rural counties, to ensure efficient use of resources.

7. Have a sliding fee schedule based on income for eligible persons above 100 percent of the federal nonfarm poverty level.

8. Include quality assurance provisions and procedures for evaluation.


(3) It is the intent of the Legislature that each county primary care program include a broad range of preventive, personal, and noninstitutional acute care services which are actively coordinated through comprehensive medical management and, further, that the health and preventive services currently offered through the county public health units are fully integrated, to the extent possible, with the services provided by the primary care programs.

(4) Each county primary care program shall coordinate obstetrical services with the Improved Pregnancy Outcome

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Program. Financially eligible women at risk for adverse pregnancy outcomes due to any potential medical complication shall not be denied access to prenatal care. Potential medical complications may arise out of, but not be limited to, alcohol abuse, drug abuse, or delay in obtaining initial prenatal care. The inability of the primary care program to provide funding for hospitalization or other specialty acute services shall not preclude an eligible patient from obtaining prenatal services.

Section 4. Section 154.331, Florida Statutes, is amended to read:

154.331 County indigent health care special districts.--Each county may establish a dependent special district pursuant to the provisions of chapter 125 or, by ordinance, create an independent special district as defined in s. 200.001(8)(e) to provide funding for indigent and other health care services throughout the county in accordance with this section. The county governing body shall obtain approval, by a majority vote of the electors, to establish the district with authority to annually levy ad valorem taxes, which shall not exceed the maximum millage rate authorized by this section. Once approved by the electorate, the county shall not be required to hold elections in future years to levy the previously approved millage. Any independent health care special district created by this section shall be required to levy and fix millage subject to the provisions of s. 200.065.

(1) Except as provided in subsection (6), the county governing body shall appoint a district indigent health care board to serve as the governing board of the independent special district. Such board shall consist of not less than

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five members, of which two members shall be appointed to the board by the Governor, and not less than three members shall be appointed by the governing body of the county. All members shall have been residents of the county for the previous 12-month period. The members' terms shall be staggered and may not exceed 4 years. No member shall serve for more than two consecutive terms. The governing body of the county shall fill any vacancies that may occur during the term of any board member. Board members may be removed for cause only by the Governor or by a majority of the electors voting within the county.

(211a) Each district indigent health care board may, subject to the limitations placed on the district by the governing body of the county at the time the independent special district was created and approved by the electorate, shall have any or all of the following powers or functions and duties:

1. To provide and maintain in the county such indigent health care clinics as the board determines are needed for the general welfare of the county.

2. To provide for the health care of indigents and to provide such other health-related services for indigents, including the purchase of institutional services from any private or publicly owned medical facility, as the board determines are needed for the general welfare of the county.

3. To allocate and provide funds for other agencies or facilities in the county which provide health benefits or health services that improve the general welfare are-operated for-the-benefit of indigents and other county residents.

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4. To collect information and statistical data that will be helpful to the board and the county in deciding the health care needs of indigents in the county.

5. To consult and coordinate with other agencies dedicated to the health care of indigents to the end that the overlapping of services will be prevented.

6. To govern, operate, administer, and fund, or any combination thereof, any county-owned or county-operated medical facility which is a major provider of charitable health care services for low-income persons.

7. To assume funding for the county's share of state or federal indigent health care programs which require financial participation by the county.

8. To lease or buy such real property and personal property and to construct such buildings as are needed to execute the foregoing powers or functions and duties; however, such purchases may not be made or construction done unless paid except for with cash with-funds on hand or secured by funds deposited in financial institutions. Nothing in this paragraph shall be construed to authorize an independent health care special district to issue bonds of any nature, nor shall it have the power to require the imposition of any bond by the governing body of the county.

9. To employ and pay, and provide benefits for any part-time or full-time personnel needed to execute the foregoing powers and functions duties.

(b) Each district health care board shall:

1. Organize immediately after the members are appointed to elect one of its members as chairman and one of its members as vice chairman, and elect other officers as deemed necessary by the board.
2. Make and adopt bylaws and rules and regulations for the board's guidance, operation, governance, and maintenance, provided such rules and regulations are not inconsistent with federal or state laws or ordinances of the county.

(c) Board members shall serve without compensation, but shall be entitled to necessary expenses incurred in the discharge of their duties.

(d) All financial records and accounts relating to the independent health care special district shall be available for review by the county governing body and for audit. Books of account must be kept by the board or its clerical assistant, and the fiscal affairs of the board must be exclusively audited by state auditors assigned from time to time to audit the affairs of the county officials.

(3)(a) The fiscal year of the district must be the same as that of the county.

(b) On or before May 1 of each year, the district indigent health care board shall prepare a tentative and adopt an annual written budget of the district's its expected income and expenditures, including a contingency fund, and shall compute a proposed millage rate within the voter-approved cap necessary to fund the tentative budget. Prior to adopting a final budget, the board shall comply with the provisions of s. 200.065, relating to the method of fixing millage, and shall fix the final millage rate by ordinance or resolution of the board. The adopted written budget and final millage rate must be certified and delivered to the county governing body no later than the time of adoption of the county's annual budget board-of-county-commissioners on or before July 1 of each year. Included in each certified budget must be an estimate of the millage rate adopted by ordinance or resolution of the
independent health care special district board as necessary to be applied to raise the funds budgeted for district operations and expenditures. In no circumstances, however, shall any independent health care special district levy millage tax which-millage-rate-may-not exceed a maximum of 5 mills for each-$¼ of assessed valuation of all properties within the county which are subject to ad valorem county taxes or the amount approved by the electorate when the district was created, whichever is less. The budget of the district indigent-health-care-board so certified and delivered to the board-of-county-governing-body commissioners may not be changed or modified by the board-of-county-governing-body commissioners or by any other authority.

(c) In order to provide funds for the indigent health care-board, the independent special district, by vote of the electorate, shall levy ad valorem taxes annually on all taxable property in the county in an amount not to exceed 5 mills. The tax shall be assessed, levied, and collected in the same manner and at the same times as is provided by law for the levy, collection, and enforcement of collection of county taxes.

(c)(d) All tax moneys collected under this section, as soon after the collection thereof as is reasonably practicable, must be paid directly to the district indigent health care board by the tax collector of the county, or by the clerk of the circuit court if the clerk collects delinquent taxes.

1. The moneys so received by the district indigent health care board must be deposited in financial institutions with separate and distinguishable accounts established specifically for the district a-special-bank-account and may
be withdrawn only by checks signed by the chairman of the
district indigent health care board and countersigned by
either one other member of the district indigent health care
board or by a chief executive officer who is so authorized by
the board.

2. Upon entering the duties of office, the chairman
and the other member of the district indigent health care
board or chief executive officer who signs its checks shall
each give a surety bond in the sum of $1,000, which bond must
be conditioned that each of them shall faithfully discharge
the duties of his office. The premium on said bond may be
paid by the special district as part of the expense of the
board. No other member of the district indigent health care
board may be required to give bond or other security.

3.2- No funds of the district indigent-health-care
board may be expended except by check as aforesaid, except
expenditures from a petty cash account, which may not at any
time exceed $25. All expenditures from petty cash must be
recorded on the books and records of the district indigent
health-care-board. No funds of the district indigent-health
care-board, excepting expenditures from petty cash, may be
expended without prior approval of the board, in addition to
the budgeting thereof.

(d) Within 10 days after the expiration of each
quarter-annual period, the district indigent health care board
shall cause to be prepared and filed with the board-of county
governing body commissioners a financial report, which
includes;

1. The total expenditures of the board for the
quarter-annual period;

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2. The total receipts of the board during the quarter-
annual period; and

3. A statement of the funds the board has on hand or
deposited with financial institutions in banks at the end of
the quarter-annual period.

(4) Any independent health care special district may
be dissolved pursuant to s. 165.051, or the county governing
body may by ordinance vote to dissolve the independent health
care special district subject to the approval of the
electorate; provided, however, the county obligates itself to
assume the debts, liabilities, contracts, and outstanding
obligations of the district within the total millage available
to the county governing body for all county and municipal
purposes as provided for under s. 9, Art. VII of the State
Constitution. After-the-first-year-of-operation-of-the
indigent-health-care-board-the-board-of-county-commissioners
may, at its option, fund the budget of the indigent health
care board from its own funds.

(5) Any independent health care special district
created under this section shall comply with all other
statutory requirements of general application which relate to
the filing of any financial reports or compliance reports
required under part III of chapter 218, or any other report or
documentation required by law.

(6) Notwithstanding this or any other provision of
law, any county governing body which operates as the governing
body or governing board of an independent special district
pursuant to s. 200.001(8)(e)3., shall have the same powers and
duties and shall be subject to the same requirements and
limitations as afforded to any other independent health care
special district board as provided in this section. The
1 county governing body acting in the capacity of the governing
2 body or governing board of an independent health care special
3 district is required to maintain separate and distinct
4 financial records and accounts from other county budgets, and
5 shall not commingle district revenues with any other county
6 funds.

7 Section 5. Paragraph (e) of subsection (8) of section
8 200.001, Florida Statutes, is amended to read:
9 200.001 Millages; definitions and general
10 provisions.--
11
12 (8)
13
14 (e) "Independent special district" means a special
15 district which meets one of the following conditions:
16
17 1. The special district's governing head of which is
18 an independent body, either appointed or elected, and the
19 budget of the special district which is established
20 independently of the local governing authority, even though
21 there may be appropriation of funds generally available to a
22 local governing authority involved.
23
24 2. A downtown development authority established prior
25 to the effective date of the 1968 State Constitution as an
26 independent body, either appointed or elected, is an
27 independent special district for purposes of this section,
28 regardless of whether or not the budget is approved by the
29 local governing body, if the district levies a millage or a
30 millage is levied for purposes of the authority, which millage
31 was authorized as of the effective date of the 1968 State
32 Constitution. Independent special district millage shall not
33 be levied in excess of a millage amount authorized by general
34 law and approved by vote of the electors pursuant to s. 9(b),
35 Art. VII of the State Constitution, except for those

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independent special districts levying millage for water management purposes as provided in that section. However, independent special district millage authorized as of the date the 1968 State Constitution became effective need not be so approved, pursuant to s. 2, Art. XII of the State Constitution.

3. Notwithstanding this or any other provision of law, an independent health care special district created pursuant to s. 154.331 in any county operating under a home rule charter adopted pursuant to s. 9, s. 10, s. 11, or s. 24, Art. VIII of the Constitution of 1885, as amended, as preserved by s. 6(e), Art. VIII of the Constitution of 1968, as amended, whose charter requires the county governing body to be the governing body or governing board of special districts, is an independent special district for the purpose of this section and is given express authority to levy millage to fund the independent health care special district, independent of and in addition to the maximum millage allowed for all county or municipal purposes.

Section 6. Subsections (17) and (18) of section 381.702, Florida Statutes, are renumbered as subsections (18) and (19), respectively, and a new subsection (17) is added to said section, to read:

381.702 Definitions.--As used in ss. 381.701-381.715, the term:

(17) "Multifacility project" means an integrated residential and health care facility consisting of independent living units, adult congregate living facility units and nursing home beds certificated on or after January 1, 1987, where:

CODING: Words stricken are deletions; words underlined are additions.
(a) The aggregate total number of independent living units and adult congregate living facility units exceeds the number of nursing home beds.

(b) The developer of the project has expended, exclusive of land acquisition costs, the sum of $500,000 or more by the conclusion of the 18th month of the life of the certificate of need.

(c) The total aggregate cost of construction of the certificated element of the project, in addition to other, noncertificated elements, is $10 million or more.

(d) All elements of the project are contiguous or immediately adjacent to each other and construction of all elements will be continuous.

Section 7. Subsection (3) is added to section 381.705, Florida Statutes, to read:

381.705 Review criteria.--

(3) For any application authorized by s. 381.706(2)(j) or (k), the department shall approve such application unless the proposed consolidation or division would result in a facility or facilities not meeting the criterion of financial feasibility or unless the consolidation or division would result in beds being moved more than 15 miles from their original certificated location.

Section 8. New paragraphs (l), (j) and (k) are added to subsection (2) of section 381.706, Florida Statutes, to read:

381.706 Projects subject to review.--

(2) PROJECTS SUBJECT TO EXPEDITED REVIEW.--Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:

CODING: Words struck through are deletions; words underlined are additions.
(1) A 50-percent increase in nursing home beds for a facility incorporated and operating in this state for at least 60 years on or before July 1, 1988, which has a licensed nursing home facility located on a campus providing a variety of residential settings and supportive services. The increased nursing home beds shall be for the exclusive use of the campus residents.

(1) Combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict.

(k) Division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. Subdivision shall not be approved if it would adversely affect the original certificate's approved cost.

The department shall develop rules to implement the provisions for expedited review, including time schedule, application content, and application processing.

Section 9. Subsection (51 of section 381.709, Florida Statutes, is amended to read:

381.709 Review process.--The review process for certificates of need shall be as follows:

(5) ADMINISTRATIVE HEARINGS.--

(a) Within 21 days after publication of notice of the State Agency Action Report and Notice of Intent, any person authorized under paragraph (b) to participate in a hearing may file a request for an administrative hearing; failure to file a request for hearing within 21 days of publication of notice shall constitute a waiver of any right to a hearing and a waiver of the right to contest the final decision of the

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A copy of the request for hearing shall be served on the applicant.

Hearings shall be held in Tallahassee unless the hearing officer determines that changing the location will facilitate the proceedings. In administrative proceedings challenging the issuance or denial of a certificate of need, only applicants considered by the department in the same batching cycle are entitled to a comparative hearing on their applications.

2.a. Except as provided in sub-subparagraph b., existing health care facilities may initiate or intervene in such administrative hearing upon a showing that an established program will be substantially affected by the issuance of a certificate of need to a competing proposed facility or program within the same district, provided that existing health care providers, other than the applicant, have no standing or right to initiate or intervene in an administrative hearing involving a health care project which is subject to certificate-of-need review solely on the basis of s. 381.706(1)(c).

b. Any existing health care facility which is affiliated with, and located on the campus of, a state university, and which is involved in research and the teaching and training of students in one or more of the medical professions, may initiate or intervene in such administrative hearing upon a showing that an established program or the overall role of the facility will be substantially affected by the issuance of a certificate of need to a competing proposed facility or program within the primary service area of the existing facility as designated in its certificate of need. Any such facility shall be taken into consideration under the

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criteria set forth in s. 381.705(1)(a)-(n) and rules adopted pursuant thereto, as if it were located within the same service district of the applicant, to the extent that such consideration is consistent with the purposes of each criterion.

3. The department shall assign proceedings requiring hearings to the Division of Administrative Hearings of the Department of Administration within 10 days after the time has run to request a hearing. Except upon unanimous consent of the parties or upon the granting by the hearing officer of a motion of continuance, hearings shall commence within 60 days after the hearing officer has been assigned. All nonstate-agency parties shall bear their own expense of preparing a transcript. In any application for a certificate of need which is referred to the Division of Administrative Hearings for hearing, the hearing officer shall complete and submit to the parties a recommended order as provided in s. 120.571(1)(b). The recommended order shall be issued within 30 days after the receipt of the proposed recommended orders or the deadline for submission of such proposed recommended orders, whichever is earlier. The division shall adopt procedures for administrative hearings which shall maximize the use of stipulated facts and shall provide for the admission of prepared testimony.

(c) The department shall issue its final order within 45 days after receipt of the recommended order.

(d) If the department fails to take action within the time specified in paragraph (4)(a) or paragraph (5)(c), or as otherwise agreed to by the applicant and the department, the applicant may take appropriate legal action to compel the department to act. When making a determination on an

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application for a certificate of need, the department is specifically exempt from the time limitations provided in s. 120.60(2).

Section 10. Subsection (2) of section 381.710, Florida Statutes, is amended to read:

381.710 Conditions and monitoring.—

(2)(a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 1 year after the date of issuance, except in the case of a multifacility project, as defined in s. 381.702(17), where the certificate of need shall terminate 2 years after the date of issuance. The department may extend the period of validity of the certificate for an additional period of up to 6 months, upon a showing of good cause, as defined by rule, by the applicant for the extension. The department shall monitor the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application with the assistance of the local health council as specified in s. 381.703(1)(b)7., and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good faith effort, as defined by rule, to meet it.

(b) A certificate of need issued to an applicant holding a provisional certificate of authority under chapter 651 shall terminate 1 year after the applicant receives a valid certificate of authority from the Department of Insurance. The certificate-of-need validity period may be

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extended by the department for an additional period of up to 6 months upon a showing of good cause, as defined by rule, by the applicant for the extension.

(c) The certificate-of-need validity period for a project shall be extended by the department, to the extent that the applicant demonstrates to the satisfaction of the department that good faith commencement of the project is being delayed by litigation or by governmental action or inaction with respect to regulations or permitting precluding commencement of the project.

(d) If an application is filed to consolidate two or more certificates as authorized by s. 381.706(2)(j) or to divide a certificate of need into two or more facilities as authorized by s. 381.706(2)(k), the validity period of the certificate or certificates of need to be consolidated or divided shall be extended for the period beginning upon submission of the application and ending when final agency action and any appeal from such action has been concluded. However, no such suspension shall be effected if the application is withdrawn by the applicant.

Section 11. Section 395.501, Florida Statutes, is renumbered as section 407.001, Florida Statutes, and amended to read:

407.001 395-501 Short title.--This chapter part shall be known and may be cited as the "Health Care Cost Containment Act of 1988 1979."

Section 12. Section 395.502, Florida Statutes, is renumbered as section 407.002, Florida Statutes, and amended to read:

407.002 395-502 Definitions.--As used in this act, the term:

CODING: Words stricken are deletions; words underlined are additions.
(1) "Adjusted admission" means the sum of acute admissions and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(2) "Audited actual data" or "audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards.

(3) "Board" means the Health Care Hospital Cost Containment Board created by s. 407.01 395.593.

(4) "Budget" means the projections by the hospital, for a specified future time period, of expenditures and revenues, with supporting statistical indicators, or a budget letter certified to the board pursuant to s. 407.50(2)(a).

(5) "Case mix" means a calculated index for each hospital, based on financial accounting and case-mix data collection as set forth in s. 407.02 395.584, reflecting the relative costliness of the mix of cases of that hospital compared to a state or national mix of cases.

(6) "Commissioner" means the Insurance Commissioner.

(7) "Comprehensive rehabilitative hospital" or "rehabilitative hospital" means a hospital licensed by the Department of Health and Rehabilitative Services as a specialty hospital, as that term is defined in s. 395 002(14); provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the hospital are classified as "comprehensive.

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"rehabilitative beds" pursuant to s. 395.003(4), and are not classified as "general beds."

(8) "Consumer" means any person other than a person who administers health activities, provides health services, has a fiduciary interest in a health facility or other health agency, or its affiliated entities, or has a material financial interest in the rendering of health services.

(9) "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing such service as to offset some of the costs of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.

(10) "Department" means the Department of Health and Rehabilitative Services Insurance.

(11) "Financial report" means a report of audited actual experience for nursing homes as required under the uniform system of financial reporting pursuant to s. 407.31.

(12) "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges, and other operating revenue. Gross revenues do not include contributions, donations, legacies, or bequests made to a hospital without restriction by the donors.

(13) "Hospital" means a health care institution as defined in s. 395.002(6).

(14) "Local health council" means the agency defined in s. 381.703.

(15) "Major health care purchaser" means a major of-the-10-largest private employer employers in the state, a

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commercial health insurer, or a health care services plan
certificated under chapter 641.

"Maximum allowable rate of increase" or "MARI"
means the maximum rate at which a hospital is expected to
increase its average gross revenues per adjusted admission for
a given period. The maximum allowable rate of increase is
composed of two parts: the market basket index and plus
points, which are defined as follows:

(16)(a) "Market basket index" means the revised market
basket index used to measure the inflation in hospital input
prices as employed on January 1, 1988, by the Secretary
of the United States Department of Health and Human Services
for Medicare reimbursement. If the measure ceases to be
calculated in this manner, the inflation index shall be the
index approved by rule promulgated by the board. The method
used in determining the index approved by rule shall be
substantially the same as the method employed on January 1,
1988, for determining the inflation in hospital input
prices by the Secretary of the United States Department of
Health and Human Services for purposes of Medicare
reimbursement.

(16)(b) "Plus points" means additional percentage points
added to the market basket index to adjust for the Florida
specific experience. The plus points to be added to the
market basket index shall be 5 percent for calendar year 1985;
4 percent for calendar year 1986; and 3 percent for each year
thereafter.

(17) "Maximum allowable rate of increase" or "MARI"
means the maximum rate at which a hospital is normally
expected to increase its average gross revenues per adjusted
admission for a given period. The board, using the most

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recent audited actual experience for each hospital, shall
calculate the MARI for each hospital as follows. The
projected rate of increase in the market basket index shall be
divided by a number which is determined by subtracting the sum
of one-half of the proportion of Medicare days plus the
proportion of Medicaid days and the proportion of charity care
days from the number one. Two percentage points shall be
added to this quotient. The formula to be employed by the
board to calculate the MARI shall take the following form:

\[
\text{MARI} = \frac{\text{NHIPI}}{1 - [(\text{Me} \times 0.5) + \text{Md} + \text{Cc}]} + 2
\]

where:

MARI = maximum allowable rate of increase applied to
gross revenue,

NHIPI = national hospital input price index, which
shall be the projected rate of change in the market basket
index.

Me = proportion of Medicare days, including when
available and reported to the board Medicare HMO days, to
total days.

Md = proportion of Medicaid days, including when
available and reported to the board Medicaid HMO days, to
total days.

Cc = proportion of charity care days to total days with
a 50-percent offset for restricted and unrestricted grants
from local governments.

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1. "Medically indigent" means a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources required to meet his basic needs for shelter, food, and clothing.

2. "Net revenue" means gross revenue minus deductions from revenue.

3. "Nursing home" means a facility licensed under s. 400.062, but does not include a facility licensed under chapter 651.

4. "Operating expenses" or "operating expenditures" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses, and other operating expenses, excluding income taxes.

5. "Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.

6. "Rate of return" means the financial indicators used to determine or demonstrate reasonableness of the financial requirements of a hospital. Such indicators shall include, but not be limited to, return on assets, return on equity, total margin, and debt service coverage.

7. "Rural hospital" means an acute care hospital licensed under chapter 395, with 85 beds or less, which is:

   (a) The sole provider within a county with a population density of no greater than 100 persons per square mile, unless it is an acute care hospital at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county, the population density of which shall also be no greater than 100 persons per square mile; or
(b) A provider supported by a hospital tax district whose boundaries encompass a population of 100 persons or less per square mile.

"Special study" means a nonrecurring data-gathering and analysis effort designed to aid the board in meeting its responsibilities pursuant to this part.

"State health planning agency" means the agency designated by the Governor to perform the health planning and development functions for the state prescribed by the National Health Planning and Resources Development Act of 1974.

"Teaching hospital" means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as reflected by at least seven different resident physician specialties and the presence of 100 or more resident physicians.

"Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts, contractual adjustments, uncompensated care, administrative, courtesy, and policy discounts and adjustments, and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

Section 13. Section 395.5025, Florida Statutes, is renumbered as section 407.003, Florida Statutes, and amended to read:

407.003 395.5025 Legislative intent to assure affordable health care.

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It is the intent of the Legislature to assure that adequate health care is affordable and accessible to all the citizens of this state. To further the accomplishment of this goal, the Health Care Hospital Cost Containment Board is created to:

(a) Advise the Governor, the President of the Senate, the Senate Minority Leader, the Speaker of the House of Representatives, and the House Minority Leader legislature regarding health care costs, inflationary trends in health care costs, the impact of health care costs on the state budget, the impact of hospital and other provider charges, and third-party reimbursement mechanisms on health care costs, and the education of:

(b) Educate consumers and providers of health care services in order to encourage price competition in the health care marketplace.

(c) Promote improved consumer and purchaser understanding of government health care funding programs and third-party reimbursement.

(d) Recommend to the Governor, the President of the Senate, the Senate Minority Leader, the Speaker of the House of Representatives, and the House Minority Leader appropriate strategies necessary to foster health care cost containment and improve access to health care services.

The Legislature further finds and declares that rising hospital and other health care costs and cost shifting and cross-subsidization by hospitals to increase revenues, whether the need is due to high levels of uncompensated care, Medicare, or other causes, are of vital concern to the people of this state because of the danger that hospital and other CODING: Words strucken are deletions; words underlined are additions.
Health care services are becoming unaffordable and thus inaccessible to residents of the state.

(3) The Legislature is further declares declared that every effort hospital costs should be made to contain hospital costs contained through improved competition between hospitals and improved competition between insurers, through financial incentives which foster efficiency instead of inefficiency, and through sincere initiatives on behalf of providers, insurers, and consumers to contain costs. However, as a safety net, it is the intent of the Legislature to

(a) Establish a program which will contain hospital charges that exceed certain thresholds, where of prospective budget-review and approval in the event that competition-oriented methods do not adequately contain costs, and the

(b) Ensure access of Floridians to adequate hospital care which may become jeopardized because of unaffordable costs.

Section 14. Section 395.503, Florida Statutes, is renumbered as section 407.01, Florida Statutes, and amended to read:

407.01 395-503 Health Care Hospital Cost Containment Board.—

(1)(a) There is created the Health Care Hospital Cost Containment Board within the Department of Health and Rehabilitative Services. The board shall be a separate budget entity and the executive director shall be its agency head for all purposes; however, in matters involving chapter 120, the board shall be the agency head as defined in s. 120.52. The Department of Health and Rehabilitative Services shall provide administrative support and service to the board to the extent requested by the executive director. The board shall not be

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subject to control, supervision, or direction by the
Department of Health and Rehabilitative Services in any
manner, including, but not limited to personnel, purchasing,
transactions involving real or personal property, and
budgetary matters. The board shall be administratively
located within the office of the secretary of the Department
of Health and Rehabilitative Services.

(b) Effective January 1, 1989, and beginning with
terms starting on that date, the board shall be composed
of eleven members appointed by the Governor and confirmed
by the Senate. Three Four members must be providers of health
care, including one representative of the for-profit
hospitals, one representative of the not-for-profit hospitals
two representatives of the hospital industry and one
representative of the nursing home industry; three members
must be major purchasers of health care; and three four
members must be consumers with no direct involvement in health
care. All members of the board must be permanent residents of
the state, and at least one consumer member of the board must
be 60 years of age or older.

(c) Each appointment to the board shall be for a 3-
year term, except that the initial appointment of the provider
member added by chapter 87-92, Laws of Florida, shall be for a
term ending December 31, 1989, and the initial appointment of
the consumer member added by chapter 87-92, Laws of Florida,
shall be for a term ending December 31, 1988. No member is
eligible for appointment for more than two consecutive terms,
regardless of the length of any one term. A vacancy on the
board shall be filled within 60 days from the date on which
the vacancy occurs, and the appointment shall be made for
the remainder of the unexpired term.

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[d] The Governor may remove from office any member who would no longer be eligible to serve on the board by virtue of the requirement that he be a provider, purchaser, consumer, or resident of the state, who becomes disqualified for neglect of any duty required by law, or who misses more than four meetings in any one year.

(2)(a) The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall meet from time to time to fulfill its responsibilities. Meetings may be called by the chairperson or any five members and, except in the event of an emergency, shall be called by written notice. Meetings shall be called in advance and be open to the public. Five voting members of the board constitute a quorum.

(b) Board members shall be remunerated at the rate of $50 per diem while on official board business and shall be reimbursed for their expenses while on official business for the board in accordance with the provisions of s. 112.061.

(3)(a) The board shall appoint an executive director who shall serve at the pleasure of the board and who shall have had experience in the organization, financing, or delivery of health care. The executive director shall perform the duties delegated to him by the board. The executive director, with the concurrence of the board, shall appoint, and may terminate, a general counsel, a director of finance, chief financial analyst with at least 5 years' experience in hospital financial management, a director of public information, a director of administration, and a director of research and may appoint, with the consent of the board, such other staff and staff attorneys as the board deems necessary.

The board may contract with persons outside the board for

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services necessary to carry out its activities when this will promote efficiency, avoid duplication of effort, and make the best use of available expertise.

(b) The board may apply for and receive and accept grants, gifts, and other payments, including property and service from any governmental or other public or private entity or person, and make arrangements as to the use of same, including the undertaking of special studies and other projects relating to health care costs.

(4) The board may create committees from its membership and may create such ad hoc advisory committees to advise the board and its staff in specialized fields related to the functions of hospitals as it deems necessary. The members of any ad hoc advisory committee shall be entitled to reimbursement for expenses incurred, including travel expenses.

Section 15. Section 395.504, Florida Statutes, as amended by chapter 88-1, Laws of Florida, is renumbered as section 407.02, Florida Statutes, and amended to read,

407.02 395.504 Powers and duties of board.--To properly carry out its authority, the board:

(1) Shall require the submission by hospitals of such case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups as the board deems necessary in order to have available the statistical information necessary to properly conduct financial analyses and budget review and approval and to carry out its public information and education functions as contained in s. 407.09.

(a) Such requirement shall be promulgated by rule if the submission of case-mix, financial, nonfinancial, accounting, and actual charge data by diagnostic groups is

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being required of all hospitals or of any group thereof; however, rules are not required for the submission of data for a special study or when information is being requested for a single hospital.

(b) Such data may include, but is not limited to, leases, contracts, debt instruments, itemized patient bills, medical record abstracts, and related diagnostic information necessary to evaluate the case mix of a hospital and to identify actual charges and lengths of stay associated with specific diagnostic groups; necessary operating expenses; appropriate expenses incurred for rendering services to patients who cannot or do not pay; all properly incurred interest charges; and reasonable depreciation expenses based on the expected useful life of the property and equipment involved.

(2) Shall approve, disapprove as amended by the board, or disapprove in part the budget of each hospital requesting increases above the maximum allowable rate of increase, including its projected expenditures and projected revenues.

(3) May contract with local health councils to disseminate information to the public on health care costs.

(4) Shall cooperate with the comprehensive Health Planning Office of the Department of Health and Rehabilitative Services in the development of a biennial work plan defining the roles and responsibilities of the board and the comprehensive Health Planning Office in the establishment of an integrated health care data base and shall consult with and make recommendations to the Governor, the President of the Senate, the Senate Minority Leader, the Speaker of the House of Representatives, the House Minority Leader, board and the

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Secretary of Health and Rehabilitative Services with respect to analyses and studies of health care costs, capital expenditures by hospitals and their relationship to health care costs, and related matters which may be undertaken by the board.

(5) May inspect and audit hospital books and records, and including records of individual or corporate ownership, including related organizations with which a hospital had transactions, for compliance with this part. Upon presentation of a written request for inspection to a hospital by the board or its staff, the hospital shall make available to the board or its staff for inspection, copying, and review all books and records relevant to the determination of whether the hospital has complied with this part.

(6) Shall publish and make available to the public a toll-free telephone number for the purpose of handling consumer complaints and shall serve as a liaison between consumer entities and other private entities and governmental entities for the disposition of problems identified by consumers of hospital care.

(7) Shall monitor and report on the effects of prospective payment arrangements preferred-provider organizations and changes in reimbursement methodologies for Medicare on cost shifting.

(8) Shall designate executive staff members to issue preliminary findings pursuant to s. 407.50(9)(a) 395-509+94.

(9)+ Shall publish, based on information provided by the Department of Insurance under s. 627.9175(1), an annual report containing premium and benefit comparisons, or the equivalent thereof, for policies of individual health insurance and shall disseminate the report in the manner

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provided in s. 407.09 395:5085. The report shall also
indicate, as applicable, the extent to which the premiums
charged by a given entity have increased over the prior
premium year.

(b) Shall publish, based on information provided by
the Department of Insurance under s. 627.9175(3), an annual
report containing available physician charge comparisons,
profiles, and related information and shall disseminate the
report in the manner provided in s. 395.5085.

(10) Shall be empowered to investigate consumer
complaints relating to problems with hospital billing
practices and issue reports to be made public in any cases
where the board determines the hospital has engaged in billing
practices which are unreasonable and unfair to the consumer.

Section 16. Section 407.025, Florida Statutes, is
created to read:

407.025 Reporting and use of data; immunity.—No
hospital or other reporting entity or its employees or agents
shall be held liable for civil damages or criminal penalties
either for the reporting of patient data to the Health Care
Cost Containment Board or for the release of this data by the
board as authorized pursuant to this chapter.

Section 17. Section 395.505, Florida Statutes, is
renumbered as section 407.03, Florida Statutes, and amended to
read:

407.03 395-505 Rules; public hearings; investigations;
subpoena power.—In addition to the powers granted to the
board elsewhere in this chapter part, the board is authorized
to:

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1 (1) Adopt, amend, and repeal rules respecting the
2 exercise of the powers conferred by this chapter part which
3 are applicable to the promulgation of rules.
4 (2) Hold public hearings, conduct investigations, and
5 subpoena witnesses, papers, records, and documents in
6 connection therewith. The board may administer oaths or
7 affirmations in any hearing or investigation.
8 (3) Exercise, subject to the limitations and
9 restrictions herein imposed, all other powers which are
10 reasonably necessary or essential to carry out the expressed
11 objects and purposes of this chapter part.
12 Section 18. Section 395.5051, Florida Statutes, is
13 renumbered as section 407.035, Florida Statutes, and amended
14 to read:
15 407.035 395.5051 Effect of - Law of Florida, on existing rules --Nothing contained in this act chapter - Law of Florida, is intended to repeal or modify any of
16 the existing rules of the Hospital Cost Containment Board, as
17 adopted to implement chapter 84-35, Laws of Florida created in
18 section 395.503, unless such rule or part thereof is in direct
19 conflict with the provisions of this act; provided, any budget
20 or budget amendment for fiscal years beginning prior to
21 February 1, 1989, shall be filed and reviewed pursuant to
22 chapter 84-35, Laws of Florida, and rules adopted by the board
23 pursuant thereto chapter 84-35.
24 Section 19. Section 395.512, Florida Statutes, is
25 renumbered as section 407.04, Florida Statutes, and amended to
26 read:
27 407.04 395.512 Budget; expenses; assessments; health
28 care hospital cost containment program account.--

CODING: Words stricken are deletions; words underlined are additions.
(1) The board shall biennially prepare a budget which shall include an estimate of income and expenditures for administration and operation of the health care hospital cost containment program for the biennium, to be submitted to the Governor for transmittal to the Legislature for approval. Subject to the approval of the Legislature, expenses of the program shall be financed by assessments against hospitals in an amount to be determined biennially by the board, but not to exceed 0.04 percent of the gross operating costs of each hospital for the provision of hospital services for its last fiscal year. Every new hospital shall pay its initial assessment upon being licensed by the state and shall base its assessment payment during the first year of operation upon its projections for gross operating costs for that year. Each hospital under new ownership shall pay its initial assessment for the first year of operation under new ownership based on its gross operating costs for the last fiscal year under previous ownership. The assessments shall be levied and collected quarterly. All moneys collected are to be deposited by the Treasurer into the Health Care Hospital Cost Containment Trust Fund in the general fund, which account is hereby created. The Health Care Hospital Cost Containment Trust Fund shall be subject to the service charge imposed pursuant to chapter 215.

(2) Any amounts raised by the collection of assessments from hospitals provided for in this section which are not required to meet appropriations in the budget act for the current fiscal year shall be available to the board in succeeding years.

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(3) Hospitals operated by the Department of Health and Rehabilitative Services or the Department of Corrections are exempt from the assessments required under this section.

(4) The Health Care Cost Containment Board shall submit its final legislative budget request directly to the Governor as chief budget officer of the state in the form and manner prescribed in the budget instructions. However, the final legislative budget request shall be submitted no later than November 1 of each even-numbered year.

Section 20. Section 395.507, Florida Statutes, is renumbered as section 407.05, Florida Statutes, and amended to read:

407.05 395.507 Uniform system of financial reporting for hospitals.--

(1) The board shall, by rule, after consulting with appropriate professional and governmental advisory bodies and holding public hearings, and considering existing and proposed systems of accounting and reporting utilized by hospitals, specify a uniform system of financial reporting based on a uniform chart of accounts developed after considering the American Hospital Association Chart of Accounts, the American Institute of Certified Public Accountants Hospital Audit Guide, and generally accepted accounting principles. However, this provision shall not be construed to authorize the board to require hospitals to adopt a uniform accounting system. As a part of such uniform system of financial reporting, the board may require the filing of any information relating to the cost, to both the provider and the consumer, of any service provided in such hospital except the cost of a physician's services which is billed independently of the hospital.

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For the purposes of this part, and in order to allow meaningful comparisons in the budget review process, the board shall, by rule, group hospitals according to characteristics, including, but not limited to, a measure of the nature and range of services provided, teaching hospital status, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, average daily census, geographical differences, and, when available, case mix. The rule shall provide for the establishment of not more than 15 general groups and for the establishment of additional specialty groups as needed; however, no group shall contain fewer than five hospitals.

In establishing such uniform reporting procedures, the board shall, among other issues, take into consideration the need for financial data which reflects the average bill per day and the average bill per stay billed by the hospital and the degree of cross-subsidization by cost center.

When appropriate, the reporting system shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred in connection with educational research and other non-patient-related activities, including, but not limited to, charitable activities of such hospitals.

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

At least 90 days prior to the commencement of its next fiscal year, each hospital requesting approval of a rate of increase in gross revenue per adjusted admission in excess of its applicable maximum allowable rate of increase for such...
The next fiscal year shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting:

(a) Its budget for the next fiscal year, including projected expenditures, projected revenues, and statistical measures necessary for the board to evaluate these projections. Any hospital the final budget of which requires public review and approval may submit its budget prior to public review and approval and shall subsequently file any amendments adopted during the public review process at least 45 days prior to the beginning of the fiscal year of the hospital.

(b) Its actual experience for the first 6 months of its current fiscal year, including actual expenditures, actual revenues, and statistical measures necessary for the board to evaluate the actual experience.

(c) Its estimated experience for the last 6 months of its current fiscal year, including estimated expenditures, estimated revenues, and statistical measures necessary for the board to evaluate these estimates.

(d) Information necessary for the board to evaluate the effectiveness of current services and the justification of the hospital for increased costs to continue current services, improve existing services, and provide new services.

(e) Its schedule of projected rates which will be implemented to generate projected revenues.

(f) Within 120 days after its fiscal year ends, each hospital shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting, its actual audited experience for that fiscal year, including expenditures, revenues, and statistical measures.
(8) The board may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of this part.

(9) The Shriners Hospital for Crippled Children, located in Tampa, is exempt from the financial reporting requirements of this chapter part until such time as it first receives revenues from or on behalf of any individual patient.

Section 21. Section 395.514, Florida Statutes, is renumbered as section 407.06, Florida Statutes, and amended to read:

407.06 395.514 Violation of chapter part or rule; penalties.--Refusal Any hospital which refuses to file, failure fails to timely file, or filing files false or incomplete reports or other information required to be filed under the provisions of this chapter part, or violation of which violates any other provision of this chapter part or rule adopted under this chapter part, shall be punished by a fine not exceeding $1,000 a day for each day in violation, to be fixed, imposed, and collected by the board. Each day in violation shall be considered a separate offense. The violation of any provision of this chapter part or of a rule adopted under this chapter part, or the knowing and willful falsification of a report required under this chapter part, is a ground for the imposition of an administrative fine not to exceed $20,000, to be fixed, imposed, and collected by the Department of Health and Rehabilitative Services.

Section 22. Section 395.508, Florida Statutes, is renumbered as section 407.07, Florida Statutes, and amended to read:

407.07 395.508 Health care Hospital costs and finances; analyses, studies, and reports.--

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(1) The board shall have the authority to:

(a) Collect data and conduct from-time-to-time
undertake analyses and studies relating to health care costs,
making maximum use of local health councils and the designated
state health planning agency whenever appropriate, possible,
and

(b) Conduct analysis and research relating to the
financial status of any hospital or hospitals subject to the
provisions of this part.

(c) The board and the department shall jointly
develop, with the Department of Insurance or the Department of
Health and Rehabilitative Services, criteria to analyze and
study the ongoing effect upon health care costs of third-party
reimbursement mechanisms, including the effects of Medicare,
Medicaid and other government reimbursement mechanisms. The
board shall incorporate into its reports the findings of the
Department of Insurance department relating to the effect upon
health care costs of third-party reimbursement mechanisms,
including health insurance as defined in ss. 624.603 and
627.652, health care service plans as defined in s. 641.01,
and health maintenance organizations as defined in s.
641.19(6).

(d) Conduct analysis and research relating to the
impact of uncompensated charity care on hospital budgets.

(e) Conduct analysis and research on the state's role
in assisting to fund indigent care.

(f) The board may publish and disseminate such
information as the board deems desirable and in the public
interest, including information which will assist consumers
and purchasers to understand the impact government-funded

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programs and third-party reimbursement mechanisms may have on hospital finances.

(2) The board shall also prepare and file such summaries and compilations or other supplementary reports based on the information analyzed by the board hereunder as will advance the purposes of this part.

Section 23. Section 395.513, Florida Statutes, is renumbered as section 407.08, Florida Statutes, and amended to read:

407.08 395.513 Program accountability.--On or before March 1 of each year, the board shall prepare and transmit to the Governor and the Legislature a report of health care hospital cost containment board program operations and activities for the preceding year. This report shall include copies of summaries, compilations, and supplementary reports required by this chapter part, together with such facts, suggestions, and policy recommendations as the board deems necessary. The board shall specifically state its findings and recommendations on the following issues:

(1) The extent to which cross-subsidization affects the rates and charges for different types of hospital services and an analysis of the reasons for existing levels of cross-

(2) The extent to which third-party reimbursement mechanisms affect health care costs.

(3) The extent to which public funding policies may be affecting health care costs.

(4) The extent to which other factors in the health care marketplace may be affecting health care costs, including, but not limited to, uncompensated care, skilled employee shortages, changes in technology, shifts from

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institutional to ambulatory care, and shifts in the
demographic makeup of the state's population.

Section 24. Section 395.5085, Florida Statutes, is
renumbered as section 407.09, Florida Statutes, and amended to read:

407.09 395.5085  Collection and dissemination of health
care hospital charges and other health-care-specific hospital-
specific information—Consumer-Information-Network.—

(1) The board, relying on summary-actual-charge data
by-diagnostic-groups-and-other-information collected pursuant
to this act §395.504(1), shall establish a reliable, timely,
and consistent information system which distributes
information utilizing the consumer information and advisory
council pursuant to s. 407.10, and any other appropriate means
available.

(2) Semiannually, the board shall identify, by
hospital, average charges and lengths of stay associated with
established diagnostic groups. Charge information shall be
cited for at least the following payer classifications:
insurance, not-for-profit insurance, Medicaid, and Medicare.
Combined average charges for all payer classifications
reported shall be published by the board semiannually for
dissemination to the media and the public at large. The
publication shall identify charges associated with at least
the 10 most frequently occurring diagnostic groups and such
other information as the board deems appropriate, published by
county or region.

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Senate-and-the-House-of-Representatives-consumer-service

offices-located-within-the-Department-of-Insurance-insurance

companies-licensed-to-write-policies-for-health-insurance-in

this-state; Florida-business-coalitions-on-health-care-local

health-councils-and-the-designated-state-health-planning

agency; the-Board-of-Medical-Examiners-and-hospitals.

(3) The Board of Medicine Medical-Examiners may

include the current publication of hospital charges in its

mailings related to license renewals. Hospitals are required

to make the current publication of hospital charges available

to patients or family members for review upon the request of

the patient or family member.

(4) The board shall through the Consumer Information

Network, conduct consumer information seminars at locations

throughout the state.

Section 25. Section 407.10, Florida Statutes, is

created to read:

407.10 Consumer information and advisory council.--The

board shall coordinate the distribution of data, special

publications, and other health care information collected or

developed by the board with the assistance of the consumer

information and advisory council.

(1) The membership of the council shall be appointed

by the board and may include members of the Senate and the

House of Representatives; a representative of the office of

the Public Counsel; representatives of consumer service

offices located within the Department of Insurance;

representatives of insurance companies licensed to write

policies for health insurance in this state; representatives

of Florida business coalitions on health care; members of

local health councils; a representative from the designated

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state health planning agency, a member of the Board of Medicine, and representatives of health care consumers, nursing homes, and hospitals.

(2) The council may conduct or sponsor consumer information and education seminars at locations throughout the state, and may hold public hearings to solicit consumer concerns or complaints relating to health care costs and make recommendations to the board for study, action, or investigation.

(3) The council shall be entitled to reimbursement for expenses incurred to fulfill the function of this part, including travel expenses.

Section 26. Section 395.5042, Florida Statutes, is renumbered as section 407.11, Florida Statutes, and amended to read:

407.11 395.5042 Office of Technical Assistance within board.--It is the intent of the Legislature to create a single entity to serve as a focal point for governmental efforts and activities to promote health care cost containment by providing technical assistance to persons, businesses, and purchaser coalitions interested in containing the costs of health care. Therefore, there is created within the Health Care Hospital Cost Containment Board the Office of Technical Assistance, which shall include such professional, technical, and clerical staff as may be necessary to enable it to carry out its duties. The Office of Technical Assistance shall:

(1) Assist employers in the formation of health care coalitions around the state.

(2) Develop model health care benefit packages for use by employers and providers in implementing health benefit

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plans which promote the cost-effective delivery of adequate care.

(3) Serve as a clearinghouse for information concerning innovations in the delivery of health care services and the enhancement of competition in the health care marketplace.

(4) Make recommendations relating to pursuit-the implementation-of mechanisms through which state government might well lead by example in the prudent purchase of cost-effective adequate health services for its employees and clients.

(5) Assist work-with existing health coalitions and local health councils as needed in carrying out their respective goals in an efficient and effective manner.

(6) Develop cost containment strategies for use by providers, employers, or consumers of health care.

(7) Serve as a clearinghouse for information concerning federal and state legislative initiatives affecting the private health care delivery system and governmental health care programs.

(8) Develop an outreach program to assist small business to include cost containment initiatives for small business health insurance plans.

Section 27. Section 395.511, Florida Statutes, is renumbered as section 407.12, Florida Statutes, and amended to read:

407.12 395.511 Quality assurance monitoring programs.--Each hospital shall maintain a quality assurance program and shall maintain and provide to the board, upon request, the information necessary to monitor--which-program shall--include--monitoring--of the necessity of admission,
appropriateness of the length of stay, proper utilization of services, variation of medical practice patterns between hospitals, mortality, and morbidity. Results of accreditation surveys which set forth this information shall also be provided to the board upon request. and-the-evaluation-of-the quality-of-services-rendered--Quality-assurance-plans-shall be-available-to-the-board-upon-request.

Section 28. Section 395.515, Florida Statutes, is renumbered as section 407.13, Florida Statutes, and amended to read:

407.13 395.515 Prospective payment arrangements.--

(1) The Legislature finds that the traditional retrospective reimbursement practices of health insurers provide hospitals with disincentives to contain costs and are a major contributing factor to the rapidly escalating costs of hospital care. The Legislature further finds that prospective payment arrangements designed to provide hospitals with financial incentives to contain costs will contribute to the deceleration of hospital cost increases while enhancing the adequacy of and access to care so highly valued by consumers. Furthermore, prospective payment arrangements that provide fixed payment amounts which are prospectively set through private-sector negotiation will provide insurers with a greater degree of investment stability. Therefore, the Legislature finds that it is the business of insurance, as well as in the best interests of the citizens of this state, that insurers, on behalf of their insureds, should negotiate with hospitals to establish prospective payment arrangements that provide financial incentives for the containment of hospital costs.

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(2) For the purposes of this chapter section, the term "prospective payment arrangement" means a financial agreement, negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payer, which contains, at a minimum, the elements provided for in subsection (4).

(3) Hospitals, as defined in s. 395.002, and health insurers, regulated pursuant to parts VI and VII of chapter 627, shall establish by no later than March 1, 1987, prospective payment arrangements that provide hospitals with financial incentives to contain costs. Each hospital shall negotiate with each health insurer which represents 10 percent or more of the private-pay patients of the hospital to establish a prospective payment arrangement. Beginning October 1, 1985, and annually thereafter Hospitals and health insurers regulated pursuant to this section shall report on October 1 of each year the results of each specific prospective payment arrangement adopted by each hospital and health insurer to the Health Care Hospital Cost Containment Board, hereinafter referred to as the "board." In the event that a hospital or a health insurer does not comply with the requirements of this section, such hospital or health insurer shall have 60 days in which to justify the reasons for its failure to comply to the board. The board shall take into account the failure of the hospital to comply in its approval or disapproval of the budget of the hospital. In addition, the board shall report a health insurer's failure to comply to the Department of Insurance, which shall take into account the failure by the health insurer to comply in conjunction with its approval authority under s. 627.410. The board shall adopt any rules CODING: Words stricken are deletions; words underlined are additions.
necessary to carry out its responsibilities required by this section.

(4) The prospective payment system established pursuant to this section shall include, at a minimum, the following elements:

(a) A maximum allowable payment amount established for individual hospital products, services, patient diagnoses, patient day, patient admission, or per insured, or any combination thereof, which is preset at the beginning of the budget year of the hospital and fixed for the entirety of that budget year, except when extenuating and unusual circumstances acceptable to the board warrant renegotiation;

(b) Timely payment to the hospital by the insurer or the insured, or both, of the maximum allowable payment amount, as so negotiated by the insurer or group of insurers;

(c) Acceptance by the hospital of the maximum payment amount as payment in full, which shall include any deductible or coinsurance provided for in the insurer's benefit plan;

(d) Utilization reviews for appropriateness of treatment; and

(e) Preadmission screening of nonemergency surgery.

(5) Nothing contained in this section prohibits the inclusion of deductibles, coinsurance, or other cost containment provisions in any health insurance policy.

Section 29. Section 400.341, Florida Statutes, is renumbered as section 407.30, Florida Statutes, and amended to read:

407.30 400.341 Legislative intent; nursing home costs.--The Legislature finds it to be in the best interest of the state that nursing home care be affordable and accessible to all persons requiring these services. Further, the

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Legislature finds there is a paucity of information on nursing home revenues and growth in those revenues, the equity of the burden in providing charity care, and nursing home rates and charges. The potential for growth in nursing home revenues and the effect of such growth on state and local government budgets and on the ability of persons to purchase nursing home care makes it vital that nursing home revenues and expenditures be documented and analyzed. The Legislature finds that the Health Care Hospital Cost Containment Board is the agency best qualified to collect, analyze, and monitor nursing home financial data and intends that the board carry out this responsibility in conjunction with the department and the State Nursing Home and Long-Term Care Facility Ombudsman Council and district nursing home and long-term care facility ombudsman councils.

Section 30. Section 400.343, Florida Statutes, is renumbered as section 407.31, Florida Statutes, and amended to read:

407.31 400.343 Uniform system of financial reporting for nursing homes.--

(1) The board shall consult with appropriate professional and governmental advisory bodies, hold public hearings, and consider existing and proposed systems of accounting and reporting utilized by nursing homes and then establish by rule a uniform system of financial reporting. Such system shall be based on a uniform chart of accounts developed after considering the American Health Care Association's Uniform Chart of Accounts for Long Term Care Facilities, appropriate audit standards from the American Institute of Certified Public Accountants, and generally accepted accounting principles. Such system shall, to the

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extent feasible, utilize existing accounting systems and shall
make every effort to minimize paperwork to nursing home
licensees. In addition, the board may not require nursing
homes to adopt a uniform accounting system. The board may
require the filing of any information relating to the
provider's and consumer's cost of services provided in a
nursing home, including physicians' compensation.

(2) Within 120 days after the end of its fiscal year,
each nursing home shall file with the board, on forms adopted
by the board and based on the uniform system of financial
reporting, its actual audited experience for that fiscal year,
including revenues, expenditures, and statistical measures,
based on examination by an independent, state-licensed
certified public accountant in accordance with generally
accepted accounting principles. Each nursing home shall also
submit a schedule of the charges in effect at the beginning of
the fiscal year and any changes that were made during the
fiscal year. A nursing home which is certified under Title
XIX of the Social Security Act and files annual Medicaid cost
reports may substitute copies of such reports and any Medicaid
audits to the board in lieu of a report and audit required
under this subsection. For such facilities, the board may
require only information in compliance with this act that is
not contained in the Medicaid cost report. Facilities which
are certified under Title XVIII but not Title XIX of the
Social Security Act must submit a report as developed by the
board. This report will be substantially the same as the
Medicaid cost report and shall not require any more
information than is contained in the Medicare cost report
unless that information is required of all nursing homes. The

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(3) In addition to information submitted in accordance with subsection (2), each nursing home shall track and file with the board, on a form adopted by the board and designed to protect the anonymity of residents, the following information, where applicable, reported for each resident or reported in the aggregate, if so directed by the board:

(a) Date of admission;
(b) Location from which admission was made;
(c) Age at the time of admission;
(d) Primary diagnosis at the time of admission;
(e) Source of financial support at the time of admission;
(f) Date of conversion to Medicaid;
(g) Amount spent on nursing home care prior to conversion to Medicaid, by payor source;
(h) Date of discharge;
(i) Reason for discharge; and
(j) Location to which resident is discharged.

(4) The board may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of ss. 407.30-407.34 407.30-407.341-407.346. Such requirements shall be established by rule unless the reports are part of a nonrecurring study or unless information is being requested for a single nursing home.

(5) If more than one licensed nursing home facility is operated by the reporting organization, the information required by this section shall be reported for each nursing home and for the organization's home office separately.

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(6) All reports filed under ss. 407.30-407.34, except privileged medical information, shall be open to public inspection.

(7) In the event the board has reason to believe that there is evidence of noncompliance with any of the provisions of ss. 407.30-407.34, the board may inspect and audit nursing home books and records, including records of individual or corporate ownership, for compliance with ss. 407.30-407.34. Upon presentation to a nursing home of a written request for inspection, the nursing home shall make available to the board or its staff for inspection, copying, and review all books and records relevant to the determination of whether the nursing home has complied with ss. 407.30-407.34.

Section 31. Section 400.344, Florida Statutes, is renumbered as section 407.32, Florida Statutes, and amended to read:

407.32. Nursing home revenues and financial analyses, studies, and reports.--

(1) The board shall evaluate data from nursing home financial reports beginning with nursing home fiscal years starting January 1, 1985, and shall document and monitor:

(a) Total revenues, annual change in revenues, and revenues by source and classification, including contributions for a patient's care from the patient's resources and from the family and contributions not directed toward any specific patient's care.

(b) Average patient charges by geographic region, payor, and type of facility ownership.

(c) Profit margins by geographic region and type of facility ownership.

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(d) Amount of charity care provided by geographic region and type of facility ownership.

(e) Patient days by payer prior category.

(f) Experience related to Medicaid conversion as reported under s. 407.31(3).

(g) Other information pertaining to nursing home revenues and expenditures.

The findings of the board shall be included in an annual report to the Governor and Legislature by January 1 each year.

(2) The board shall provide information relating to nursing home charges to the public through pamphlets, brochures, and other appropriate means pursuant to s. 407.09 and through the consumer information and advisory council referred to in s. 407.10.

(3) The board shall cooperate with and provide pertinent information on nursing home costs and charges to the department, local health councils, and the State Nursing Home and Long-Term Care Ombudsman Council and district nursing home and long-term care facility ombudsman councils.

(4) The board shall also prepare and make available such summaries and compilations or other supplementary studies and reports based on the information analyzed by the board hereunder as will advance the purposes of this part.

Section 32. Section 400.345, Florida Statutes, is renumbered as section 407.33, Florida Statutes, and amended to read:

(a) The board shall include in its biennial budget a separate estimate of income and expenditures for the

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administration and operation of the nursing home financial
disclosure program. Subject to legislative approval, expenses
of the program shall be financed by assessments against each
nursing home in an amount set by the Department of Health and
Rehabilitative Services to cover the board’s approved budget.

(b) The board shall annually notify the department of
its approved budget. The department shall calculate the
amount to be collected per bed, rounded to the nearest whole
dollar. All license fees collected under this section which
are due after the date of notification by the board shall be
at a rate sufficient to cover the board’s approved budget.

(c) Assessments shall be levied and collected annually
by the department. Moneys collected shall be deposited by the
department into the Health Care Hospital Cost Containment
Board Trust Fund as collected, but such funds shall be
maintained in a separate account.

(d) Each new nursing home shall pay its initial
assessment upon being licensed, and each nursing home under
new ownership shall pay its initial assessment under the new
ownership based on its number of beds.

(2) Moneys raised by collection of assessments from
nursing homes which are not required to meet the appropriation
for the current fiscal year shall be available to the board in
succeeding years.

Section 33. Section 400.346, Florida Statutes, is
renumbered as section 407.34, Florida Statutes, and amended to
read:

407.34 400-346 Nursing home violations; penalty.--Any
nursing home which refuses to file a report, fails to timely
file a report, files a false report, or files an incomplete
report and upon notification fails to timely file a complete

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report required under ss. 407.30-407.34 400-341-400-346, or
which violates any provision of ss. 407.30-407.34 400-341-
400-346 or rule adopted thereunder, shall be punished by a
fine not exceeding $1,000 per day for each day in violation,
to be imposed and collected by the board.

Section 34. Section 395.509, Florida Statutes, is
renumbered as section 407.50, Florida Statutes, and amended to
read:

(Substantial rewording of section. See
s. 395.509, F.S., for present text.)

407.50 Review of hospital budgets.--

(1) To establish a base for hospital budget review,
the board shall determine if the prior year's actual
experience exceeded the maximum allowable rate of increase or
exceeded the board-approved gross revenue per adjusted
admission. The base for such determination shall be the
lesser of the hospital's most recent gross revenue per
adjusted admission or the prior year's actual gross revenue
per adjusted admission inflated by the applicable maximum
allowable rate of increase.

(2)(a) Except for hospitals filing a budget pursuant
to subsection (3), each hospital, at least 90 days prior to
the commencement of its next fiscal year, shall file with the
board a certified statement, hereafter known as the "budget
letter," acknowledging its applicable maximum allowable rate
of increase in gross revenue per adjusted admission from the
previous fiscal year as calculated pursuant to s. 407.002(17)
and its maximum projected gross revenue per adjusted admission
for the next fiscal year and shall affirm that the hospital
shall not exceed such applicable maximum allowable rate of
increase. Such letter shall be deemed to be the budget for
the hospital for that fiscal year and shall be automatically
approved by operation of law. However, the board shall have
30 days from receipt of the budget letter to determine if the
gross revenues per adjusted admission submitted by the
hospital are within the maximum allowable rate of increase for
that hospital.

(b) If a hospital's gross revenues per adjusted
admission, as determined by its audited actual experience in
any one year, increases at a percentage rate less than the
maximum allowable rate of increase or board-approved rate of
increase, whichever is lower, the hospital may carry forward
the difference, and earn up to a cumulative maximum of 3
"banked" percentage points which may be banked to be used in
the future. Such banked percentage points may be added to the
hospital's maximum allowable rate of increase to increase the
gross revenues per adjusted admission in future years, or such
points may be used in the current fiscal year if a budget
amendment would have been required to keep the hospital out of
a penalty situation, provided that the hospital shall use its
original approved maximum allowable rate of increase as its
base. When determining the base, the hospital's prior year
actual experience shall be used, inflated by the current
year's board-approved applicable maximum rate of increase.
This amount shall be increased by the maximum allowable rate
of increase applicable to the hospital for the budget year.
The hospital shall specify in the budget letter, or in an
amendment to the budget letter submitted before the end of the
hospital's fiscal year, the number of banked percentage points
it intends to add to its maximum allowable rate of increase to
increase its gross revenues per adjusted admission. A
hospital shall be required to use banked percentage points

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before submitting a budget for detailed review or before
submitting a request for a budget amendment. The board shall
adopt rules which specify procedures for hospitals to bank and
use any percentage points as authorized under this section.

(3) At least 90 days prior to the beginning of its
fiscal year, each hospital requesting a rate of increase in
gross revenue per adjusted admission in excess of the maximum
allowable rate of increase for the hospital's next fiscal
year, or each hospital utilizing banked percentage points
pursuant to paragraph (2)(b) and requesting a rate of increase
in excess of the maximum allowable rate of increase plus the
available banked percentage points, shall be subject to
detailed budget review and shall file its projected budget
with the board for approval. The projected budget filed under
s. 407.05(6) shall be deemed approved unless it is disapproved
by the board within 120 days after filing. Upon agreement by
the board and the hospital, the 120-day period may be waived
or extended. As part of the review process conducted by the
board, the board may approve, disapprove, or disapprove in
part the projected budget. No hospital submitting a budget
for approval shall operate at a level of expenditures or
revenues which exceeds the maximum allowable rate of increase
minus 1 percentage point, unless a higher rate of increase has
been approved by the board. However, a hospital with banked
percentage points requesting a rate of increase which exceeds
the maximum allowable rate of increase plus the banked
percentage points shall not operate at a level of expenditures
or revenues in excess of 1 percentage point below the maximum
allowable rate of increase plus the banked percentage points.

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(4) For purposes of budget review and comparison and to assist in making determinations pursuant to subsection (8), the board shall:

(a) Establish groupings of hospitals according to characteristics, including, but not limited to, a measure of the nature and range of services provided, teaching hospital status, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, average daily census, geographical differences, and case mix. The rule shall provide for the establishment of not more than 15 general groups and for the establishment of additional specialty groups as needed. However, no group shall contain fewer than five hospitals.

(b) Establish statistical indicators per adjusted admission to serve as measures of comparison based on the most recent audited actual experience filed pursuant to s. 407.05(7) for the hospitals in each group. The statistical indicators shall include, but not be limited to, gross revenue, net revenue, and operating expenditures.

(5) The board shall review each budget filed pursuant to subsection (3) and amendments filed pursuant to subsection (6) to determine whether the rate of increase contained in the budget or amendment is just, reasonable, and not excessive. In making such determination, the board shall consider and the hospital may use the following criteria in the following priority, with (a) the highest priority, and (k) the lowest priority:

(a) The ability of the hospital to earn a reasonable rate of return.

(b) The impact of patient days attributable to the medically indigent.
(c) The impact of patient days reimbursed by Medicaid.
(d) The number of patient days reimbursed by Medicare or Medicaid.
(e) The cost and efficiency of providing the current level of services.
(f) The cost as measured by changes in the severity of illness, including changes in the case-mix score.
(g) The actions taken by or the ability of a hospital to reduce the cost of services.
(h) The cost of providing new services or facilities regulated under s. 381.706. The cost of these services may not be included until these services or facilities have been approved by the designated state agency.
(i) The accuracy of previous budget submissions compared to the actual experience of the hospital.
(j) The research and educational services provided by the hospital if it is a teaching hospital.
(k) For psychiatric hospitals, the impact on hospital gross revenues associated with changes in the average length of stay of patients, changes in admissions to hospital units and changes in admissions to specific services and, when available, case mix.

(6) After a hospital budget is approved, amended, or disapproved for a given fiscal year, no amendment to such budget shall be made, except in accordance with the following procedures:
(a) A request by a hospital to amend its budget shall be filed in writing with supporting documents no later than 90 days before the end of the hospital's fiscal year. The budget amendment shall be deemed approved unless it is disapproved or disapproved in part by the board within 120 days after such amendment.
filing. Upon agreement by the board and the hospital, the
120-day period may be waived or extended.

(b) After a hospital requests a budget amendment, but
before the final decision by the board on the amendment, the
board may extend provisional approval to any part of the
amendment. This provisional approval shall be superseded by
the final decision of the board.

(c) If approved by the board as part of a budget
amendment, the following items shall be applied retroactively
for the entire budget year of the hospital:

1. Increased case mix, including increased severity of
illness; and

2. Unforeseen and unforeseeable increases in
malpractice insurance premiums, prior-year Medicare cost
report settlements, and retroactive changes in Medicare
reimbursement methodology.

(7) The board shall disapprove any budget or amendment
or part thereof as excessive that contains a rate of increase
which is not necessary to maintain total hospital costs at a
level reasonably related to total services provided and which
is not necessary to maintain a prudently managed hospital.

(8) The board shall disapprove, in its entirety or in
part, any budget or any budget amendment that contains a rate
of increase which the board finds, pursuant to subsection (5),
to be unjust, unreasonable, or excessive.

(9)(a) Upon receipt of a budget or an amendment to a
budget, the staff of the board shall review the budget and
executive staff members designated by the board shall make
preliminary findings and recommendations in writing as to
whether the budget should be approved, disapproved, or
disapproved in part. The staff shall send the preliminary

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findings by certified mail to the hospital. The hospital shall have 14 days from the receipt of the preliminary findings and recommendations to file written objections and request a hearing with the board if a hearing is desired; or to file written objections if a hearing is not requested by the hospital.

(b) If a hearing is requested, it shall be conducted by the board or, at the election of the board, by a hearing officer of the Division of Administrative Hearings of the Department of Administration, pursuant to the provisions of s. 120.57. The Division of Administrative Hearings shall assign at least two full-time hearing officers exclusively to hear matters pertaining to this part. Hearings shall be held within 30 days of filing the request, unless waived by the board and the hospital. All hearings shall be held in Tallahassee, unless the board determines otherwise.

(c) Recommended orders shall be issued within 30 days from the close of the hearing, unless waived by all parties. The board shall enter a final order within 120 days from the date of filing of the budget.

(d) Any waiver of the time limits within which to conduct a hearing or to issue a recommended order also constitutes a waiver of the time limit to issue the final order and tolls the 120-day automatic approval provision of subsection (3). The provision shall be tolled beginning from the date the waiver is entered and shall resume 10 days after the recommended order is submitted to the board. The failure to request a hearing within 14 days of the receipt of the preliminary findings of the staff constitutes a waiver of the right of the hospital to contest the final decision of the board, and the board is authorized to enter a final order.

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consistent with the staff's preliminary findings without
further proceedings.

(e) During the pendency of any hearing or an appeal of
a final order of the board, no hospital shall operate at a
level of expenditures and revenues which exceeds the maximum
allowable rate of increase minus 1 percentage point, unless a
higher rate of increase has been approved by the board.
However, a hospital with banked percentage points requesting a
rate of increase which exceeds the maximum allowable rate of
increase plus the banked percentage points shall not operate
at a level of expenditures or revenues in excess of 1
percentage point below the maximum allowable rate of increase
plus the banked percentage points.

(10) The board may publish its findings in connection
with any review conducted under this section in the newspaper
of the largest circulation in the county in which the hospital
is located.

(11) Notwithstanding any other provisions of this
part:

(a) Any hospital operated by the Department of Health
and Rehabilitative Services or the Department of Corrections,
or any comprehensive rehabilitative hospital as defined in s.
407.002(7), or any rural hospital as defined in s.
407.002(24), is exempt from filing a budget, is exempt from
budget review and approval for exceeding the maximum allowable
rate of increase, and is exempt from any penalties arising
therefrom. However, each such hospital is required to submit
to the board its audited actual experience, as required by s.
407.05(7).

(b) In addition, the board shall exempt any hospital
from filing a budget, from budget review and approval for
exceeding the maximum allowable rate of increase, and from any
penalties arising therefrom, upon a finding of the board that
the hospital, during the hospital's most recent audited actual
experience, had a prospective payment system, as defined in s.
407.13(2), which contained all of the elements set forth in s.
407.13(4)(a)-(e) for at least 90 percent of the hospital's
admissions, exclusive of Medicare, Medicaid, and any other
patients which meet the board's definition for charity care.
Such exemption shall be on a year-to-year basis, upon a
finding by the board that the hospital has met the
requirements of this subsection each year. Each hospital
exempted from budget review pursuant to this paragraph shall
submit to the board its audited actual experience, as required
by s. 407.05(7). This paragraph is repealed, and shall be
subject to review by the Legislature pursuant to s. 11.11,
upon a finding by the board that at least 25 percent of
hospitals which would have otherwise been subject to budget
review are excluded from budget review pursuant to this
paragraph. Such repeal shall take effect on July 1 following
the date on which the board makes a finding that the 25-
percent level, as set forth in this paragraph, has been
reached.

(12) The review and approval of hospital budgets
pursuant to this act shall apply to hospital budgets for
fiscal years which begin on or after February 1, 1989.
Notwithstanding any other provision in this act to the
contrary, any budget or budget amendment for fiscal years
beginning prior to February 1, 1989, shall be filed and
reviewed pursuant to chapter 84-35, Laws of Florida, and rules
adopted by the board pursuant thereto.
Section 35  Section 395.5094, Florida Statutes, is
renumbered as section 407.51, Florida Statutes, and amended to
read:

407.51 395-5094 Exceeding approved budget or previous
year's actual experience by more than maximum rate of
increase; allowing or authorizing operating revenue or
expenditures to exceed amount in approved budget; penalties.--

(1) The board shall annually compare the audited
actual experience of each hospital to the audited actual
experience of that hospital for the previous year.

(a) For hospitals submitting budget letters, if the
board determines that the audited actual experience of a
hospital exceeded its previous year's audited actual
experience by more than the maximum allowable rate of increase
as certified in the budget letter, the amount of such excess
shall be determined by the board and a penalty shall be levied
against such hospital pursuant to subsection (2).

(b) For hospitals subject to budget review, if the
board determines that the audited actual experience of a
hospital exceeded its previous year's audited actual
experience by more than the approved budget or approved budget
as amended the-projected-budget-as-approved-by-the-board,
whichever-is-greater, the amount of such excess shall be
determined by the board, and a penalty shall be levied against
such hospital pursuant to subsection (2), based-thereon-as
follows:

(2) Penalties shall be assessed as follows:

(a) For the first occurrence within a 5-year period,
the board shall prospectively reduce the current budget of the
hospital by the amount of the excess up to 5 percent; and, if
such excess is greater than 5 percent over the maximum

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1 allowable rate of increase, any amount in excess of 5 percent
2 shall be levied by the board as a fine against such hospital,
3 to be deposited in the Public Medical Assistance Trust Fund,
4 as created in s. 409.2662.
5
6 (b) For the second occurrence within the 5-year period
7 following the first occurrence as set forth in paragraph (a),
8 the board shall prospectively reduce the current budget of the
9 hospital by the amount of the excess up to 2 percent; and, if
10 such excess is greater than 2 percent over the maximum
11 allowable rate of increase, any amount in excess of 2 percent
12 shall be levied by the board as a fine against such hospital,
13 to be deposited in the Public Medical Assistance Trust Fund.
14
15 (c) For the third occurrence within the 5-year period
16 following the first occurrence as set forth in paragraph (a),
17 the board shall:
18
19 1. Levy a fine against the hospital in the total
20 amount of the excess, to be deposited in the Public Medical
21 Assistance Trust Fund.
22
23 2. Notify the Department of Health and Rehabilitative
24 Services of the violation, whereupon, the department shall not
25 accept any application for a certificate of need pursuant to
26 ss. 381.701-381.7155 381.701-381.725 from or on behalf of such
27 hospital until such time as the hospital has demonstrated, to
28 the satisfaction of the board, that, following the date the
29 penalty was imposed under subparagraph 1., the hospital has
30 stayed within its projected or amended budget or its
31 applicable maximum allowable rate of increase for a period of
32 at least 1 year. However, this provision does not apply with
33 respect to a certificate-of-need application filed to satisfy
34 a life or safety code violation.
35
36 CODING: Words stricken are deletions; words underlined are additions.
3. Upon a determination that the hospital knowingly and willfully generated such excess, notify the Department of Health and Rehabilitative Services, whereupon the department shall initiate disciplinary proceedings to deny, modify, suspend, or revoke the license of such hospital or impose an administrative fine on such hospital not to exceed $20,000.

The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital pursuant to s. 409.266(7) or s. 409.2663. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.101 minus the amount of revenues received by the hospital through the operation of s. 409.266(7) or s. 409.2663. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, its entitlement to such reduction. It is the intent of the Legislature that the Health Care Hospital Cost Containment Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, any change in its case mix. For psychiatric hospitals, the board shall also reduce the amount of excess by utilizing as a proxy for case mix the change in a hospital's audited actual average length of stay as compared to the previous year's audited actual average length of stay without any thresholds or limitations.

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(3) The following factors may be used by the board to reduce the amount of excess of the hospital as determined pursuant to this section:

(a) Unforeseen and unforeseeable events which affect the net revenue per adjusted admission and which are beyond the control of the hospital, such as prior-year Medicare cost report settlements, retroactive changes in Medicare reimbursement methodology, and increases in malpractice insurance premiums, which occurred in the last 3 months of the hospital fiscal year during which the hospital generated the excess; or

(b) Imposition of the penalty would have a severe adverse affect which would jeopardize the continued existence of an otherwise economically viable hospital.

(4)(2) If the board finds that any hospital chief executive officer, or any person who is in charge of hospital administration or operations, has knowingly and willfully allowed or authorized actual operating revenues or expenditures that are in excess of projected operating revenues or expenditures in the hospital's approved hospital budget as approved by the board, the board shall order such officer or person to pay an administrative fine not to exceed $5,000.

(3) The board may not reduce the budget of or levy a fine upon any hospital based on the hospital's audited actual experience for fiscal year 1986 if the hospital treated inmates from the Department of Corrections and if the hospital exceeded its previous year's audited actual experience by more than the maximum allowable rate of increase or exceeded its projected budget as approved by the board for fiscal year 1986.
solely-as-a-result-of-revenue-paid-to-such-hospital-by-the
Department-of-Corrections-for-treatment-of-inmates.

Section 36. Section 395.5125, Florida Statutes, is
renumbered as section 407.52, Florida Statutes.

Section 37. Section 395.5135, Florida Statutes, is
renumbered as section 407.53, Florida Statutes.

Section 38. Section 395.5092, Florida Statutes, is
renumbered as section 407.54, Florida Statutes, and amended to
read:

407.54 395.5092 Budget review proceedings; duty of
Public Counsel --Notwithstanding any other provisions of this
chapler part, it shall be the duty of the Public Counsel to
represent the general public of the state in any proceeding
before the board or its advisory panels, in any administrative
hearing conducted pursuant to the provisions of s. 120.57, or
before any other state and federal agencies and courts, in any
issue related to budget review. With respect to any such
proceeding, the Public Counsel is subject to the provisions
of, and may utilize the powers granted to him by, ss. 350.061-
350.0614.

Section 39. Section 395.52, Florida Statutes, is
renumbered as section 407.70, Florida Statutes, and amended to
read:

407.70 395.52 Information relating to physician's
charges.--

(1) The Health Care Cost Containment Board may, in its
discretion, require the submission by hospitals of information
relating to charges made by a physician with respect to
hospital services. However, any physician who provides
services within a hospital is exempt from the provisions of

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this section if he bills his services independently of the hospital.

(2) The board shall publish, based on information provided by insurers under s. 627.9175(3), an annual report containing available physician charge comparisons, profiles, and related information and shall disseminate the report in the manner provided in s. 407.09.

Section 40. The board shall contract with the University of Florida for an 18-month study. Within the established time frame, the study shall determine the following:

(1) By February 1, 1989, a recommendation to the board for a Florida-specific measure of hospital expenses, which shall be adjusted for geographic differences between Florida hospitals. The Florida Hospital Input Price Index (FHIPPI) shall consider and include, but not be limited to, the components of the National Hospital Input Price Index weighted for Florida-specific experience as well as other expenses not currently included in the National Hospital Input Price Index. The study is directed to consider expense trends during the past 8 years, as well as unusual expense increases such as for nurses. By February 1, 1989, the contractor shall also recommend to the board a methodology and reporting system to measure the impact annually of changes in reimbursement methodologies and changes in reimbursement levels from all government payers and increases in uncompensated care, including bad debts. The board shall submit the results of these two parts of the study to the Legislature along with recommendations as to application by March 1, 1989.

(2) By February 1, 1990, a recommendation to the board as to a statistical measure or index for severity of illness.

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The board shall submit the results of this part of the study to the Legislature along with recommendations as to application by March 1, 1990.

(3) By July 1, 1990, a recommendation to the board for the development of a severity index for psychiatric hospitals. The board shall submit the results of this part of the study to the Legislature along with its recommendations as to application by March 1, 1990.

Section 41. Subsections (7) and (8) of section 409.266, Florida Statutes, are amended, and subsection (18) is added to said section, to read:

409.266 Medical assistance.--

(7) The Department of Health and Rehabilitative Services shall, within the intent of this section, expand payment for medical services to additional eligible persons as provided herein:

(a) The department shall, by rule, increase the Medicaid outpatient hospital services cap from $500 to $1,000, effective October 1, 1987.

(b) Beginning July 1, 1984, the department is authorized to use up to $10 million from the Public Medical Assistance Trust Fund, as created in s. 409.2662, to establish a primary care system programs for Medicaid clients and other low-income persons by developing primary care programs contracted through the county public health units pursuant to s. 154.011.

(c) Beginning July 1, 1985 1987, the department is authorized to use up to $20 million from the Public Medical Assistance Trust Fund in addition to the moneys authorized in paragraph (b), for a total of $30 million for fiscal year 1988-1989 1987-1988, in order to expand

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primary care programs for low-income persons to each county pursuant to s 154.011.

(d) Beginning July 1, 1985, the department shall provide by rule for the delivery of Medicaid services to:

1. Financially eligible individuals under age 21 who are children in intact families;
2. Financially eligible unemployed parents and their children who are under age 18; and
3. Financially eligible married pregnant women.

Financial eligibility shall be based on the income and resource standards for Aid to Families with Dependent Children. The definition of the term "unemployed" shall be based on federal regulations.

(e) The department shall provide, by rule, for the delivery of federally approved Medicaid services to qualified elderly persons and disabled persons whose family incomes are below 100 percent of the federal nonfarm poverty level.

(f) Beginning October 1, 1987, the department shall provide, by rule, for the delivery of Medicaid services as specified in paragraph (j) to qualified pregnant women whose family incomes are below 100 percent of the federal nonfarm poverty level.

(g) Beginning October 1, 1988, the department shall provide, by rule, for the delivery of federally approved Medicaid services to qualified infants and children under 2 years of age, whose family incomes are below 100 percent of the federal nonfarm poverty level, and shall phase in additional age limits as follows:

CODING: Words stricken are deletions; words underlined are additions.
1. Beginning October 1, 1989 and 1990, Medicaid benefits shall be extended to cover eligible children under the age of 3.

2. Beginning October 1, 1990 and 1991, Medicaid benefits shall be extended to cover eligible children under the age of 5.

3. Beginning October 1, 1991 and 1992, Medicaid benefits shall be extended to cover eligible children under the age of 5.

(h) The department is prohibited from applying a resource test to those pregnant women or children who are made eligible for Medicaid services under paragraph (f) or paragraph (g), unless such persons also receive Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) benefits.

(i) Beginning October 1, 1987, the department is directed to implement the federal option of presumptive eligibility in accordance with 42 U.S.C., ss. 1396(a)(47) and 1396r, for all Medicaid-eligible pregnant women who affirm their family income to be within the Medicaid eligibility standards.

(j) The specific Medicaid services referred to be provided in paragraphs (e) through (i) shall be those authorized by the Federal Sixth Omnibus Budget Reconciliation Act or the Federal Seventh Omnibus Budget Reconciliation Act and provided for in the General Appropriations Act.

(k) Beginning July 1, 1986, the department shall establish, by rule, a Medicaid medically needy program that will provide services for which categorically eligible persons are entitled, except for long-term institutional services. These services shall be provided to persons who meet...
categorical eligibility requirements, other than requirements relating to income limitations. The maximum income eligibility for services through the medically needy program shall be set at up to 133 1/3 percent of the payment standard for eligibility for Aid to Families with Dependent Children, the percentage to be set by the department in consultation with the appropriations committees of the Senate and the House of Representatives and based upon recurring funds available.

2. On or before March 1, 1989, the department shall submit to the President of the Senate, the Senate Minority Leader, the Speaker of the House of Representatives, and the Minority Leader of the House of Representatives, a report on the status of the Medicaid medically needy program and any of the other Medicaid programs which expand eligibility to optional groups and which are funded from the Public Medical Assistance Trust Fund. The report shall include, but need not be limited to, the following:

a. The amounts reimbursed to providers, arranged by major types of providers, and the amount hospitals were assessed for the Public Medicaid Assistance Trust Fund.

b. Any evidence of a shift in the burden of uncompensated care among hospitals, based on hospital assessments and reimbursements from the Public Medical Assistance Trust Fund.

c. The impact in the eligibility for and the reimbursements from the expanded Medicaid eligibility programs on the budgets of county public health units and the children's medical services budget.

d. Caseload information concerning Aid to Families With Dependent Children and Supplemental Security Income clients who were screened, and determined eligible, as a
result of the medically needy eligibility determination process.

e. Information relating to attrition rates at the various stages of the application process.

f. An assessment of the impact of the payment level for clients receiving Aid to Families With Dependent Children on the average medically needy spend-down payment level.

g. Recommendations for program improvements, including recommendations relating to administrative issues, additional services to be offered, interface with providers, and possible funding mechanism.

h. Projections of caseloads for the next 3 fiscal years for programs funded from the Public Medical Assistance Trust Fund and projections of any surplus or deficit resulting from those caseload projections.

(8) The department shall, within the intent of this section, expand payment for Medicaid services as follows:

(a) Beginning October 1, 1987, the department is directed to increase all Medicaid physician reimbursement up to a minimum of the Medicare 50th percentile as published in the 1986 Medicare Part B Procedure Codes and Prevailing Allowances, to be phased in over a 5-year period, except, however, effective October 1, 1987:

1. The department shall increase the Medicaid physician reimbursement rate for office visits to the Medicare 50th percentile.

2. Reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which include prenatal, delivery, and postpartum care, shall be at least $800 per delivery for a pregnant woman with low medical risk and at least $1,200 per delivery for a pregnant woman.

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with high medical risk. Nurse midwives licensed under chapter 2464 and chapter 467 shall be paid at no less than 80 percent of the low medical risk fee. The department shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman. Such determination shall not include a consideration of whether a caesarean section was performed. The department shall by rule determine a prorated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed. The department shall review these reimbursement fees annually in relation to the actual cost of providing the obstetrical care, and shall make recommendations to the Legislature for appropriate increases as necessary.

3. Reimbursement per day per patient to a physician licensed under chapter 458 or chapter 459, who is certified or is eligible for certification by an appropriate board to practice neonatal-perinatal medicine, shall be limited to no more than 10 percent of the total obstetrical service delivery rate for a high medical risk pregnant woman. The department may by rule establish a graduated fee schedule which is based on the complexity and severity of the infant’s medical problems. However, in no instance shall the physician's daily reimbursement per patient be set at less than $50.

(b) The department shall phase in increases to the Medicaid physician reimbursement rates up to a minimum of the Medicare 50th percentile, utilizing the Florida Medicare Area B allowances, as follows:

1. Beginning October 1, 1988, the department shall increase fees for all remaining physician visits, including critical care visits, hospital visits, and nursing home visits; and for services rendered within the 25 most frequent

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surgical procedure code groups as determined by the
department.

2. Beginning October 1, 1989, the department shall
increase fees for anesthesiologist procedures.

3. Beginning October 1, 1990, the department shall
increase fees for radiology and pathology procedures.

4. Beginning October 1, 1991, the department shall
increase fees for the remaining surgical procedures and for
all remaining procedures not previously increased.

(c) Consistent with the legislative intent to
emphasize primary and preventive health services as they apply
to children, beginning October 1, 1987, the department is
directed to provide, by rule, for the expansion of Medicaid
coverage to increase provider fees for early periodic
screening, diagnosis and treatment of Medicaid-eligible
children up to a minimum of $30 per unit. The department
shall review provider fees annually in relation to the actual
cost of providing the screening, diagnosis, and treatment, and
shall make recommendations to the Legislature for appropriate
increases as necessary.

(d) Beginning October 1, 1987, the department shall
provide, by rule, for a 100-percent increase in Medicaid
provider fees for home health care services, up to a maximum
of 55 percent of the Medicare maximum allowance; however,
licensed practical nurses shall be reimbursed 15 percent less
than registered nurses.

(e) Beginning October 1, 1987, the department shall
reimburse physicians $35 per unit to provide annual health
screening and diagnostic services for Medicaid-eligible
adults. The department shall review provider fees annually in
relation to the actual cost of providing the screening and

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diagnosis, and shall make recommendations to the Legislature for appropriate increases as necessary.

Beginning October 1, 1987, the department shall increase access to primary dental care by increasing Medicaid dental fees to 100 percent of the October 1, 1984, departmental fee schedule for non-Medicaid clients as determined by the advisory Dental Fee Committee.

The department is directed to pursue alternatives with the Federal Health Care Financing Administration to extend the limit on inpatient hospitalization to 90 days beginning October 1, 1988, for all Medicaid eligible neonates receiving services in regional perinatal intensive care centers as defined in s. 383.16(3), or in affiliated centers as defined in s. 383.16(4). If by January 1, 1989, the department is unable to reach agreement with the Health Care Financing Administration to extend the length of inpatient hospital days for such neonates, then the department is directed to extend the length of stay for inpatient hospital services to 90 days for all eligible children under 21, which participate in the Medicaid Early Periodic Screening, Diagnosis, and Treatment Program. Notwithstanding the provisions of s. 409.267, counties shall be exempt from contributing towards the cost of this extension from the 46th to the 90th day.

Section 42. Subsections (1) and (6) of section 409.266, Florida Statutes, are amended to read:

409.2661 Medically indigent demonstration projects.-- Beginning July 1, 1987, the department is directed to plan for and establish medically indigent demonstration projects and to evaluate the impact of each on improving access to services by persons who are medically underserved.

CODING: Words stricken are deletions; words underlined are additions.
(1) The department shall contract to assist in funding two one rural and two one urban demonstration primary care health training project which links the provision of primary care services to low-income persons with the education of medical students, interns, and residents. Such program shall at a minimum:

(a) Be sponsored by state-approved medical schools which shall be responsible for the clinical training and supervision.

(b) Cover large geographical areas and large numbers of patients.

(c) Utilize a multidisciplinary approach with appropriate medical supervision.

Nothing in this subsection shall preclude a primary care health training demonstration project from utilizing current community resources such as county public health units, primary care programs, or other established cooperative agreements. Each primary care health training demonstration project shall be eligible for up to $1 million of funds appropriated pursuant to subsection (6).

(6) Not more than $5 65 million in total shall be appropriated for the medically indigent demonstration projects; provided, however, that each demonstration project shall be awarded no more than $1 million to cover service, administration, and start-up costs. This money shall be derived exclusively from the Public Medical Assistance Trust Fund.

Section 43. Effective July 1, 1988, or upon becoming a law, whichever occurs later, section 409.2663, Florida Statutes, is amended to read:

CODING: Words stricken are deletions; words underlined are additions.
409.2663 Redistribution of funds in the Public Medical Assistance Trust Fund.--

(1) LEGISLATIVE INTENT.--The Legislature finds that the Public Medical Assistance Trust Fund was created for the purpose of providing equity among hospitals in the provision of indigent health care services. The Legislature further finds that at this time, the Medicaid medically needy program and the categorical expansion of the Medicaid program are insufficient in and of themselves to redistribute the funds in the Public Medical Assistance Trust Fund and therefore a surplus has accumulated. The Legislature concludes that additional mechanisms for the redistribution of funds in the Public Medical Assistance Trust Fund are needed in order to accomplish the original intent, including a direct redistribution of trust fund dollars to hospitals which are major providers of indigent care. However, a redistribution formula is considered appropriate only for the short term until other, more appropriate, mechanisms for equalizing the indigent care burden among hospitals can be established. Further, it is the intent of the Legislature that local governments or tax districts county-governments shall not reduce county contributions to hospitals for indigent care as a result of funds redistributed to hospitals pursuant to this section and shall provide, at a minimum, the same level of funding as provided for during the last fiscal year in that county.

(2) DEFINITIONS.--As used in this section:
(a) "Adjusted patient day" means the sum of acute patient days and intensive care patient days divided by the ratio of inpatient revenues generated from acute, intensive, and...
ambulatory, and ancillary patient services to gross revenues.

(b) "Audited actual data" or "audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant, in accordance with generally accepted auditing standards.

d) "Bad-debts" means that portion of hospital charges for care provided to a patient whose family income fails to qualify him for charity care and for which there is no compensation. --Bad-debts shall not include administrative or courtesy discounts, contractual allowances to third-party payers, or failure of a hospital to collect full charges due to partial payment by government programs.

(c) "Board" means the Health Care Hospital Cost Containment Board as established in s. 407.01 395.593.

(d) "Charity care" means that portion of hospital charges reported to the board for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to below 150 percent of the federal nonfarm poverty level unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal nonfarm poverty level for a family of four be considered charity care, for the purposes of this section, shall not include administrative or courtesy discounts, contractual allowances to third-party payers, or failure of a hospital to collect full per diem charges from Medicare or Medicaid sponsored patients; failure to collect full charges due to grants or partial payment by

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governments programs; or charity care reported to comply with
the requirements of the Hill-Burton Hospital and Medical
Facilities Construction Plan.

"Charity care days" means the sum of charity
care divided by gross revenues per adjusted patient day.

"Department" means the Department of Health and
Rehabilitative Services.

"Hospital" means a health care institution as
defined in s. 395.002(6).

"Gross revenue" means the sum of daily hospital
service charges, ambulatory service charges, ancillary service
charges, and other operating revenue. Gross revenues do not
include contributions, donations, legacies, or bequests made
to a hospital without restriction by the donors.

"Public Medical Assistance Trust Fund" or
"trust fund" means the Public Medical Assistance Trust Fund as
established in s. 409.2662.

"Uncompensated-care" means the sum of charity-care
and bad-debts.

"Uncompensated-care-days" means the sum of
uncompensated-care-divided-by-gross-revenue-per-adjusted
patient-day.

(3) HOSPITAL REDISTRIBUTION OF PUBLIC MEDICAL
ASSISTANCE TRUST FUND SURPLUS.--The-hospital-redistribution-of
surplus-funds-in-the-Public-Medical-Assistance-Trust-Fund
shall-be-based-upon-fiscal-1986-hospital-data-as-reported-to
the-board.

(a) Beginning September 30, 1988, the department shall
distribute, pursuant to this subsection, up to $70 million
from surplus trust funds in four quarterly payments to
hospitals which meet the following criteria:

CODING: Words stricken are deletions; words underlined are additions.
1. The hospital began contributing to the trust fund on or before January 1, 1988; and

2. The dollar volume of charity care reported to the board for the quarter for which payment is requested was equal to or exceeded 2 percent of the hospital's gross revenues.

(b) Hospitals which meet the criteria of subparagraphs (a)(1) and (2), and which desire to participate in the redistributions designated in this subsection, shall submit the following data to the board for each reporting period in which the hospital wishes to participate:

1. Actual gross revenues for the reporting period.

2. Actual documented charity care written off for the reporting period, based on patients discharged, provided that the last service rendered to a given charity patient occurred not more than 60 days prior to the beginning of the reporting period.

3. One-fourth of its annual budgeted restricted and unrestricted revenues from local governments or tax districts as reported to the Health Care Cost Containment Board for the year or years which comprise the reporting period.

4. For any charity care reported for a patient whose length of stay exceeded 12 days, the aggregate total charges associated with the 13th and subsequent days.

(c) Hospitals shall report and be paid based on the following schedule:

1. For the months of April, May, and June 1988, the hospital shall report by August 1, 1988, to qualify for a quarterly payment due on September 30, 1988.

2. For the months of July, August, and September 1988, the hospital shall report by November 1, 1988, to qualify for a quarterly payment due on December 31, 1988.

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3. For the months of October, November, and December 1988, the hospital shall report by February 1, 1989, to qualify for a quarterly payment due on March 31, 1989.

4. For the months of January, February, and March 1989, the hospital shall report by May 1, 1989, to qualify for a quarterly payment due on June 30, 1989.

(d) Hospitals which report to the board under the provisions of paragraph (c) shall maintain documented data on each charity care patient's income as determined by rule by the board. Such documented data shall be subject to periodic audit by the board.

(e) By the first day of September 1988, December 1988, March 1989, and June 1989, the board shall determine and certify to the department for payment the amount of funds to be redistributed to each hospital, for each eligible quarter, according to the following formula:

1. For each quarter, the board shall calculate the dollar amount by which charity care exceeds 2 percent of the hospital's gross revenues after deducting 50 percent of the restricted and unrestricted revenues provided to a hospital by local governments or tax districts; and shall subtract from such excess the total charges associated with the 13th and subsequent days. The board then shall convert the difference remaining from such subtraction into charity care days. For each such charity care day, the hospital shall earn 80 percent of the hospital's most recent Medicaid per diem rate, as determined by the department. Hospitals ineligible to participate in the Medicaid program shall be reimbursed at 90 percent of their cost per adjusted day as determined from the most recent audited actual data accepted by the board.
2. If the total quarterly amount due to all hospitals eligible under this paragraph exceeds $17.5 million, each hospital's share shall be reduced on a pro rata basis so that the total dollars redistributed from the trust fund do not exceed $70 million a year; provided that no hospital shall earn more than one-third of each quarterly distribution. If the total $17.5 million dollars is not distributed for any quarter, the unspent portion shall be rolled forward and shall be distributed with any moneys due on the fourth and final distribution.

(f) Based on the amount due each hospital as certified by the board, the department shall redistribute surplus trust funds in quarterly payments as provided for in subsection (c).

(g) Each hospital which receives any of the redistribution under this subsection shall, at the end of the hospital's fiscal year in which any redistribution was received, provide audited actual data to the board to substantiate the quarterly reported data on which the redistribution was based. The board shall calculate any overpayment paid to the hospital or underpayment owed to the hospital based on this audited data and correct the error in the next scheduled quarterly redistribution. In the event that the hospital does not qualify for the last quarterly redistribution or there is not any future redistribution available, and the hospital received more surplus trust funds than the hospital was entitled to under this section, the hospital shall, as a condition of participating in the redistribution, agree to reimburse the department for the excess. If the department is unable to collect these excess funds from the hospital for any reason, it is authorized to impose administrative fines of up to $500 per day for each day.
the hospital fails to pay, for the first 30 days, and up to
$5,000 per day for each day the hospital fails to pay
thereafter. Neither the department nor the board shall be
held liable for any funds underpaid to a hospital after the
fourth quarterly payment, once the total $70 million has been
redistributed.

(a) -- During state fiscal year 1987-1988, the department
shall redistribute $69.5 million in trust funds to hospitals
which meet the following criteria:

1. The hospital began contributing to the trust fund
on or before January 1, 1987;

2. The hospital provided at least 2.5 percent of its
total inpatient days to Medicaid eligibles or a combination of
charity care days and Medicaid days which, when added
together, equals at least 5 percent of the total inpatient
days during the hospital's 1986 fiscal year;--A hospital
ineligible to participate in the Medicaid program due to the
nature of the services it provides is exempt from this
requirement;--For the purposes of this subsection, charity
care days shall be calculated based on the actual charity care
rendered as reported to the board for fiscal year 1986.

3. The dollar value of uncompensated care provided by
the hospital during the hospital's 1986 fiscal year exceeded 5
percent of the hospital's gross revenues.

(b) -- By July 1, 1987, the board shall calculate the
first-year redistribution amount for each hospital meeting all
criteria of paragraph (a) based on the following formula:

1. The board shall calculate the dollar amount by
which uncompensated care exceeded 5 percent of the hospital's
gross revenue and then convert the dollar amount of excess
revenue into uncompensated care days.

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2.--For each uncompensated care day provided above the
5-percent-of-gross-revenues-level, the hospital shall earn 80
percent of the hospital's Medicaid per-diem rate as determined
by the department, for up to 12 days per admission.--The 12-
day length-of-stay adjustment factor as determined by the
indigent care study conducted pursuant to section 84-35, laws of Florida, 1981-1982.--The number of uncompensated
care days are to be reduced by this factor.
3.--Fifty-percent-of-the-restricted-and-unrestricted
revenues provided to a hospital by local governments or tax
districts shall be considered as offsets against uncompensated
care.
4.--No hospital shall be entitled to receive more than
30-percent-of-the-total-amount-of-trust-funds-to-be
distributed.
5.--If the total amount earned by all hospitals under
this paragraph exceeds $69.5 million, each hospital's share
shall be reduced on a pro-rata basis so that the total dollars
redistributed from the trust fund do not exceed $69.5 million
for the year.
6.--The board shall certify to the department the
amount owed each hospital by July 31, 1987, and the department
shall disburse the funds in quarterly allotments as follows:
1.--One quarterly payment by July 31, 1987.
2.--One quarterly payment by October 31, 1987.
4.--One quarterly payment by April 30, 1988.
(4) Funds distributed to a hospital pursuant to this
section shall not be considered as net revenues of such
hospital in determining whether an excess has occurred
pursuant to s. 407.51 395-5894. However, if an excess occurs,
the amount of the excess shall be reduced by the difference derived from subtracting such funds shall be included in determining the reduction of the amount of the excess for the amount of revenues received by the hospital pursuant to this section or s. 409.266(7) from the assessment paid by the hospital pursuant to s. 395.101 minus the amount of revenues received by the hospital pursuant to this section or s. 409.266(7).

A hospital may correct, subject to verification by the hospital's independent certified auditors, its 1986 fiscal year data up until 90 days after the effective date of this act. Based upon this corrected data the board shall recalculate the distribution due under this act no later than October 15, 1987, and shall certify to the department a revised formula by October 25, 1987. Amounts previously distributed may be adjusted based upon this final determination.

Section 44. Subsection (3) of section 627.9175, Florida Statutes, is amended to read:

(3) Each health insurer shall annually submit to the department and to the Health Care Cost Containment Board available information related to physician charges. The department shall provide by rule a uniform format for the submission of this information in order to allow for meaningful comparisons of physician charge data. The department in conjunction with the health insurance industry and the Hospital Cost Containment Board shall make an initial report to the 1985 regular session of the Legislature as to the feasibility of subdividing total physician charges by specialty and subdividing the most commonly used procedures by

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Section 45. Sections 45 through 53 may be cited as the "Rural Hospital Act of 1988."

Section 46. Legislative findings and intent.--

(1) The Legislature finds that rural hospitals are the nucleus or "backbone" of rural health care systems. Public health programs and physicians depend on rural hospitals to meet many of their medical needs. Rural hospitals are usually the only source of emergency medical care in rural areas for life-threatening situations and play a crucial role in attracting physicians to rural areas. The Legislature deems the benefits derived from these features to be truly significant, as rural counties with hospitals have lower accidental death rates and lower incidence of low birth-weight than rural counties without hospitals. In addition, rural hospitals enhance their communities beyond the scope of health care, as they are among the largest employers in rural areas and substantially foster economic development and growth. For these reasons, the Legislature finds that rural hospitals are widely viewed as integral to the welfare of rural communities.

However, the rural health care system is experiencing significant instability as the financial viability of many of these hospitals is threatened. The Legislature finds that sharply declining occupancy rates, increasing dependence on Medicaid and Medicare reimbursements, liability concerns, frequent changes in ownership, high levels of bad debt, greater competition on more sophisticated levels with urban...
hospitals, and physician and personnel staffing problems threaten the existence of some rural hospitals.

(2) It is the intent of the Legislature to ease the burdens experienced by rural hospitals in personnel staffing by:

(a) Providing financial incentives under the Medical Education Tuition Reimbursement Program in order to increase the number of primary care physicians and nurses in rural areas; and

(b) Requiring a study of problems unique to rural hospitals generated by existing licensure and certification requirements for allied health care practitioners in the state.

(3) In addition, it is the intent of the Legislature to ease the severe financial constraints being experienced by some rural hospitals by extending Medicaid reimbursements to rural hospital swing-beds and establishing the full utilization, when feasible, of rural hospital services by departmental primary care programs and programs serving the elderly citizens of the state.

(4) Furthermore, the Legislature encourages the Department of Health and Rehabilitative Services to actively foster the provision of health care services in rural areas and serve as a catalyst for improved health services to citizens in rural areas of the state. Among other considerations, the department is encouraged to:

(a) Promote location and relocation of health care practitioners in rural areas.

(b) Promote the financial viability of rural hospitals and their continued existence in rural counties.
(c) Integrate policies related to physician manpower, hospitals, primary care, and state regulatory functions.

(d) Collect relevant data on rural health care issues for use in departmental policy development.

(e) Propose solutions for problems affecting health care delivery in rural areas.

Section 47. Definitions.--As used in sections 45 through 53:

(1) "Rural hospital" means an acute care hospital licensed under chapter 395, Florida Statutes, with 85 beds or less, which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county; or

(c) A provider supported by a hospital tax district whose boundaries encompass a population of 100 persons or less per square mile.

(2) "Rural area health education center" means an area health education center (AHEC), as authorized by Pub. L. No. 94-484, which provides services in a county with a population density of no greater than 100 persons per square mile.

(3) "Swing-bed" means a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to the Code of Federal Regulations, Parts 405, 435, 440, 442, and 447.

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Section 48. Paragraph (c) of subsection (1) of section 154.011, Florida Statutes, is amended to read:

154.011 Primary care services.--

(1) It is the intent of the Legislature that all 67 counties offer primary care services through contracts, as required by s. 154.011(3), for Medicaid recipients and other qualified low-income persons. Therefore, beginning July 1, 1987, the Department of Health and Rehabilitative Services is directed, to the extent that funds are appropriated, to develop a plan to implement a program in cooperation with each county. The department shall coordinate with the county's primary care panel, as created by s. 154.013, or with the county's governing body if no primary care panel is appointed. Such primary care programs shall be phased-in and made operational as additional resources are appropriated pursuant to s. 409.266(6)(c), and shall be subject to the following:

(c) Each primary care program shall conform to the requirements and specifications of the department, and shall at a minimum:

1. Adopt a minimum eligibility standard of at least 100 percent of the federal nonfarm poverty level.

2. Provide a comprehensive mix of preventive and illness care services.

3. Be family oriented and be easily accessible regardless of income, physical status, or geographical location.

4. Ensure 24-hour telephone access and offer evening and weekend clinic services.

5. Offer continuity of care over time.

6. Make maximum use of existing providers to ensure efficient use of resources.

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7. Have a sliding fee schedule based on income for eligible persons above 100 percent of the federal nonfarm poverty level.

8. Include quality assurance provisions and procedures for evaluation.


10. Fully utilize and coordinate with rural hospitals for outpatient services, including contracting for services when advisable in terms of cost effectiveness and feasibility.

Section 49. There is hereby annually appropriated from the General Revenue Fund to the Department of Health and Rehabilitative Services the sum of $100,000 for the purpose of increasing the number of primary care physicians and nurses in rural areas pursuant to s. 240.4067, Florida Statutes, pertaining to the Medical Education Tuition Reimbursement Program. Reimbursement through the program shall be limited to:

(1) Primary care physicians and nurses employed by or affiliated with rural hospitals, as defined in this act; and

(2) Primary care physicians and nurses employed by or affiliated with rural area health education centers, as defined in this act. Such physicians and nurses shall practice:

(a) In a county with a population density of no greater than 100 persons per square mile; or

(b) Within the boundaries of a hospital tax district which encompasses a population of no greater than 100 persons per square mile.

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These funds may be used for federal loan repayment programs which require state matching funds, such as that provided for in section 338 of Pub L. No. 100-177.

Section 50. Subsection (18) is added to section 409.266, Florida Statutes, to read:

409.266 Medical assistance.--

(18) Medicaid funding shall be extended to intermediate and skilled nursing patients in rural hospital swing-beds, subject to federal financial participation. Such reimbursement shall not be provided for skilled nursing or intermediate care beyond the 30th day of swing-bed service provision, unless the Office of the Deputy Assistant Secretary for Medicaid within the Department of Health and Rehabilitative Services gives prior authorization for a longer length of stay.

Section 51. Paragraph (n) is added to subsection (2) of section 410.016, Florida Statutes, to read:

410.016 Elderly population; departmental responsibilities.--

(n) Duties and responsibilities of the Department of Health and Rehabilitative Services.--The department shall:

Fully utilize and coordinate with rural hospitals when carrying out activities under this chapter with regard to the aged, when advisable in terms of cost-effectiveness and feasibility.

Section 52. Manpower shortage study.--The Department of Health and Rehabilitative Services shall conduct a study of existing state licensure or certification requirements for allied health personnel employed in licensed rural hospitals, and report its findings and recommendations to the Legislature.

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on or before March 1, 1989. The study shall include, but not be limited to, the following:

1. A review of current licensure or certification requirements for:
   a. Clinical laboratory personnel in accordance with chapter 483, Florida Statutes.
   b. Nursing practitioners in accordance with chapter 464, Florida Statutes.
   c. Physical therapy practitioners in accordance with chapter 486, Florida Statutes.
   d. Radiologic technology practitioners in accordance with chapter 468, Florida Statutes.
   e. Respiratory care practitioners in accordance with chapter 468, Florida Statutes.
   f. Any other category of allied health personnel licensed or certified by the state which may be employed in licensed rural hospitals.

2. An analysis of problems unique to rural hospitals in this state generated by practice requirements for the personnel enumerated in subsection (1).

3. An analysis of the availability of personnel, recruiting problems, supervision problems, and budget or other constraints for rural hospitals in this state.

Section 53. The Department of Health and Rehabilitative Services is hereby authorized to adopt all necessary rules pertaining to the standards of care applicable to rural hospital swing-beds and the criteria whereby swing-bed stays of longer than 30 days shall be authorized. The latter length-of-stay criteria shall include, but not be limited to, the medical needs of the patient, the county of residence of the patient and patient's family, patient

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preference, proximity to relatives and friends, and distance to available nursing home beds, if any.

Section 54. Notwithstanding the provisions of section 50 of chapter 87-92, Laws of Florida, s. 409.266(7)(k), Florida Statutes, relating to the Medicaid medically needy program shall not stand repealed on October 1, 1988, as scheduled by such act, but shall continue in full force and effect as amended herein until October 1, 1989, at which time s. 409.266(7)(k), Florida Statutes, shall stand repealed unless reenacted by the Legislature.

Section 55. Notwithstanding the provisions of section 24 of chapter 82-182, part II of chapter 395, Florida Statutes, relating to the Hospital Cost Containment Board shall not stand repealed on October 1, 1988, as scheduled by such act, but shall continue in full force and effect, as amended and transferred to chapter 407, Florida Statutes; and shall stand repealed on October 1, 1992, subject to review by the Legislature pursuant to s. 11.61, Florida Statutes.

Section 56. Section 400.342, Florida Statutes, as amended by chapter 86-104, Laws of Florida, is hereby repealed.

Section 57. In editing manuscript for the next edition of the official Florida Statutes, the Statutory Revision Division of the Joint Legislative Management Committee shall change "Hospital Cost Containment Board" to "Health Care Cost Containment Board" wherever that term appears in the Florida Statutes, and shall exercise its authority under s. 11.242(5)(g), Florida Statutes, to renumber the references to sections and subsections which have been renumbered by this act, so that they will agree with such renumbering.

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Section 58. Except as otherwise provided herein, this act shall take effect October 1, 1988.

HOUSEx SUMMARY

Creates the "Affordable Health Care Assurance Act of 1988." Revises various existing provisions to provide for a system of primary care programs; independent health care special districts, with authority to levy ad valorem taxes; additional projects subject to certificate-of-need review; further redistribution of surplus Public Medical Assistance Trust Fund moneys; and expanded Medicaid eligibility and increased physician reimbursement.

Creates chapter 407, F.S., and revises, and transfers thereto, provisions relating to health care cost containment. Renames and revises various responsibilities of the cost containment board. Revises procedures and requirements with respect to review of hospital budgets. Provides exemptions. Provides a penalty. Eliminates the Consumer Information Network and creates a consumer information and advisory council. Provides for additional analysis, research, and studies.

Creates the "Rural Hospital Act of 1988." Provides for expanded utilization of rural hospitals for certain primary care programs and services to the aged. Extends Medicaid funding to certain patients in rural areas. Provides for a study of certain personnel shortages.

Postpones Sunset repeal of the Medicaid medically needy program until October 1, 1989. Saves provisions relating to health care cost containment from Sunset repeal on October 1, 1988, and reschedules review and repeal on October 1, 1992.

See bill for details.

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A bill to be entitled
An act relating to health care; creating the
"Affordable Health Care Assurance Act of 1988";
amending s. 154.01, F.S.; authorizing counties
to relinquish public health facilities and
equipment; amending s. 154.011, F.S.; modifying
provisions relating to a system of primary care
programs; amending s. 154.301, F.S.; renaming
"The Florida Health Care Responsibility Act" as
"The Florida Health Care Responsibility Act of
1988"; amending s. 154.302, F.S.; revising
legislative intent; amending s. 154.304, F.S.;
revising definitions; amending s. 154.306, F.S.; specifying financial responsibilities of
hospitals and counties for certified residents
who are qualified indigent patients; specifying
county obligation per calendar year; providing
duties of the Health Care Cost Containment
Board and the Department of Health and
Rehabilitative Services; amending s. 154.308,
F.S.; requiring uniform statewide eligibility
criteria; requiring that rules be adopted;
increasing the time frame for determination of
financial eligibility; providing for qualified
indigents; authorizing counties to establish
less restrictive financial eligibility
thresholds; creating s. 154.309, F.S.;
providing for certification of county of
residence; providing minimum criteria;
requiring certain notification to treating
hospitals; amending s. 154.31, F.S.; specifying

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obligation of participating hospitals and
regional referral hospitals to admit patients;
providing penalties; creating s. 154.3105,
F.S.; providing for rules; requiring a work
group; providing membership criteria; requiring
promulgation of certain rules; amending s.
154.312, F.S.; providing procedure for
settlement of disputes; amending s. 154.314,
F.S.; revising time frames for payment to
hospitals; requiring the Comptroller to provide
a quarterly accounting; amending s. 154.316,
F.S.; providing conditions for reimbursement
for treatment of patients; amending s. 154.331,
F.S.; providing for establishment of
independent health care special districts, with
authority to levy ad valorem taxes; providing
for appointment and powers and functions of
governing boards; providing procedures and
restrictions with respect to millage rates;
providing for dissolution of districts;
providing for compliance with statutory
requirements; amending s. 200.001, F.S.;
providing certain authority to independent
health care special districts in described home
rule charter counties; amending s. 381.702,
F.S.; defining "multifacility project";
amending s. 381.703, F.S.; providing sources of
funding for the local health councils and
Statewide Health Council; amending ss. 381.705,
381.706, 381.709, and 381.710, F.S.; providing
additional projects subject to certificate-of-
need review; providing review criteria;
modifying review process; extending validity
period for certain certificates of need;
creating chapter 407, F.S., relating to health
care cost containment; renumbering ss. 395.5125
and 395.5135, F.S., and amending and
renumbering ss. 395.501, 395.502, 395.5025,
395.503, 395.504, 395.5042, 395.505, 395.5051,
395.507, 395.508, 395.5085, 395.509, 395.5092,
395.5094, 395.511, 395.512, 395.513, 395.514,
395.515, and 395.52, F.S., formerly
constituting part II of chapter 395, F.S.;
changing short title; providing and changing
definitions; providing legislative intent with
respect to the Health Care Cost Containment
Board, formerly the Hospital CostContainment
Board; revising administration, membership, and
terms; modifying powers and duties; providing
for effect of existing board rules; providing
for submission of the board's final legislative
budget request; requiring certain hospitals to
submit budget information to the board;
providing for additional research and analysis
relating to health care costs; modifying
contents of a report to the Legislature;
revising provisions relating to consumer
information; eliminating the Consumer
Information Network; providing additional
responsibilities of the Office of Technical
Assistance; providing for quality assurance
monitoring; revising provisions relating to

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review of hospital budgets; requiring hospitals
not exceeding maximum allowable rate of
increase to file a budget letter, rather than a
detailed budget; allowing banking of percentage
points for future use; providing review
criteria and procedures; providing for budget
amendments; providing for objections and
hearing; providing exemptions for certain
hospitals; providing a penalty; clarifying duty
of the Public Counsel with respect to budget
proceedings; providing an exemption for
information relating to charges by certain
physicians; requiring an annual report by
health insurers relating to physician charges;
requiring publication of specified information;
conforming terminology; deleting obsolete
language; creating s. 407.025, F.S.; providing
immunity from liability for certain report or
release of patient data; creating s. 407.10,
F.S.; creating the consumer information and
advisory council; amending and renumbering ss.
400.341, 400.343, 400.344, 400.345, and
400.346, F.S.; directing the board to make
certain nursing home financial information
available; correcting cross-references;
conforming language; directing the board to
contract with the State University System for
certain studies; directing the board to conduct
a study of the shortage of registered nurses in
Florida; providing contents; providing for a
technical assistance panel; requiring reports;

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providing for an appropriation; directing the
board to undertake a study of the impact on and
reimbursement for hospitals in providing
services to migrant and rural farmworkers;
providing for a report; amending s. 409.266,
F.S.; authorizing certain use of moneys in the
Public Medical Assistance Trust Fund; expanding
Medicaid eligibility to certain persons;
requiring a report; providing for increases in
physician reimbursement; extending the length
of stay for certain hospital services; amending
s. 409.2661, F.S.; providing for additional
primary care health training demonstration
projects; increasing funding; amending s.
409.2662, F.S.; specifying additional uses of
moneys in the Public Medical Assistance Trust
Fund; amending s. 409.2663, F.S.; revising
provisions for redistribution of surplus public
medical assistance funds; providing for an
accounting of funds; providing a methodology to
qualify for funds; providing a timetable;
amending s. 627.9175, F.S.; deleting
requirement for certain reports by health
insurers; creating the "Rural Hospital Act of
1988"; providing legislative intent and
definitions; amending s. 154.011, F.S.;
requiring certain primary care programs to
utilize and coordinate with rural hospitals for
outpatient services; providing for an
appropriation to increase primary care
physicians and nurses in rural areas; amending

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s. 409.266, F.S.; extending Medicaid funding to
certain patients in rural areas; amending s.
410.016, F.S.; requiring the Department of
Health and Rehabilitative Services to utilize
rural hospitals in providing services to the
aged; providing for a study of personnel
shortages in rural hospitals; requiring a
report; providing certain rulemaking authority;
postponing Sunset repeal of s. 409.266(7)(k),
F.S., relating to the Medicaid medically needy
program; saving part II of chapter 395, F.S.,
from Sunset repeal; providing for future review
and repeal; repealing s. 212.055(2), F.S.,
relating to an indigent care surtax in
Millsborough County; repealing s. 400.342,
F.S., which provides definitions relating to
nursing homes; providing appropriations;
providing a directive to statute editors;
providing effective dates.

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

Section 1. This act may be cited as the "Affordable
Health Care Assurance Act of 1986."

Section 2. Subsection (4) of section 154.01, Florida
Statutes, is amended to read:

154.01 Public health unit delivery system.--
(4) The use and maintenance of public health unit
facilities and equipment shall be subject to the provisions of
the contract between the Department of Health and
Rehabilitative Services and each county. However, the
counties may shall retain ownership of such facilities and
equipment and the right to use such facilities and equipment
as the need arises, to the extent that such use would not
impose an unwarranted interference with the operation of the
public health unit pursuant to the provisions of the contract.
In all cases, such facilities shall be used primarily for
purposes related to public health. Ownership of public health
unit facilities and equipment may be relinquished by a county
to the Department of Health and Rehabilitative Services by
mutual consent of the parties in the contract.
Section 3. Subsections (1), (3), and (4) of section
154.011, Florida Statutes, are amended to read:
154.011 State/county primary care system services.--
(1) It is the intent of the Legislature that all 67
counties offer primary care services through a system of
primary care programs organized through contracts, as required
by s. 154.01(3), for Medicaid recipients and other qualified
low-income persons. Therefore, beginning July 1, 1987, the
Department of Health and Rehabilitative Services is directed,
to the extent that funds are appropriated, to develop a plan
to implement a primary care program in cooperation with each
county. The department shall coordinate with the county's
primary care panel, as created by s. 154.013, or with the
county's governing body if no primary care panel is appointed.
Such primary care system programs shall be phased-in and made
operational as additional resources are appropriated pursuant
to s. 409.266(7)(6)(C), and shall be subject to the following:
(a) The department shall enter into contracts with the
county governing body for the purpose of expanding primary
care coverage. The county governing body shall have the
option of organizing the primary care programs through county

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1 public health units or through county public hospitals owned
2 and operated directly by the county. The department shall, as
3 its first priority, maximize the number of counties
4 participating in the primary care system programs under this
5 section, but shall establish priorities for funding based on
6 need and the willingness of counties to participate. The
7 department shall select counties for program funding programs
8 through a formal request-for-proposal process that requires
9 compliance with program standards for cost-effective quality
10 care and seeks to maximize access throughout the county.
11 (b) Each county's primary care program may utilize
12 county—shall-have the following options of providing services:
13 offering services directly through the county public health
14 units by contracting with individual or group practitioners
15 for all or part of the services, or by developing service
16 delivery models which are organized through the county public
17 health units, but which utilize other service or delivery
18 systems available, such as federal primary care programs or
19 prepaid health plans. In addition, counties shall have the
20 option of pooling resources and joining with neighboring
21 counties in order to fulfill the intent of this section.
22 (c) Each primary care program shall conform to the
23 requirements and specifications of the department, and shall
24 at a minimum:
25 1. Adopt a minimum eligibility standard of at least
26 100 percent of the federal nonfarm poverty level.
27 2. Provide a comprehensive mix of preventive,
28 personal, and noninstitutional acute illness care services.
29 3. Be family oriented and be easily accessible
30 regardless of income, physical status, or geographical
31 location.

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4. Ensure 24-hour telephone access and offer evening and weekend clinic services.

5. Offer continuity of care over time.

6. Make maximum use of existing providers and closely coordinate its services and funding with existing federal primary care programs, especially in rural counties, to ensure efficient use of resources.

7. Have a sliding fee schedule based on income for eligible persons above 100 percent of the federal nonfarm poverty level.

8. Include quality assurance provisions and procedures for evaluation.


(3) It is the intent of the Legislature that each county primary care program include a broad range of preventive, personal, and noninstitutional acute care services which are actively coordinated through comprehensive medical management and, further, that the health and preventive services currently offered through the county public health units are fully integrated, to the extent possible, with the services provided by the primary care programs.

(4) Each county primary care program shall coordinate obstetrical services with the Improved Pregnancy Outcome Program. Financially eligible women at risk for adverse pregnancy outcomes due to any potential medical complication shall not be denied access to prenatal care. Potential medical complications may arise out of, but not be limited to, alcohol abuse, drug abuse, or delay in obtaining initial prenatal care. The inability of the primary care program to provide funding for hospitalization or other specialty acute service.
services shall not preclude an eligible patient from obtaining prenatal services.

Section 4. Section 154.301, Florida Statutes, is amended to read:

154.301 Short title.--Sections 154.301-154.316 This act may be cited as "The Florida Health Care Responsibility Act of 1988."

Section 5. Section 154.302, Florida Statutes, is amended to read:

154.302 Legislative intent.--The Legislature finds that certain hospitals provide a disproportionate share of charity care for persons who are indigent and not able to pay their medical bills and who are not eligible for government-funded programs. The burden of absorbing the cost of this uncompensated charity care is borne by the hospital, the private pay patients, and, many times, by the taxpayers in the county when the hospital is subsidized by tax revenues. The Legislature further finds that it is inevitable for hospitals and taxpayers of one county to be expected to subsidize the care of out-of-county indigent persons. Finally, the Legislature declares that the state and the counties must share the responsibility of assuring that adequate and affordable health care is available to all Floridians. Therefore, it is the intent of the Legislature to place the ultimate financial obligation for the out-of-county hospital care of qualified indigent patients resides, for all those costs not fully reimbursed by other governmental programs or third-party-payers.

Section 6. Section 154.304, Florida Statutes, is amended to read:

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154.304 Definitions.--For the purpose of this act:

(1) "Board" means the Health Care Cost Containment Board as established in chapter 407.

(2) "Certification determination procedures" means the process used by the county of residence or the department to determine a person's county of residence.

(3) "Certified resident indigent-patient" means a person patient who has been certified as a resident of the county indigent by a person designated by the county governing body to provide certification determination procedures for the county in which the patient resides, by the department if such county does not make a determination of residency within 60 days of receiving a certified letter from the treating hospital or by the department if the hospital appeals the decision of the county making such determination.

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

(5) "Department" means the Department of Health and Rehabilitative Services.

(6) "Eligibility determination procedures" means the process used by a county or the department to evaluate a person's financial eligibility, eligibility for state-funded or federally funded programs, and the availability of

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Insurance, in order to document a person as a qualified indigent for the purpose of this act,

(7)(3) "Hospital" for the purposes of this act, means an establishment as defined in s. 395.002 and licensed by the department which qualifies as either a participating hospital or as a regional referral hospital pursuant to this section; except that, hospitals operated by the department shall not be considered participating hospitals for purposes of this act.

(8) "Participating hospital" means a hospital which is eligible to receive reimbursement under the provisions of this act because it has been certified by the board as having met its charity care obligation and has either:

(a) A formal signed agreement with a county or counties to treat such county's indigent patients; or

(b) Demonstrated to the board that at least 5 percent of its uncompensated charity care, as reported to the board, is generated by out-of-county residents.

(9) "Qualified indigent person" or "qualified indigent patient" means a person who has been determined pursuant to s. 154.308 to have an average family income, for the 12 months preceding the determination, which is below 100 percent of the federal nonfarm poverty level, who is not eligible to participate in any other government program which provides hospital care, and who has no private insurance or has inadequate private insurance.

(10)(4) "Regional referral hospital" means any hospital which is eligible to receive reimbursement under the provision of this act because it has met its charity care obligation and it meets the definition of teaching hospital as defined in s. 407.002 that provides services to patients who

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Section 7. Section 154.306, Florida Statutes, is amended to read:

154.306 Financial responsibility for certified residents who are qualified out-of-county indigent patients treated at an out-of-county participating hospital or a regional referral hospital.--Ultimate financial responsibility for treatment received at a participating hospital or a regional referral hospital by a qualified certified indigent patient who is a certified resident of a county in the State of Florida, but is not a resident of the county in which the participating hospital or regional referral hospital is located, shall be the obligation of the county of which the qualified certified indigent patient is a resident. Effective January 1, 1989, each county is directed to reimburse participating hospitals or regional referral hospitals as provided for in this act, and shall provide or arrange for indigent eligibility determination procedures and resident certification determination procedures as provided for in rules developed to implement this act. The department, or any county determining eligibility of a qualified indigent, shall provide to the county of residence, upon request, a copy of any documents, forms, or other information, as determined by rule, which may be used in making an eligibility determination.

(1) A county's financial obligation responsibility for each certified out-of-county resident who qualifies as an certified indigent patient under this act, and who has received patients receiving treatment at an out-of-county a-regional-referral hospital, shall be limited-to-payment-for-12-days-of-services.

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per-admission, not to exceed 45 days per calendar year annually,
at not less than 80 percent of the per diem reimbursement rate
currently in effect for the out-of-county regional-referral
hospital under the medical assistance program for the needy
under Title XIX of the Social Security Act, as amended.
However, nothing in this section shall preclude a hospital
which has a formal signed agreement with a county to treat
such county's indigents from negotiating a higher or lower per
diem rate with the county. In addition, no county shall be
required by this act to pay more than the equivalent of $4 per
capita in the county's fiscal year. The department shall
calculate and certify to each county by March 1 of each year,
the maximum amount the county may be required to pay under
this act by multiplying the most recent official state
census estimate for the total population of the county by
$4 per capita. Each county shall certify to the department
within 60 days of the end of the county's fiscal year, or upon
reaching the $4 per capita threshold, should that occur before
the end of the fiscal year, the amount of reimbursement it
paid to all out-of-county hospitals under this act.

(2) However, no county shall be required to pay for
any elective or nonemergency admissions or services at an out-
of-county a-regional-referral hospital for a qualified
indigent who is a certified resident of the county when the
county provides funding for such services and the services are
available at a local hospital in the county where the indigent
resides, or the out-of-county hospital has not obtained prior
written authorization and approval for such hospital admission
or services, provided that the resident county has established
a procedure to authorize and approve such admissions, except
that

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(3) The county where the indigent resides shall, in all instances, be liable for the cost of treatment provided to a qualified said-certified indigent patient at an out-of-county a-regional-referral hospital for any emergency medical condition which will deteriorate from failure to provide such treatment and when such condition is determined and documented by the attending physician to be of an emergency nature; provided that the patient has been certified to be a resident of such county pursuant to s. 154.309.

(4) No county shall be liable for payment for treatment of a qualified indigent who is a certified resident and has received services at an out-of-county participating hospital or regional referral hospital, until such time as that hospital provides documentation to the county that it has met its charity care obligation based on the most recent audited actual experience as reported and certified by the board.

Section 8. Section 154.308, Florida Statutes, is amended to read:

154.308 Determination Certification of a qualified indigent patient's eligibility indigency for the purpose of this act.--

(1) Not later than October 1, 1977, The department, pursuant to s. 154.3105 in consultation with the Florida Association of County-Welfare-Executives, shall adopt rules which provide a statewide eligibility determination procedures, forms, and criteria which shall be used by all counties standard for determining whether a person financially qualifies certifying-residents-of-each-county as indigent for the purposes of this act.
(a) The criteria used to determine eligibility shall be uniform statewide and shall include, at a minimum, which assets, if any, may be included in the determination, which verification of income shall be required, which categories of persons shall be eligible, and any other criteria which may be determined as necessary.

(b) The methodology by which to determine financial eligibility shall also be uniform statewide such that any county or the state could determine whether a person would be a qualified indigent under this act.

(2) Determination of financial eligibility as a qualified indigent. These rules shall further provide that certification as indigent for the purposes of this act may occur either prior to a person’s admission to a participating hospital or a regional referral hospital or subsequent to such admission, but in any event if a patient already determined eligible meets or does not meet eligibility standards to financially qualify him for certification as indigent for the purpose of this act shall be made within 30 days following notification by the hospital requesting a determination of indigency by certified letter to any county or the department. If for any reason, the county or department is unable to determine a patient’s eligibility within the allotted time frame, the hospital shall be notified in writing of the reason or reasons to the county-of-residence-of-the-patient’s-admission-to-a-regional referral-hospital—the-patient-shall-be-considered-to-have been-a-certified-indigent-patient-upon-admission.

(3) Determination of whether a hospital patient not already determined eligible meets or does not meet eligibility standards to financially qualify him for certification as indigent for the purpose of this act shall be made within 30 days following notification by the hospital requesting a determination of indigency by certified letter to any county or the department. If for any reason, the county or department is unable to determine a patient’s eligibility within the allotted time frame, the hospital shall be notified in writing of the reason or reasons to the county-of-residence-of-the-patient’s-admission-to-a-regional referral-hospital—the-patient-shall-be-considered-to-have been-a-certified-indigent-patient-upon-admission.

(4) A patient determined eligible as a qualified certified-as-indigent for the purpose of this act subsequent

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to his or her admission to a participating hospital or a regional referral hospital shall be considered to have been qualified certified upon admission. Such determination certification shall be made by a person designated by the governing board of the county to make such a determination or by the department commissioners-or,-in-the-absence-of-such-a designated-person,-by-the-director-of-the-full-time-health unit.

[5] Notwithstanding any other provision within this act, Furthermore, any county may establish thresholds standards of financial eligibility to qualify indigents under this act which are less restrictive than 100 percent of the federal poverty line. However, the standards adopted by the department under this section, and no county may establish eligibility thresholds standards which are more restrictive than 100 percent of the federal poverty line the standards adopted by the department under this section.

Section 9. Section 154.309, Florida Statutes, is created to read:

154.309 Certification of county of residence for the purpose of this act.--

(1) The department, pursuant to s. 154.3105, shall adopt rules for certification determination procedures which provide criteria to be used for determining a qualified indigent's county of residence. Such criteria shall include, at a minimum, how and to what extent residency shall be verified and how a hospital shall be notified of a patient's certification or the inability to certify a patient.

(2) In all instances, the county known or thought to be the county of residence shall be given first opportunity to certify a resident. If the county known or thought to be the
county of residence fails to, or is unable to, make such
determination within 60 days following written notification by
a hospital, the department shall determine residency utilizing
the same criteria required by rule as the county, and the
department's determination of residency shall be binding on
the county of residence. The county determined as the
residence of any qualified indigent under this act shall be
liable to reimburse the treating hospital pursuant to s.
154.304. If for any reason a county or the department is
unable to determine an indigent's residency, the hospital
shall be notified in writing of such reason or reasons.

Section 10. Section 154.31, Florida Statutes, is
amended to read:

154.31 Obligation of the participating hospital or a
regional referral hospital. -- As a condition of accepting the
procedures of this act, each participating hospital or
regional referral hospital in Florida shall be obligated to
admit for emergency treatment all Florida residents, without
regard to county of residence, who meet the eligibility
standards established pursuant to s. 154.305 and who meet the
medical standards for admission to such institutions. If the
department determines that a participating hospital or a
regional referral hospital has failed to meet the requirements
of this section, the department may impose an administrative
fine, not to exceed $5,000 per incident, and suspend the
hospital from eligibility for reimbursement under the
provisions of this act.

Section 11. Section 154.3105, Florida Statutes, is
created to read:

154.3105 Rules. -- Rules governing the Health Care
Responsibility Act of 1988 shall be developed by the

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department based on recommendations of a work group consisting
of equal representation by the department, the hospital
industry, and the counties. County representatives to this
work group shall be appointed by the Florida Association of
Counties. Hospital representatives to this work group shall
be appointed by the associations representing those hospitals
which best represent the positions of the hospitals most
likely to be eligible for reimbursement. Rules governing the
various aspects of this act shall be promulgated by the
department by December 1, 1988. Such rules shall address, at
a minimum:

(1) Eligibility determination procedures and criteria.

(2) Certification determination procedures and methods
of notification to hospitals.

Section 12. Section 154.312, Florida Statutes, is
amended to read:

154.312 Procedure for settlement of disputes.—All
disputes among counties, the board, the department, a
participating hospital, or between a county and a regional
referral hospital shall be resolved by order as provided in
chapter 120. Hearings held under this provision shall be
conducted in the same manner as provided in s. 120.57, except
that the hearing officer's order shall be final agency action.
Cases filed under chapter 120 may combine all disputes between
parties. Notwithstanding any other provisions of this part,
when a county alleges that a residency determination or
eligibility determination made by the department is incorrect,
the burden of proof shall be on the county to demonstrate that
such determination is, in light of the total record, not
supported by the evidence.

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Section 13. Section 154.314, Florida Statutes, is amended to read:

154.314 Certification of the State of Florida.--

(1) In the event payment for the costs of services rendered by a participating hospital or a regional referral hospital is not received from the responsible county within 20 days of receipt of a statement for services rendered to a qualified indigent who is a certified resident of the county, or if the payment is disputed and said payment is not received from the responsible county determined to be responsible within 60 days of the date of exhaustion of all administrative and legal remedies, as provided in chapter 120, the hospital shall certify to the Comptroller the amount owed by the county, due to

(2) The Comptroller—who shall have not longer than 45 days from the date of receiving the hospital's certified notice to forward the amount delinquent to the appropriate regional-referral hospital from any funds due to the county under any revenue-sharing or tax-sharing fund established by the state, except as otherwise provided by the State Constitution. The Comptroller shall provide the Governor and the appropriations and finance and tax committees in the House of Representatives and the Senate with a quarterly accounting of the amounts certified by hospitals as owed by counties and the amount paid to hospitals out of any revenue or tax-sharing funds due to the county.

Section 14. Section 154.316, Florida Statutes, is amended to read:

154.316 Hospital's responsibility to notify of admission of indigent patients.--Except-in-the-case-of-an emergency, no patient shall be treated by or admitted to a

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1. Regional referral hospital—As an indigent—unless and until the board of county commissioners of the county providing certification notifies the hospital that the patient is certified as an indigent and that he is approved by the board for treatment or admission:

   (1) Any hospital admitting or treating any out-of-county patient who may qualify as indigent under this act shall, within 10 days after admitting or treating such patient, notify the county known or thought to be, the county of residency and the department of such admission, or such hospital forfeits its right to reimbursement.

   (2) It shall be the responsibility of any participating hospital or regional referral hospital to initiate any eligibility or certification determination procedures with any appropriate state or county agency which can determine financial eligibility or certify an indigent as a resident under this act.

Section 15. Section 154.331, Florida Statutes, is amended to read:

154.331 County indigent health care special districts.—Each county may establish a dependent special district pursuant to the provisions of chapter 125 or, by ordinance, create an independent special district as defined in s. 200.001(8)(e) to provide funding for indigent and other health care services throughout the county in accordance with this section. The county governing body shall obtain approval by a majority vote of the electors to establish the district with authority to annually levy ad valorem taxes which shall not exceed the maximum millage rate authorized by this section. Once approved by the electorate, the county shall not be required to hold elections in future years to

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In addition, the function of the independent health care board shall:

1. Provide and maintain the county's indigent health care board,

2. Be appointed by the governor of the county and not exceed 5 members, no more than 1 member shall be an employee of the independent health care board.

Governing body shall appoint a district independent health care board.

Each district independent health care board shall have any or all of the following powers or functions:

1. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

2. To provide for the health care of indigents and to govern the health care of indigents within the county.

3. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

Each district independent health care board shall have any or all of the following powers or functions:

1. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

2. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

3. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

4. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

5. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

6. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

7. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

8. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

9. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

10. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

11. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

12. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

13. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

14. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

15. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

16. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

17. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

18. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

19. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

20. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

21. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

22. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

23. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

24. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

25. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

26. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

27. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

28. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

29. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

30. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

31. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

32. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

33. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

34. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

35. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

36. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

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44. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

45. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

46. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

47. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

48. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.

49. To provide and maintain any indigent health care clinics as deemed necessary by the governing body.

50. To provide for the health care of indigents and to provide such other health-related services as needed for the health care of indigents.
private or publicly owned medical facility, as the board
determines are needed for the general welfare of the county.

3. To allocate and provide funds for other agencies or
facilities in the county which provide health benefits or
health services that improve the general welfare are operated
for the benefit of indigents and other county residents.

4. To collect information and statistical data that
will be helpful to the board and the county in deciding the
health care needs of indigents in the county.

5. To consult and coordinate with other agencies
dedicated to the health care of indigents to the end that the
overlapping of services will be prevented.

6. To govern, operate, administer, and fund, or any
combination thereof, any county-owned or county-operated
medical facility which is a major provider of charitable
health care services for low-income persons.

7. To assume funding for the county's share of state
or federal indigent health care programs which require
financial participation by the county.

8. To lease or buy such real property and personal
property and to construct such buildings as are needed to
execute the foregoing powers or functions and duties; however,
such purchases may not be made or construction done unless
paid except for with cash with funds on hand or secured by
funds deposited in financial institutions. Nothing in this
paragraph shall be construed to authorize an independent
health care special district to issue bonds of any nature; nor
shall it have the power to require the imposition of any bond
by the governing body of the county.
To employ and pay and provide benefits for any part-time or full-time personnel needed to execute the foregoing powers and functions.

(b) Each district health care board shall:

1. Organize immediately after the members are appointed to elect one of its members as chairman and one of its members as vice chairman, and elect other officers as deemed necessary by the board.

2. Make and adopt bylaws and rules and regulations for the board's guidance, operation, governance, and maintenance, provided such rules and regulations are not inconsistent with federal or state laws or ordinances of the county.

(c) Board members shall serve without compensation but shall be entitled to necessary expenses incurred in the discharge of their duties.

(d) All financial records and accounts relating to the independent health care special district shall be available for review by the county governing body and for audit. Books of account must be kept by the board or its clerical assistants and the fiscal affairs of the board must be exclusively audited by state auditors assigned from time to time to audit the affairs of the county officials.

(3) The fiscal year of the district must be the same as that of the county.

(b) On or before May 1 of each year, the district
indigent health care board shall prepare a tentative and adopt an annual written budget of the district's its expected income and expenditures, including a contingency fund, and shall compute a proposed millage rate within the voter-approved cap necessary to fund the tentative budget. Prior to adopting a final budget, the board shall comply with the provisions of...
200.065, relating to the method of fixing millage, and shall 
fix the final millage rate by ordinance or resolution of the 
board. The adopted written budget and final millage rate must 
be certified and delivered to the county governing body no 
later than the time of adoption of the county's annual budget 
board-of-county-commissioners on or before July 1 of each 
year. Included in each certified budget must be an estimate 
of the millage rate adopted by ordinance or resolution of the 
independent health care special district board as necessary to 
be applied to raise the funds budgeted for district operations 
and expenditures. In no circumstances, however, shall any 
independent health care special district levy millage tax 
which-millage-rate-may-not-exceed-a-maximum-of-5-mills-for 
each-dollar-of-assessed-valuation-of-all-properties-within-the 
county which are subject to ad valorem county taxes or the 
amount approved by the electorate when the district was 
created, whichever is less. The budget of the district 
independent-health-care-board so certified and delivered to the 
board-of-county-governing-body commissioners may not be 
changed or modified by the board-of-county-governing-body 
commissioners or by any other authority.

(o)--In order to provide funds for the indigent health 
care-board, the independent special district by vote of the 
electorate shall levy ad valorem taxes annually on all 
taxable-property in the county in an amount not to exceed 5 
mills--The tax shall be assessed, levied, and collected in 
the same manner and at the same times as is provided by law 
for the levy, collection, and enforcement of collection of 
county-taxes.

(g)(d) All tax moneys collected under this section, as 
soon after the collection thereof as is reasonably 

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practicable, must be paid directly to the district indigent health care board by the tax collector of the county, or by the clerk of the circuit court if the clerk collects delinquent taxes.

1. The moneys so received by the district indigent health care board must be deposited in financial institutions with separate and distinguishable accounts established specifically for the district a-special-bank-account and may be withdrawn only by checks signed by the chairman of the district indigent health care board and countersigned by either one other member of the district indigent health care board or by a chief executive officer who is so authorized by the board.

2. Upon entering the duties of office, the chairman and the other member of the district indigent health care board or chief executive officer who signs its checks shall each give a surety bond in the sum of $1,000, which bond must be conditioned that each of them shall faithfully discharge the duties of his office. The premium on said bond may be paid by the special district as part of the expense of the board. No other member of the district indigent health care board may be required to give bond or other security.

3. No funds of the district indigent-health-care board may be expended except by check as aforesaid, except expenditures from a petty cash account, which may not at any time exceed $25. All expenditures from petty cash must be recorded on the books and records of the district indigent health-care-board. No funds of the district indigent-health care-board, excepting expenditures from petty cash, may be expended without prior approval of the board, in addition to the budgeting thereof.

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Within 10 days after the expiration of each quarter-annual period, the district indigent health care board shall cause to be prepared and filed with the board of county governing body commissioners a financial report, which includes:

1. The total expenditures of the board for the quarter-annual period;
2. The total receipts of the board during the quarter-annual period; and
3. A statement of the funds the board has on hand or deposited with financial institutions in banks at the end of the quarter-annual period.

Any independent health care special district may be dissolved pursuant to s. 165.051, or the county governing body may by ordinance vote to dissolve the independent health care special district subject to the approval of the electorate, provided, however, the county obligates itself to assume the debts, liabilities, contracts, and outstanding obligations of the district within the total millage available to the county governing body for all county and municipal purposes as provided for under s. 9, Art. VII of the State Constitution. After the first year of operation of the indigent-health-care-board, the board of county commissioners may, at its option, fund the budget of the indigent-health-care-board from its own funds.

Any independent health care special district created under this section shall comply with all other statutory requirements of general application which relate to the filing of any financial reports or compliance reports required under part III of chapter 218, or any other report or documentation required by law.
(6) Notwithstanding this or any other provision of
law, any county governing body which operates as the governing
body or governing board of an independent special district
pursuant to s. 200.001(8)(e)13, shall have the same powers and
duties and shall be subject to the same requirements and
limitations as afforded to any other independent health care
special district board as provided in this section. The
county governing body acting in the capacity of the governing
body or governing board of an independent health care special
district is required to maintain separate and distinct
financial records and accounts from other county budgets, and
shall not commingle district revenues with any other county
funds.

Section 16. Paragraph (e) of subsection (8) of section
200.001, Florida Statutes, is amended to read:
200.001 Millages; definitions and general provisions.--

(8)
(e) "Independent special district" means a special
district which meets one of the following conditions:
1. The special district's governing head of which is
an independent body, either appointed or elected, and the
budget of the special district which is established
independently of the local governing authority, even though
there may be appropriation of funds generally available to a
local governing authority involved.
2. A downtown development authority established prior
to the effective date of the 1968 State Constitution as an
independent body, either appointed or elected, is an
independent special district for purposes of this section,
regardless of whether or not the budget is approved by the

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local governing body, if the district levies a millage or a
millage is levied for purposes of the authority, which millage
was authorized as of the effective date of the 1968 State
Constitution. Independent special district millage shall not
be levied in excess of a millage amount authorized by general
law and approved by vote of the electors pursuant to s. 9(b),
Art. VII of the State Constitution, except for those
independent special districts levying millage for water
management purposes as provided in that section. However,
independent special district millage authorized as of the date
the 1968 State Constitution became effective need not be so
approved, pursuant to s. 2, Art. XII of the State
Constitution.

3. Notwithstanding this or any other provision of law,
an independent health care special district created pursuant
to s. 154.331 in any county operating under a home rule
charter adopted pursuant to s. 9, s. 10, s. 11, or s. 24, Art.
VIII of the Constitution of 1885, as amended, as preserved by
s. 6(e), Art. VIII of the Constitution of 1968, as amended,
whose charter requires the county governing body to be the
governing body or governing board of special districts, is an
independent special district for the purpose of this section
and is given express authority to levy millage to fund the
independent health care special district, independent of and
in addition to the maximum millage allowed for all county or
municipal purposes.

Section 17. Effective July 1, 1988, or upon becoming a
law, whichever occurs later, subsections (17) and (18) of
section 381.702, Florida Statutes, are renumbered as
subsections (18) and (19), respectively, and a new subsection
(17) is added to said section, to read:

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381.702 Definitions.—As used in ss. 381.701-381.715, the term:

(17) "Multifacility project" means an integrated residential and health care facility consisting of independent living units, adult congregate living facility units, and nursing home beds certified on or after January 1, 1987, where:

(a) The aggregate total number of independent living units and adult congregate living facility units exceeds the number of nursing home beds.

(b) The developer of the project has expended, exclusive of land acquisition costs, the sum of $500,000 or more by the conclusion of the 18th month of the life of the certificate of need.

(c) The total aggregate cost of construction of the certificated element of the project, when combined with other noncertificated elements, is $10 million or more.

(d) All elements of the project are contiguous or immediately adjacent to each other and construction of all elements will be continuous.

Section 18. Paragraph (a) of subsection (3) of section 381.703, Florida Statutes, is amended to read:

381.703 Local and state health planning.—

(3) FUNDING.—

(a) The Legislature intends that the cost of local health councils and the Statewide Health Council be supported primarily borne by application fees for certificates of need, and such other funds as may be authorized for health planning purposes. However, upon consultation with the appropriations committees of the Legislature, funds authorized under s. 409.266(4) may be utilized for the purpose of...
Section 19. Effective July 1, 1988, or upon becoming a law, whichever occurs later, subsection (3) is added to section 381.705, Florida Statutes, to read:

381.705 Review criteria.--

(3) For any application authorized by s. 381.706(2)(i) or (k), the department shall approve such application unless the proposed consolidation or division would result in a facility or facilities not meeting the criterion of financial feasibility or unless the consolidation or division would result in beds or services being moved more than 15 miles from their original certificated location.

Section 20. Effective July 1, 1988, or upon becoming a law, whichever occurs later, new paragraphs (i), (j) and (k) are added to subsection (2) of section 381.706, Florida Statutes, to read:

381.706 Projects subject to review.--

(2) PROJECTS SUBJECT TO EXPEDITED REVIEW.--Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:

(i) A 50-percent increase in nursing home beds for a facility incorporated and operating in this state for at least 60 years on or before July 1, 1968, which has a licensed nursing home facility located on a campus providing a variety of residential setting and supportive services; The increased nursing home beds shall be for the exclusive use of the campus residents.

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(j) Combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict.

(k) Division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. Subdivision shall not be approved if it would adversely affect the original certificate's approved cost.

The department shall develop rules to implement the provisions for expedited review, including time schedule, application content, and application processing.

Section 21. Effective July 1, 1988, or upon becoming a law, whichever occurs later, subsection (5) of section 381.709, Florida Statutes, is amended to read:

381.709 Review process.--The review process for certificates of need shall be as follows:

(5) ADMINISTRATIVE HEARINGS.--

(a) Within 21 days after publication of notice of the State Agency Action Report and Notice of Intent, any person authorized under paragraph (b) to participate in a hearing may file a request for an administrative hearing; failure to file a request for hearing within 21 days of publication of notice shall constitute a waiver of any right to a hearing and a waiver of the right to contest the final decision of the department. A copy of the request for hearing shall be served on the applicant.

(b) Hearings shall be held in Tallahassee unless the hearing officer determines that changing the location will facilitate the proceedings. In administrative proceedings challenging the issuance or denial of a certificate of need,
only applicants considered by the department in the same batching cycle are entitled to a comparative hearing on their applications.

2.a. Existing health care facilities may initiate or intervene in such administrative hearing upon a showing that an established program will be substantially affected by the issuance of a certificate of need to a competing proposed facility or program within the same district, provided that existing health care providers, other than the applicant, have no standing or right to initiate or intervene in an administrative hearing involving a health care project which is subject to certificate-of-need review solely on the basis of s. 381.706(1)(c).

b. In addition to any rights granted under sub-
subparagraph 2.a., any existing health care facility which is affiliated with, and located on the campus of, a state university, and which is involved in research and the teaching and training of students in one or more of the medical professions, may initiate or intervene in such administrative hearing upon a showing that an established program or the overall role of the facility will be substantially affected by the issuance of a certificate of need to a competing proposed facility or program within the primary service area of the existing facility as designated in its certificate of need.
Any such facility shall be taken into consideration under the criteria set forth in s. 381.705(1)(a)-(n) and rules adopted pursuant thereto, as if it were located within the same service district of the applicant, to the extent that such consideration is consistent with the purposes of each criterion.

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2. The department shall assign proceedings requiring hearings to the Division of Administrative Hearings of the Department of Administration within 10 days after the time has run to request a hearing. Except upon unanimous consent of the parties or upon the granting by the hearing officer of a motion of continuance, hearings shall commence within 60 days after the hearing officer has been assigned. All nonstate-agency parties shall bear their own expense of preparing a transcript. In any application for a certificate of need which is referred to the Division of Administrative Hearings for hearing, the hearing officer shall complete and submit to the parties a recommended order as provided in s. 120.57(1)(b). The recommended order shall be issued within 30 days after the receipt of the proposed recommended orders or the deadline for submission of such proposed recommended orders, whichever is earlier. The division shall adopt procedures for administrative hearings which shall maximize the use of stipulated facts and shall provide for the admission of prepared testimony.

(c) The department shall issue its final order within 45 days after receipt of the recommended order.

(d) If the department fails to take action within the time specified in paragraph (4)(a) or paragraph (5)(c), or as otherwise agreed to by the applicant and the department, the applicant may take appropriate legal action to compel the department to act. When making a determination on an application for a certificate of need, the department is specifically exempt from the time limitations provided in s. 120.60(2).
Section 22. Effective July 1, 1988, or upon becoming a law, whichever occurs later, subsection (2) of section 381.710, Florida Statutes, is amended to read:
381.710 Conditions and monitoring.--

(2)(a) Unless the applicant has commenced construction, if the project provides for construction, unless the applicant has incurred an enforceable capital expenditure commitment for a project, if the project does not provide for construction, or unless subject to paragraph (b), a certificate of need shall terminate 1 year after the date of issuance, except in the case of a multifacility project, as defined in s. 381.702(17), where the certificate of need shall terminate 2 years after the date of issuance. The department may extend the period of validity of the certificate for an additional period of up to 6 months, upon a showing of good cause, as defined by rule, by the applicant for the extension. The department shall monitor the progress of the holder of the certificate of need in meeting the timetable for project development specified in the application with the assistance of the local health council as specified in s. 381.703(1)(b)17., and may revoke the certificate of need, if the holder of the certificate is not meeting such timetable and is not making a good faith effort, as defined by rule, to meet it.

(b) A certificate of need issued to an applicant holding a provisional certificate of authority under chapter 651 shall terminate 1 year after the applicant receives a valid certificate of authority from the Department of Insurance. The certificate-of-need validity period may be extended by the department for an additional period of up to 6 months.
months upon a showing of good cause, as defined by rule, by
the applicant for the extension.

(c) The certificate-of-need validity period for a
project shall be extended by the department, to the extent
that the applicant demonstrates to the satisfaction of the
department that good faith commencement of the project is
being delayed by litigation or by governmental action or
inaction with respect to regulations or permitting precluding
commencement of the project.

(d) If an application is filed to consolidate two or
more certificates as authorized by s. 391.706(2)(i) or to
divide a certificate of need into two or more facilities as
authorized by s. 391.706(2)(k), the validity period of the
certificate or certificates of need to be consolidated or
divided shall be extended for the period beginning upon
submission of the application and ending when final agency
action and any appeal from such action has been concluded.
However, no such suspension shall be effected if the
application is withdrawn by the applicant.

Section 23. Section 395.501, Florida Statutes, is
renumbered as section 407.001, Florida Statutes, and amended
to read:

407.001 395.501 Short title. -- This chapter Part shall
be known and may be cited as the "Health Care Cost Containment
Act of 1988 1979."

Section 24. Section 395.502, Florida Statutes, is
renumbered as section 407.002, Florida Statutes, and amended
to read:

407.002 395.502 Definitions. -- As used in this act, the
term:

CODING: Words stricken are deletions; words underlined are additions.
(1) "Adjusted admission" means the sum of acute admissions and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(2) "Audited actual data" or "audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards.

(3) "Board" means the Health Care Hospital Cost Containment Board created by s. 407.01 395.503.

(4) "Budget" means the projections by the hospital, for a specified future time period, of expenditures and revenues, with supporting statistical indicators, or a budget letter certified to the board pursuant to s. 407.50(2)(a).

(5) "Case mix" means a calculated index for each hospital, based on financial accounting and case-mix data collection as set forth in s. 407.02 395.504, reflecting the relative costliness of the mix of cases of that hospital compared to a state or national mix of cases.

(6) "Commissioner" means the Insurance Commissioner.

(7) "Comprehensive rehabilitative hospital" or "rehabilitative hospital" means a hospital licensed by the Department of Health and Rehabilitative Services as a specialty hospital, as that term is defined in s. 395.002(14), provided that the hospital provides a program of comprehensive medical rehabilitative services and is designed, equipped, organized, and operated solely to deliver comprehensive medical rehabilitative services, and further provided that all licensed beds in the hospital are classified as "comprehensive".
'rehabilitative beds' pursuant to s. 395.003(4), and are not
classified as "general beds."

(8) "Consumer" means any person other than a person
who administers health activities, provides health services,
has a fiduciary interest in a health facility or other health
agency, or its affiliated entities, or has a material
financial interest in the rendering of health services.

(9) "Cross-subsidization" means that the revenues from
one type of hospital service are sufficiently higher than the
costs of providing such service as to offset some of the costs
of providing another type of service in the hospital. Cross-
subsidization results from the lack of a direct relationship
between charges and the costs of providing a particular
hospital service or type of service.

(10) "Department" means the Department of Health and
Rehabilitative Services Insurance.

(11) "Financial report" means a report of audited
actual experience for nursing homes as required under the
uniform system of financial reporting pursuant to s. 407.31.

"Gross revenue" means the sum of daily
hospital service charges, ambulatory service charges,
ancillary service charges, and other operating revenue. Gross
revenues do not include contributions, donations, legacies, or
bequests made to a hospital without restriction by the donors.

"Hospital" means a health care institution as
defined in s. 395.002(6).

"Local health council" means the agency
defined in s. 381.705 381.793(5)(g).

"Major health care purchaser" means a major 
off-the-10-largest private employer employers in the state, a

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commercial health insurer, or a health care services plan certificated under chapter 641.

(15) "Maximum-allowable-rate-of-increase" or "MARI" means the maximum rate at which a hospital is expected to increase its average gross revenues per adjusted admission for a given period. The maximum-allowable-rate-of-increase is composed of two parts, the market-basket-index and plus points, which are defined as follows:

(16) "Market basket index" means the revised market basket index used to measure the inflation in hospital input prices as employed on January 1, 1986, by the Secretary of the United States Department of Health and Human Services for Medicare reimbursement. If the measure ceases to be calculated in this manner, the inflation index shall be the index approved by rule promulgated by the board. The method used in determining the index approved by rule shall be substantially the same as the method employed on January 1, 1986, for determining the inflation in hospital input prices by the Secretary of the United States Department of Health and Human Services for purposes of Medicare reimbursement.

(16) "Plus-points" means additional percentage points added to the market-basket-index-to-adjust-for-the-Florida specific-experience—The-plus-points-to-be-added-to-the market-basket-index-shall-be-5-percent-for-calendar-year-1985—4-percent-for-calendar-year-1986—and-3-percent-for-each-year thereafter.

(17) "Maximum allowable rate of increase" or "MARI" means the maximum rate at which a hospital is normally expected to increase its average gross revenues per adjusted admission for a given period. The board, using the most

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recent audited actual experience for each hospital, shall
calculate the MARI for each hospital as follows: the
projected rate of increase in the market basket index shall be
divided by a number which is determined by subtracting the sum
of one-half of the proportion of Medicare days plus the
proportion of Medicaid days and the proportion of charity care
days from the number one. Two percentage points shall be
added to this quotient. The formula to be employed by the
board to calculate the MARI shall take the following form:

\[ \text{MARI} = \left( \frac{\text{NHPI}}{1 - ((\text{Me} \times .5) + \text{Md} + \text{Cc})} \right) + 2 \]

where:

\[ \text{MARI} = \text{maximum allowable rate of increase applied to} \]
gross revenue.

\[ \text{NHPI} = \text{national hospital input price index, which} \]
shall be the projected rate of change in the market basket
index.

\[ \text{Me} = \text{proportion of Medicare days, including when} \]
available and reported to the board Medicare HMO days, to
total days.

\[ \text{Md} = \text{proportion of Medicaid days, including when} \]
available and reported to the board Medicaid HMO days, to
total days.

\[ \text{Cc} = \text{proportion of charity care days to total days with} \]
a 50-percent offset for restricted grants for charity care and
unrestricted grants from local governments.

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"Medically indigent" means a person who has insufficient resources or assets to pay for needed medical care without utilizing his resources required to meet his basic needs for shelter, food, and clothing.

"Net revenue" means gross revenue minus deductions from revenue.

"Nursing home" means a facility licensed under 3-400.062, but does not include a facility licensed under chapter 651.

"Operating expenses" or "operating expenditures" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses, and other operating expenses, excluding income taxes.

"Other operating revenue" means all revenue generated from hospital operations other than revenue directly associated with patient care.

"Rate of return" means the financial indicators used to determine or demonstrate reasonableness of the financial requirements of a hospital. Such indicators shall include, but not be limited to, return on assets, return on equity, total margin and debt service coverage.

"Rural hospital" means an acute care hospital licensed under chapter 395, with 85 beds or less, which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county; or
(c) A provider supported by a hospital tax district whose boundaries encompass a population of 100 persons or less per square mile.

(25)-(26) "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the board in meeting its responsibilities pursuant to this part.

(26)-(27) "State health planning agency" means the agency designated by the Governor to perform the health planning and development functions for the state prescribed by section 15837, Pub.L. 95-500, the National Health Planning and Resources Development Act of 1974.

(27)-(28) "Teaching hospital" means any hospital formally affiliated with an accredited medical school that exhibits activity in the area of medical education as reflected by at least seven different resident physicians in specialties and the presence of 100 or more resident physicians.

(28)-(29) "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts; contractual adjustments; uncompensated care; administrative, courtesy, and policy discounts and adjustments; and other such revenue deductions, but also includes the offset of restricted donations and grants for indigent care.

Section 25. Section 395.5025, Florida Statutes, is renumbered as section 407.003, Florida Statutes, and amended to read:

407.003 395.5025 Legislative intent to assure affordable health care.--

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It is the intent of the Legislature to assure that adequate health care is affordable and accessible to all the citizens of this state. To further the accomplishment of this goal, the Health Care Hospital Cost Containment Board is created to:

(a) Advise the Governor, the President of the Senate, the Senate Minority Leader, the Speaker of the House of Representatives, and the House Minority Leader legislature regarding health care costs, inflationary trends in health care costs, the impact of health care costs on the state budget, the impact of hospital and other provider charges, and third-party reimbursement mechanisms on health care costs and the education of

(b) Educate consumers and providers of health care services in order to encourage price competition in the health care marketplace.

c) Promote improved consumer and purchaser understanding of government health care funding programs and third-party reimbursement.

d) Recommend to the Governor, the President of the Senate, the Senate Minority Leader, the Speaker of the House of Representatives, and the House Minority Leader appropriate strategies necessary to foster health care cost containment and improve access to health care services.

The Legislature further finds and declares that rising hospital and other health care costs and cost shifting and cross-subsidization by hospitals to increase revenues, whether the need is due to high levels of uncompensated care, Medicare, or other causes, are of vital concern to the people of this state because of the danger that hospital and other
Health care services are becoming unaffordable and thus inaccessible to residents of the state.

(3) The Legislature it is further declared that every effort hospital-seats should be made to contain hospital costs contained through improved competition between hospitals and improved competition between insurers, through financial incentives which foster efficiency instead of inefficiency, and through sincere initiatives on behalf of providers, insurers, and consumers to contain costs. However, as a safety net, it is the intent of the Legislature to:

(a) Establish a program which will contain hospital charges that exceed certain thresholds, where of-prospective budget-review-and-approval-in-the-event-that competition-oriented methods do not adequately contain costs, and the

(b) Assure access of Floridians to adequate hospital care which may become jeopardized because of unaffordable costs.

Section 26. Section 395.503, Florida Statutes, is renumbered as section 407.01, Florida Statutes, and amended to read:

407.01 395.503 Health Care Hospital Cost Containment Board.—

(1)(a) There is created the Health Care Hospital Cost Containment Board within the Department of Health and Rehabilitative Services. The board shall be a separate budget entity and the executive director shall be its agency head for all purposes; however, in matters involving chapter 120, the board shall be the agency head as defined in s. 120.52. The Department of Health and Rehabilitative Services shall provide administrative support and service to the board to the extent requested by the executive director. The board shall not be

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subject to control, supervision, or direction by the
Department of Health and Rehabilitative Services in any
manner, including, but not limited to personnel, purchasing,
transactions involving real or personal property, and
budgetary matters. The board shall be administratively
located within the office of the secretary of the Department
of Health and Rehabilitative Services.

(b) Effective January 1, 1989, and beginning with
terms starting on that date, the board and shall be composed
of nine eleven members appointed by the Governor and confirmed
by the Senate. Three Four members must be providers of health
care, including one representative of the for-profit
hospitals; one representative of the not-for-profit hospitals
two representatives of the hospital industry and one
representative of the nursing home industry; three members
must have experience as be major purchasers of health care;
and three four members must be consumers with no direct
involvement in health care. All members of the board must be
permanent residents of the state, and at least one consumer
member of the board must be 60 years of age or older.

(c)(b) Each appointment to the board shall be for a 3-
year term, except that the initial appointment of the provider
member added by chapter 87-92, Laws of Florida, shall be for a
term ending December 31, 1989, and the initial appointment of
the consumer member added by chapter 87-92, Laws of Florida,
shall be for a term ending December 31, 1988. No member is
eligible for appointment for more than two full consecutive
terms, regardless of the length of any one term. A vacancy on
the board shall be filled within 60 days from the date on
which the vacancy occurs, and which appointment shall be made
for the remainder of the unexpired term.
The Governor may remove from office any member who would no longer be eligible to serve on the board by virtue of the requirement that he be a provider, purchaser, consumer, or resident of the state who becomes disqualified for neglect of any duty required by law or who misses more than four meetings in any one year.

(a) The members of the board shall biennially elect a chairperson and a vice chairperson from its membership. The board shall meet from time to time to fulfill its responsibilities. Meetings may be called by the chairperson or any five members and, except in the event of an emergency, shall be called by written notice. Meetings shall be called in advance and be open to the public. Five voting members of the board constitute a quorum.

(b) Board members shall be remunerated at the rate of $50 per diem while on official board business and shall be reimbursed for their expenses while on official business for the board in accordance with the provisions of s. 112.061.

(a) The board shall appoint an executive director who shall serve at the pleasure of the board and who shall have had experience in the organization, financing, or delivery of health care. The executive director shall perform the duties delegated to him by the board. The executive director, with the concurrence of the board, shall appoint, and may terminate, a general counsel, a director of finance, chief-financial-analyst with at least 5 years' experience in hospital financial management, a director of public information, a director of administration, and a director of research and may appoint, with the consent of the board, such other staff and staff attorneys as the board deems necessary.

The board may contract with persons outside the board for

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services necessary to carry out its activities when this will
promote efficiency, avoid duplication of effort, and make the
best use of available expertise.

(b) The board may apply for and receive and accept
grants, gifts, and other payments, including property and
service from any governmental or other public or private
entity or person, and make arrangements as to the use of same,
including the undertaking of special studies and other
projects relating to health care costs.

(4) The board may create committees from its
membership and may create such ad hoc advisory committees to
advise the board and its staff in specialized fields related
to-the-functions-of-hospitals as it deems necessary. The
members of any ad hoc advisory committee shall be entitled to
reimbursement for expenses incurred, including travel
expenses.

Section 27. Section 395.504, Florida Statutes, as
amended by chapter 86-1, Laws of Florida, is renumbered as
section 407.02, Florida Statutes, and amended to read:

407.02 395.504 Powers and duties of board.--To
properly carry out its authority, the board:

(1) Shall require the submission by hospitals of such
case-mix, financial, nonfinancial, accounting, and actual
charge data by diagnostic groups as the board deems necessary
in order to have available the statistical information
necessary to properly conduct financial analyses and budget
review and approval and to carry out its public information
and education functions as contained in s. 407.09 395.5085.

(a) Such requirement shall be promulgated by rule if
the submission of case-mix, financial, nonfinancial,
accounting, and actual charge data by diagnostic groups is

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being required of all hospitals or of any group thereof;
however, rules are not required for the submission of data for
a special study or when information is being requested for a
single hospital.
(b) Such data may include, but is not limited to:
leases, contracts, debt instruments, itemized patient bills,
medical record abstracts, and related diagnostic information
necessary to evaluate the case mix of a hospital and to
identify actual charges and lengths of stay associated with
specific diagnostic groups; necessary operating expenses;
appropriate expenses incurred for rendering services to
patients who cannot or do not pay; all properly incurred
interest charges; and reasonable depreciation expenses based
on the expected useful life of the property and equipment
involved.
(2) Shall approve, disapprove approve-as-amended-by
the board, or disapprove in part the budget of each hospital
requesting increases above the maximum allowable rate of
increase, including its projected expenditures and projected
revenues.
(3) May contract with local health councils to
disseminate information to the public on health care costs.
(4) Shall cooperate with the comprehensive Health
Planning Office of the Department of Health and Rehabilitative
Services in the development of a biennial work plan defining
the roles and responsibilities of the board and the
comprehensive Health Planning Office in the establishment of
an integrated health care data base and shall consult with and
make recommendations to the Governor, the President of the
Senate, the Senate Minority Leader, the Speaker of the House
of Representatives, the House Minority Leader, board and the

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Secretary of Health and Rehabilitative Services with respect
to analyses and studies of health care costs, capital
expenditures by hospitals and their relationship to health
care costs, and related matters which may be undertaken by the
board.

(5) May inspect and audit hospital books and records,
and including records of individual or corporate ownership
including books and records of related organizations with
which a hospital had transactions, for compliance with this
part. As used in this subsection, the term "related
organizations" means organizations related to the hospital by
common ownership or control. Upon presentation of a written
request for inspection to a hospital by the board or its
staff, the hospital shall make available to the board or its
staff for inspection, copying, and review all books and
records relevant to the determination of whether the hospital
has complied with this part.

(6) Shall publish and make available to the public a
toll-free telephone number for the purpose of handling
consumer complaints and shall serve as a liaison between
consumer entities and other private entities and governmental
entities for the disposition of problems identified by
consumers of hospital care.

(7) Shall monitor and report on the effects of
prospective payment arrangements preferred-provider
organizations and changes in reimbursement methodologies for
Medicare on cost shifting.

(8) Shall designate executive staff members to issue
preliminary findings pursuant to s. 407.50(9)(a) 395-509-94.

(9)(a) Shall publish, based on information provided by
the Department of Insurance under s. 627.9175(1), an annual

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1 report containing premium and benefit comparisons, or the
2 equivalent thereof, for policies of individual health
3 insurance and shall disseminate the report in the manner
4 provided in s. 407.07 395.5085. The report shall also
5 indicate, as applicable, the extent to which the premiums
6 charged by a given entity have increased over the prior
7 premium year.
8 (b) Shall publish, based on information provided by
9 the Department of Insurance under s. 627.9375(3), an annual
10 report containing available physician-charge comparisons;
11 profiles, and related information and shall disseminate the
12 report in the manner provided in s. 395.5085.
13 (10) Shall be empowered to investigate consumer
14 complaints relating to problems with hospital billing
15 practices and issue reports to be made public in any cases
16 where the board determines the hospital has engaged in billing
17 practices which are unreasonable and unfair to the consumer.

Section 28. Section 407.025, Florida Statutes, is
created to read:
407.025 Reporting and use of data; immunity.—No
hospital or other reporting entity or its employees or agents
shall be held liable for civil damages or criminal penalties
either for the reporting of patient data to the Health Care
Cost Containment Board or for the release of this data by the
board as authorized pursuant to this chapter.

Section 29. Section 395.505, Florida Statutes, is
renumbered as section 407.03, Florida Statutes, and amended to
read:
407.03 395.505 Rules; public hearings; investigations;
subpoena power.—In addition to the powers granted to the

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board elsewhere in this chapter part, the board is authorized to:

1. Adopt, amend, and repeal rules respecting the exercise of the powers conferred by this chapter part which are applicable to the promulgation of rules.

2. Hold public hearings, conduct investigations, and subpoena witnesses, papers, records, and documents in connection therewith. The board may administer oaths or affirmations in any hearing or investigation.

3. Exercise, subject to the limitations and restrictions herein imposed, all other powers which are reasonably necessary or essential to carry out the expressed objects and purposes of this chapter part.

Section 30. Section 395.5051, Florida Statutes, is renumbered as section 407.035, Florida Statutes, and amended to read:

407.035 395.5051 Effect of chv-84-35y-laws-of-Florida, on existing rules.—Nothing contained in this act chapter-84-
35y-laws-of-Florida is intended to repeal or modify any of the existing rules of the Hospital Cost Containment Board, as adopted to implement chapter 84-35, Laws of Florida enacted-in
s-395-503, unless such rule or part thereof is in direct conflict with the provisions of this act provided: any budget or budget amendment for fiscal years beginning prior to
February 1, 1989, shall be filed and reviewed pursuant to chapter 84-35, Laws of Florida, and rules adopted by the board pursuant thereto chapter-84-35.

Section 31. Section 395.512, Florida Statutes, is renumbered as section 407.04, Florida Statutes, and amended to read:

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407.04 395.512 Budget; expenses; assessments; health care hospital cost containment program account.--

(1) The board shall biennially prepare a budget which shall include an estimate of income and expenditures for administration and operation of the health care hospital cost containment program for the biennium, to be submitted to the Governor for transmittal to the Legislature for approval. Subject to the approval of the Legislature, expenses of the program shall be financed by assessments against hospitals in an amount to be determined biennially by the board, but not to exceed 0.04 percent of the gross operating costs of each hospital for the provision of hospital services for its last fiscal year. Every new hospital shall pay its initial assessment upon being licensed by the state and shall base its assessment payment during the first year of operation upon its projections for gross operating costs for that year. Each hospital under new ownership shall pay its initial assessment for the first year of operation under new ownership based on its gross operating costs for the last fiscal year under previous ownership. The assessments shall be levied and collected quarterly. All moneys collected are to be deposited by the Treasurer into the Health Care Hospital Cost Containment Trust Fund in the general fund, which account is hereby created. The Health Care Hospital Cost Containment Trust Fund shall be subject to the service charge imposed pursuant to chapter 215.

(2) Any amounts raised by the collection of assessments from hospitals provided for in this section which are not required to meet appropriations in the budget act for the current fiscal year shall be available to the board in succeeding years.

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(3) Hospitals operated by the Department of Health and Rehabilitative Services or the Department of Corrections are exempt from the assessments required under this section.

(4) The Health Care Cost Containment Board shall submit its final legislative budget request directly to the Governor as chief budget officer of the state in the form and manner prescribed in the budget instructions. However, the final legislative budget request shall be submitted no later than November 1 of each even-numbered year.

Section 32. Section 395.507, Florida Statutes, is renumbered as section 407.05, Florida Statutes, and amended to read:

407.05 395.507 Uniform system of financial reporting for hospitals.--

(1) The board shall, by rule, after consulting with appropriate professional and governmental advisory bodies and holding public hearings, and considering existing and proposed systems of accounting and reporting utilized by hospitals, specify a uniform system of financial reporting based on a uniform chart of accounts developed after considering the American Hospital Association Chart of Accounts, the American Institute of Certified Public Accountants Hospital Audit Guide, and generally accepted accounting principles. However, this provision shall not be construed to authorize the board to require hospitals to adopt a uniform accounting system. As a part of such uniform system of financial reporting, the board may require the filing of any information relating to the cost, to both the provider and the consumer, of any service provided in such hospital except the cost of a physician's services which is billed independently of the hospital.

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For the purposes of this part, and in order to allow meaningful comparisons in the budget review process, the board shall, by rule, group hospitals according to characteristics, including, but not limited to, a measure of the nature and range of services provided, teaching hospital status, number of medical specialties represented on the hospital staff, percentage of Medicare inpatient days, average daily census, geographical differences, and, when available, case mix. The rule shall provide for the establishment of not more than 15 statistically valid general groups and for the establishment of additional specialty groups as needed; however, no group shall contain fewer than five hospitals.

In establishing such uniform reporting procedures, the board shall, among other issues, take into consideration the need for financial data which reflects the average bill per day and the average bill per stay billed by the hospital and the degree of cross-subsidization by cost center.

When appropriate, the reporting system shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals, as distinguished from those incurred in connection with educational research and other non-patient-related activities, including, but not limited to, charitable activities of such hospitals.

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

At least 90 days prior to the commencement of its next fiscal year, each hospital requesting approval of a rate of increase in gross revenue per adjusted admission in excess of its applicable maximum allowable rate of increase for such

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next fiscal year shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting:

(a) Its budget for the next fiscal year, including projected expenditures, projected revenues, and statistical measures necessary for the board to evaluate these projections. Any hospital the final budget of which requires public review and approval may submit its budget prior to public review and approval and shall subsequently file any amendments adopted during the public review process at least 45 days prior to the beginning of the fiscal year of the hospital.

(b) Its actual experience for the first 6 months of its current fiscal year, including actual expenditures, actual revenues, and statistical measures necessary for the board to evaluate the actual experience.

(c) Its estimated experience for the last 6 months of its current fiscal year, including estimated expenditures, estimated revenues, and statistical measures necessary for the board to evaluate these estimates.

(d) Information necessary for the board to evaluate the effectiveness of current services and the justification of the hospital for increased costs to continue current services, improve existing services, and provide new services.

(e) Its schedule of projected rates which will be implemented to generate projected revenues.

(f) Within 120 days after its fiscal year ends, each hospital shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting, its actual audited experience for that fiscal year, including expenditures, revenues, and statistical measures.

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(8) The board may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of this part.

(9) The Shriner's Hospital for Crippled Children, located in Tampa, is exempt from the financial reporting requirements of this chapter part until such time as it first receives revenues from or on behalf of any individual patient.

Section 33. Section 395.514, Florida Statutes, is renumbered as section 407.06, Florida Statutes, and amended to read:

407.06 395.514 Violation of chapter part or rule; penalties.--Refusal Any hospital which refuses to file, failure to file, or filing false or incomplete reports or other information required to be filed under the provisions of this chapter part, or violation of which violates any other provision of this chapter part or rule adopted under this chapter part, shall be punished by a fine not exceeding $1,000 a day for each day in violation, to be fixed, imposed, and collected by the board. Each day in violation shall be considered a separate offense. The violation of any provision of this chapter part or of a rule adopted under this chapter part, or the knowing and willful falsification of a report required under this chapter part, is a ground for the imposition of an administrative fine not to exceed $20,000, to be fixed, imposed, and collected by the Department of Health and Rehabilitative Services.

Section 34. Section 395.508, Florida Statutes, is renumbered as section 407.07, Florida Statutes, and amended to read:

407.07 395.508 Health care Hospital costs and finances; analyses, studies, and reports.--
(1) The board shall have the authority to:
   (a) Collect data and conduct from-time-to-time
   undertake analyses and studies relating to health care costs,
   making maximum use of local health councils and the designated
   state health planning agency whenever appropriate, possible,
   and
   (b) Conduct analysis and research relating to the
   financial status of any hospital or hospitals subject to the
   provisions of this part.
   (c) The board-and-the-department—shall jointly
   develop, with the Department of Insurance or the Department of
   Health and Rehabilitative Services, criteria to analyze and
   study the ongoing effect upon health care costs of third-party
   reimbursement mechanisms, including the effects of Medicare,
   Medicaid and other government reimbursement mechanisms. The
   board shall incorporate into its reports the findings of the
   Department of Insurance department relating to the effect upon
   health care costs of third-party reimbursement mechanisms,
   including health insurance as defined in ss. 624.603 and
   627.652, health care service plans as defined in s. 641.01,
   and health maintenance organizations as defined in s.
   641.19(6).
   (d) Conduct analysis and research relating to the
   impact of uncompensated charity care on hospital budgets,
   (e) Conduct analysis and research on the state’s role
   in assisting to fund indigent care,
   (f) The board may publish and disseminate such
   information as the board deems desirable and in the public
   interest, including information which will assist consumers
   and purchasers to understand the impact government-funded

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programs and third-party reimbursement mechanisms may have on hospital finances.

(2) The board shall also prepare and file such summaries and compilations or other supplementary reports based on the information analyzed by the board hereunder as will advance the purposes of this part.

Section 35. Section 395.513, Florida Statutes, is renumbered as section 407.08, Florida Statutes, and amended to read:

407.08 395.513 Program accountability.—On or before March 1 of each year, the board shall prepare and transmit to the Governor and the Legislature a report of health care hospital cost containment board program operations and activities for the preceding year. This report shall include copies of summaries, compilations, and supplementary reports required by this chapter part, together with such facts, suggestions, and policy recommendations as the board deems necessary. The board shall specifically state its findings and recommendations on the following issues:

(1) The extent to which cross-subsidization affects the rates and charges for different types of hospital services and an analysis of the reasons for existing levels of cross-subsidization.

(2) The extent to which third-party reimbursement mechanisms affect health care costs.

(3) The extent to which public funding policies may be affecting health care costs.

(4) The extent to which other factors in the health care marketplace may be affecting health care costs, including, but not limited to, uncompensated care, skilled employee shortages, changes in technology, shifts from

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institutional to ambulatory care, and shifts in the
demographic makeup of the state's population.

Section 36. Section 395.5085, Florida Statutes, is
renumbered as section 407.09, Florida Statutes, and amended to
read:

407.09 395.5085 Collection and dissemination of health
care hospital charges and other health-care-specific hospital-
specific information—Consumer-Information-Network.—

1. The board, relying on summary-actual-charge data
by-diagnostic-groups-and-other-information collected pursuant
to this act s-395.504(3), shall establish a reliable, timely,
and consistent information system which distributes
information utilizing the consumer information and advisory
council pursuant to s. 407.10, and any other appropriate means
available.

2. Semiannually, the board shall identify, by
hospital, average charges and lengths of stay associated with
established diagnostic groups. Charge information shall be
cited for at least the following payer classifications:
insurance, not-for-profit insurance, Medicaid, and Medicare.
Combined average charges for all payer classifications
reported shall be published by the board semiannually for
dissemination to the media and the public at large. The
publication shall identify charges associated with at least
the 10 most frequently occurring diagnostic groups and such
other information as the board deems appropriate, published by
county or region.

3. The board shall coordinate the distribution of
summary-actual-charge-data-by-diagnostic-groups-and-special
publications through a Consumer-Information-Network.—The
membership of this network may include the members of the
The Board of Medicine may include the current publication of hospital charges in its mailings related to license renewals. Hospitals are required to make the current publication of hospital charges available to patients or family members for review upon the request of the patient or family member.

The board shall through the Consumer Information Network, conduct consumer information seminars at locations throughout the state.

Section 37. Section 407.10, Florida Statutes, is created to read:

407.10 Consumer information and advisory council.—The board shall coordinate the distribution of data, special publications, and other health care information collected or developed by the board with the assistance of the consumer information and advisory council.

(1) The membership of the council shall be appointed by the board and may include members of the Senate and the House of Representatives; a representative of the office of the Public Counsel; representatives of consumer service offices located within the Department of Insurance; representatives of insurance companies licensed to write policies for health insurance in this state; representatives of Florida business coalitions on health care; representatives of local health councils; a representative from the designated...
(2) The council may conduct or sponsor consumer information and education seminars at locations throughout the state, and may hold public hearings to solicit consumer concerns or complaints relating to health care costs and make recommendations to the board for study, action, or investigation.

(3) The council shall be entitled to reimbursement for expenses incurred to fulfill the function of this part, including travel expenses.

Section 38. Section 395.504E, Florida Statutes, is renumbered as section 407.11, Florida Statutes, and amended to read:

407.11 395.504E Office of Technical Assistance within board.--It is the intent of the Legislature to create a single entity to serve as a focal point for governmental efforts and activities to promote health care cost containment by providing technical assistance to persons, businesses, and purchaser coalitions interested in containing the costs of health care. Therefore, there is created within the Health Care Hospital Cost Containment Board the Office of Technical Assistance, which shall include such professional, technical, and clerical staff as may be necessary to enable it to carry out its duties. The Office of Technical Assistance shall:

(1) Assist employers in the formation of health care coalitions around the state.

(2) Develop model health care benefit packages for use by employers and providers in implementing health benefit CODING: Words stricken are deletions; words underlined are additions.
plans which promote the cost-effective delivery of adequate

care.

(3) Serve as a clearinghouse for information

concerning innovations in the delivery of health care services

and the enhancement of competition in the health care

marketplace.

(4) Make recommendations relating to Pursue-the

implementation of mechanisms through which state government

might well head by example in the prudent purchase of cost-

effective adequate health services for its employees and

clients.

(5) Assist Work-with existing health coalitions and

local health councils as needed in carrying out their

respective goals in an efficient and effective manner.

(6) Develop cost containment strategies for use by

providers, employers, or consumers of health care.

(7) Serve as a clearinghouse for information

concerning federal and state legislative initiatives affecting

the private health care delivery system and governmental

health care programs.

(8) Develop an outreach program to assist small

business to include cost containment initiatives for small

business health insurance plans.

Section 39. Section 395.511, Florida Statutes, is

renumbered as section 407.12, Florida Statutes, and amended to

read:

407.12 395.511 Quality assurance monitoring

programs.--Each hospital shall maintain a quality assurance

program which program shall include monitoring of the

necessity of admission, appropriateness of the length of stay,

proper utilization of services, and the evaluation of the

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quality of service rendered. Quality assurance plans shall be available to the board upon request. The Department of Health and Rehabilitative Services, the Department of Insurance, or the Department of Professional Regulation shall provide, upon request, any information the board determines necessary to monitor a hospital's quality assurance. The board shall exercise the same confidentiality restrictions imposed by law on the providing agency.

Section 40. Section 395.515, Florida Statutes, is renumbered as section 407.13, Florida Statutes, and amended to read:

407.13 395.515 Prospective payment arrangements.--
(1) The Legislature finds that the traditional retrospective reimbursement practices of health insurers provide hospitals with disincentives to contain costs and are a major contributing factor to the rapidly escalating costs of hospital care. The Legislature further finds that prospective payment arrangements designed to provide hospitals with financial incentives to contain costs will contribute to the deceleration of hospital cost increases while enhancing the adequacy of and access to care so highly valued by consumers. Furthermore, prospective payment arrangements that provide fixed payment amounts which are prospectively set through private-sector negotiation will provide insurers with a greater degree of investment stability. Therefore, the Legislature finds that it is the business of insurance, as well as in the best interests of the citizens of this state, that insurers, on behalf of their insureds, should negotiate with hospitals to establish prospective payment arrangements that provide financial incentives for the containment of hospital costs.

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(2) For the purposes of this chapter section, the term "prospective payment arrangement" means a financial agreement, negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payer, which contains, at a minimum, the elements provided for in subsection (4).

(3) Hospitals, as defined in s. 395.002, and health insurers, regulated pursuant to parts VI and VII of chapter 627, shall establish by-no-later-than-March-1, 1987, prospective payment arrangements that provide hospitals with financial incentives to contain costs. Each hospital shall negotiate with each health insurer which represents 10 percent or more of the private-pay patients of the hospital to establish a prospective payment arrangement. Beginning October 1, 1985, and annually thereafter, hospitals and health insurers regulated pursuant to this section shall report on October 1 of each year the results of each specific prospective payment arrangement adopted by each hospital and health insurer to the Health Care Hospital Cost Containment Board, hereinafter referred to as the "board." In the event that a hospital or a health insurer does not comply completely by March 1, 1987, with the requirements of this section, such hospital or health insurer shall have 60 days in which to justify the reasons for its failure to comply to the board. The board shall take into account the failure of the hospital to comply in its approval or disapproval of the budget of the hospital. In addition, the board shall report a health insurer's failure to comply to the Department of Insurance, which shall take into account the failure by the health insurer to comply in conjunction with its approval authority under s. 627.410. The board shall adopt any rules.

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necessary to carry out its responsibilities required by this section.

(4) The prospective payment system established pursuant to this section shall include, at a minimum, the following elements:

(a) A maximum allowable payment amount established for individual hospital products, services, patient diagnoses, patient day, patient admission, or per insured, or any combination thereof, which is preset at the beginning of the budget year of the hospital and fixed for the entirety of that budget year, except when extenuating and unusual circumstances acceptable to the board warrant renegotiation;

(b) Timely payment to the hospital by the insurer or the insured, or both, of the maximum allowable payment amount, as so negotiated by the insurer or group of insurers;

(c) Acceptance by the hospital of the maximum payment amount as payment in full, which shall include any deductible or coinsurance provided for in the insurer's benefit plan;

(d) Utilization reviews for appropriateness of treatment; and

(e) Preadmission screening of nonemergency surgery.

(5) Nothing contained in this section prohibits the inclusion of deductibles, coinsurance, or other cost containment provisions in any health insurance policy.

Section 41. Section 400.341, Florida Statutes, is renumbered as section 407.30, Florida Statutes, and amended to read:

407.30 400.341 Legislative intent; nursing home costs.--The Legislature finds it to be in the best interest of the state that nursing home care be affordable and accessible to all persons requiring these services. Further, the

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Legislature finds there is a paucity of information on nursing home revenues and growth in those revenues, the equity of the burden in providing charity care, and nursing home rates and charges. The potential for growth in nursing home revenues and the effect of such growth on state and local government budgets and on the ability of persons to purchase nursing home care makes it vital that nursing home revenues and expenditures be documented and analyzed. The Legislature finds that the Health Care Hospital Cost Containment Board is the agency best qualified to collect, analyze, and monitor nursing home financial data and intends that the board carry out this responsibility in conjunction with the department and the State Nursing Home and Long-Term Care Facility Ombudsman Council and district nursing home and long-term care facility ombudsman councils.

Section 42. Section 400.343, Florida Statutes, is renumbered as section 407.31, Florida Statutes, and amended to read:

407.31 400.343 Uniform system of financial reporting for nursing homes.--

(1) The board shall consult with appropriate professional and governmental advisory bodies, hold public hearings, and consider existing and proposed systems of accounting and reporting utilized by nursing homes and then establish by rule a uniform system of financial reporting. Such system shall be based on a uniform chart of accounts developed after considering the American Health Care Association's Uniform Chart of Accounts for Long Term Care Facilities, appropriate audit standards from the American Institute of Certified Public Accountants, and generally accepted accounting principles. Such system shall, to the

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extent feasible, utilize existing accounting systems and shall make every effort to minimize paperwork to nursing home licensees. In addition, the board may not require nursing homes to adopt a uniform accounting system. The board may require the filing of any information relating to the provider's and consumer's cost of services provided in a nursing home, including physicians' compensation.

(2) Within 120 days after the end of its fiscal year, each nursing home shall file with the board, on forms adopted by the board and based on the uniform system of financial reporting, its actual audited experience for that fiscal year, including revenues, expenditures, and statistical measures, based on examination by an independent, state-licensed certified public accountant in accordance with generally accepted accounting principles. Each nursing home shall also submit a schedule of the charges in effect at the beginning of the fiscal year and any changes that were made during the fiscal year. A nursing home which is certified under Title XIX of the Social Security Act and files annual Medicaid cost reports may substitute copies of such reports and any Medicaid audits to the board in lieu of a report and audit required under this subsection. For such facilities, the board may require only information in compliance with this act that is not contained in the Medicaid cost report. Facilities which are certified under Title XVIII but not Title XIX of the Social Security Act must submit a report as developed by the board. This report will be substantially the same as the Medicaid cost report and shall not require any more information than is contained in the Medicare cost report unless that information is required of all nursing homes. The
audit under Title XVIII shall satisfy the audit requirement under this subsection.

(3) In addition to information submitted in accordance with subsection (2), each nursing home shall track and file with the board, on a form adopted by the board and designed to protect the anonymity of residents, the following information, where applicable, reported for each resident or reported in the aggregate, if so directed by the board:

(a) Date of admission;

(b) Location from which admission was made;

(c) Age at the time of admission;

(d) Primary diagnosis at the time of admission;

(e) Source of financial support at the time of admission;

(f) Date of conversion to Medicaid;

(g) Amount spent on nursing home care prior to conversion to Medicaid, by payor source;

(h) Date of discharge;

(i) Reason for discharge; and

(j) Location to which resident is discharged.

(4) The board may require other reports based on the uniform system of financial reporting necessary to accomplish the purposes of ss. 407.30-407.34, 408.34-408.346. Such requirements shall be established by rule unless the reports are part of a nonrecurring study or unless information is being requested for a single nursing home.

(5) If more than one licensed nursing home facility is operated by the reporting organization, the information required by this section shall be reported for each nursing home and for the organization's home office separately.

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1. (6) All reports filed under ss. 407.30-407.34 400-341-400-346, except privileged medical information, shall be open to public inspection.

2. (7) In the event the board has reason to believe that there is evidence of noncompliance with any of the provisions of ss. 407.30-407.34 this act, the board may inspect and audit nursing home books and records, including records of individual or corporate ownership, for compliance with ss. 407.30-407.34 this act. Upon presentation to a nursing home of a written request for inspection, the nursing home shall make available to the board or its staff for inspection, copying, and review all books and records relevant to the determination of whether the nursing home has complied with ss. 407.30-407.34 400-341-400-346.

3. Section 43. Section 400.344, Florida Statutes, is renumbered as section 407.32, Florida Statutes, and amended to read:

   407.32 400-344 Nursing home revenues and financial analysis: analysis, studies, and reports.--

4. (1) The board shall evaluate data from nursing home financial reports beginning with nursing home fiscal years starting January 1, 1985, and shall document and monitor:

   (a) Total revenues, annual change in revenues, and revenues by source and classification, including contributions for a patient's care from the patient's resources and from the family and contributions not directed toward any specific patient's care.

   (b) Average patient charges by geographic region, payor, and type of facility ownership.

   (c) Profit margins by geographic region and type of facility ownership.

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(d) Amount of charity care provided by geographic region and type of facility ownership.
(e) Patient days by payer prior category.
(f) Experience related to Medicaid conversion as reported under s. 407.31(3), 400.3453(3).
(g) Other information pertaining to nursing home revenues and expenditures.

The findings of the board shall be included in an annual report to the Governor and Legislature by January 1 each year.

(2) The board shall provide information relating to nursing home charges to the public through pamphlets, brochures, and other appropriate means pursuant to s. 407.09 and through the consumer information and advisory council referred to in s. 407.10 Network-established-by-s.395.5085.

(3) The board shall cooperate with and provide pertinent information on nursing home costs and charges to the department, local health councils, and the State Nursing Home and Long-Term Care Ombudsman Council and district nursing home and long-term care facility ombudsman councils.

(4) The board shall also prepare and make available such summaries and compilations or other supplementary studies and reports based on the information analyzed by the board hereby as will advance the purposes of this part.

Section 44. Section 400.345, Florida Statutes, is renumbered as section 407.33, Florida Statutes, and amended to read:

407.33 400.345 Budget, expenses, assessments; nursing home financial disclosure program.--

(1)(a) The board shall include in its biennial budget a separate estimate of income and expenditures for the

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administration and operation of the nursing home financial

disclosure program. Subject to legislative approval, expenses

of the program shall be financed by assessments against each

nursing home in an amount set by the Department of Health and

Rehabilitative Services to cover the board's approved budget.

(b) The board shall annually notify the department of

its approved budget. The department shall calculate the

amount to be collected per bed, rounded to the nearest whole

dollar. All license fees collected under this section which

are due after the date of notification by the board shall be

at a rate sufficient to cover the board's approved budget.

(c) Assessments shall be levied and collected annually

by the department. Money collected shall be deposited by the

department into the Health Care Hospital Cost Containment

Board Trust Fund as collected, but such funds shall be

maintained in a separate account.

(d) Each new nursing home shall pay its initial

assessment upon being licensed, and each nursing home under

new ownership shall pay its initial assessment under the new

ownership based on its number of beds.

(2) Money raised by collection of assessments from

nursing homes which are not required to meet the appropriation

for the current fiscal year shall be available to the board in

succeeding years.

Section 45. Section 400.346, Florida Statutes, is

renumbered as section 407.34, Florida Statutes, and amended to

read:

407.34 400.346 Nursing home violations; penalty.—Any

nursing home which refuses to file a report, fails to timely

file a report, files a false report, or files an incomplete

report and upon notification fails to timely file a complete

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report required under ss. 407.30-407.34, or
which violates any provision of ss. 407.30-407.34, or rule adopted thereunder, shall be punished by a
fine not exceeding $1,000 per day for each day in violation,
to be imposed and collected by the board.

Section 46. Section 395.509, Florida Statutes, is
renumbered as section 407.50, Florida Statutes, and amended to
read:

(Substantial wording of section. See
a. 395.509, F.S., for present text.)

407.50 Review of hospital budgets.--

1. The base for hospital budget review for fiscal
year 1990-1991 shall be the hospital's prior year actual gross
revenues per adjusted admission inflated forward by the
hospital's applicable current year's maximum allowable rate of
increase or the board-approved budgeted gross revenues per
adjusted admission, whichever is higher; provided that, in
cases where the board has approved a rate of increase below
the MARY, the board-approved maximum allowable rate of
increase shall apply.

2. Except for hospitals filing a budget pursuant
to subsection (1), each hospital, at least 90 days prior to
the commencement of its next fiscal year, shall file with the
board a certified statement, hereafter known as the "budget
letter," acknowledging its applicable maximum allowable rate
of increase in gross revenue per adjusted admission from the
previous fiscal year as calculated pursuant to s. 407.302(17),
and its maximum projected gross revenue per adjusted admission
for the next fiscal year, and shall affirm that the hospital
shall not exceed such applicable maximum allowable rate of
increase. Such letter shall be deemed to be the budget for

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the hospital for that fiscal year and shall be automatically
approved by operation of law. However, the board shall have
30 days from receipt of the budget letter to determine if the
gross revenues per adjusted admission submitted by the
hospital are within the maximum allowable rate of increase for
that hospital.
(b) If a hospital's gross revenues per adjusted
admission, as determined by its audited actual experience in
any one year, increases at a percentage rate less than the
maximum allowable rate of increase or board-approved rate of
increase, whichever is lower, the hospital may carry forward
the difference, and earn up to a cumulative maximum of 3
"banked" percentage points which may be banked to be used in
the future. Such banked percentage points may be added to the
hospital's maximum allowable rate of increase to increase the
gross revenues per adjusted admission in future years; or such
points may be used in the current fiscal year if a budget
amendment would have been required to keep the hospital out of
a penalty situation, provided that the hospital shall use its
original approved maximum allowable rate of increase as its
base. The hospital shall specify in the budget letter, or in
an amendment to the budget letter submitted before the end of
the hospital's fiscal year, the number of banked percentage
points it intends to add to its maximum allowable rate of
increase to increase its gross revenues per adjusted
admission. A hospital shall be required to use banked
percentage points before submitting a budget for detailed
review or before submitting a request for a budget amendment.
The board shall adopt rules which specify procedures for
hospitals to bank and use any percentage points as authorized
under this section.

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(3) At least 90 days prior to the beginning of its fiscal year, each hospital requesting a rate of increase in gross revenue per adjusted admission in excess of the maximum allowable rate of increase for the hospital's next fiscal year, or each hospital utilizing banked percentage points pursuant to paragraph (2)(b) and requesting a rate of increase in excess of the maximum allowable rate of increase plus the available banked percentage points, shall be subject to an in-depth budget review and shall file its projected budget with the board for approval. In determining the base, the hospital's prior year audited actual experience shall be used, unless the hospital's prior year audited actual experience exceeded the applicable rate of increase, in which case the base shall be the gross revenue per adjusted admission from the year before the prior year, increased by the applicable rate of increase for the prior year, and then inflated by the applicable rate of increase for the current year. As used in this subsection, "applicable rate of increase" means the HARI unless the board has approved a different rate of increase, in which case such rate of increase shall apply. The projected budget filed under 3, 407.05(5) shall be deemed approved unless it is disapproved by the board within 90 days after filing, except that where the hospital requests a hearing, the 90 days shall be tolled until 10 days after the board's receipt of the recommended order from the Division of Administrative Hearings of the Department of Administration. Upon agreement by the board and the hospital, the 90-day period may be waived or extended. As part of the review process conducted by the board, the board may approve, disapprove, or disapprove in part the projected budget. No hospital submitting a budget for approval shall operate at a

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level of expenditures or revenues which exceeds the maximum
allowable rate of increase minus 1 percentage point, unless a
higher rate of increase has been approved by the board.

However, a hospital with banked percentage points requesting a
rate of increase which exceeds the maximum allowable rate of
increase plus the banked percentage points shall not operate
at a level of expenditures or revenues in excess of 1
percentage point below the maximum allowable rate of increase
plus the banked percentage points.

(4) For purposes of budget review and comparison and
to assist in making determinations pursuant to subsection (5),
the board shall:

(a) Establish groupings of hospitals according to
characteristics, including, but not limited to, a measure of
the nature and range of services provided, teaching hospital
status, number of medical specialties represented on the
hospital staff, percentage of Medicare inpatient days, average
daily census, geographical differences, and case mix. The
rule shall provide for the establishment of not more than 15
general groups and for the establishment of additional
specialty groups as needed. However, no group shall contain
fewer than five hospitals.

(b) Establish statistical indicators per adjusted
admission to serve as measures of comparison based on the most
recent audited actual experience filed pursuant to s.
497.05(7) for the hospitals in each group. The statistical
indicators shall include, but not be limited to, gross
revenue, net revenue, and operating expenditures.

(5) The board shall review each budget filed pursuant
to subsection (3) and amendments filed pursuant to subsection
(6) to determine whether the rate of increase contained in the

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budget or amendment is just, reasonable, and not excessive.

In making such determination, the board shall consider and the hospital may use the following criteria in the following priority, with (a) the highest priority, and (l) the lowest priority:

(a) The ability of the hospital to earn a reasonable rate of return.

(b) The impact of patient days attributable to the medically indigent.

(c) The impact of patient days reimbursed by Medicaid.

(d) The impact of patient days reimbursed by Medicare.

(e) The cost and efficiency of providing the current level of services.

(f) The change in hospital costs as measured by changes in the severity of illness, including changes in the case mix.

(g) The actions taken by or the ability of a hospital to reduce the cost of services.

(h) The cost of providing new services or facilities regulated under s. 381.706. The cost of these services may not be included until these services or facilities have been approved by the designated state agency.

(i) The accuracy of previous budget submissions compared to the actual experience of the hospital.

(j) The research and educational services provided by the hospital if it is a teaching hospital.

(k) For psychiatric hospitals, the impact on hospital gross revenues associated with changes in the average length of stay of patients, changes in admissions to hospital units and changes in admissions to specific services and, when available, case mix.

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1. The expenses associated with the opening of a new
2. hospital for the first 3 years, and the nonrecurring or time-
3. limited expenses associated with a replacement hospital
4. relocated to a different medical service area for the first 3
5. years.
6. (6) After a hospital budget is approved, approved as
7. amended, or disapproved for a given fiscal year, no amendment
8. to such budget shall be made, except in accordance with the
9. following procedures:
10. (a) A request by a hospital to amend its budget shall
11. be filed in writing with supporting documents no later than 90
12. days before the end of the hospital's fiscal year. The budget
13. amendment shall be deemed approved unless it is disapproved or
14. disapproved in part by the board within 120 days after such
15. filing. Upon agreement by the board and the hospital, the
16. 120-day period may be waived or extended.
17. (b) After a hospital requests a budget amendment, but
18. before the final decision by the board on the amendment, the
19. board may extend provisional approval to any part of the
20. amendment. This provisional approval shall be superseded by
21. the final decision of the board.
22. (c) If approved by the board as part of a budget
23. amendment, the following items shall be applied retroactively
24. for the entire budget year of the hospital:
25. 1. Increased case mix, including increased severity of
26. illness and
27. 2. Unforeseen and unforeseeable increases in
28. malpractice insurance premiums, prior-year Medicare cost
29. report settlements, and retroactive changes in Medicare
30. reimbursement methodology.

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17. The board shall disapprove any budget or amendment
or part thereof as excessive that contains a rate of increase
which is not necessary to maintain total hospital costs at a
level reasonably related to total services provided and which
is not necessary to maintain a prudently managed hospital.

18. The board shall disapprove, in its entirety or in
part, any budget or any budget amendment that contains a rate
of increase which the board finds, pursuant to subsection (5),
to be unjust, unreasonable, or excessive.

19(a) Upon request of a budget or an amendment to a
budget, the staff of the board shall review the budget and
executive staff members designated by the board shall make
preliminary findings and recommendations in writing as to
whether the budget should be approved, disapproved, or
disapproved in part. The staff shall send the preliminary
findings by certified mail to the hospital. The hospital
shall have 14 days from the receipt of the preliminary
findings and recommendations to file written objections and
request a hearing with the board. If a hearing is desired, or
to file written objections if a hearing is not requested by
the hospital.

19(b) If a hearing is requested, it shall be conducted
by the board or, at the election of the board, by a hearing
officer of the Division of Administrative Hearings of the
Department of Administration, pursuant to the provisions of a.
Section 120.57. The Division of Administrative Hearings shall assign
at least two full-time hearing officers exclusively to hear
matters pertaining to this part. Hearings shall be held
within 30 days of filing the request, unless waived by the
board and the hospital. All hearings shall be held in
Tallahassee, unless the board determines otherwise.
(c) Recommended orders shall be issued within 30 days from the close of the hearing, unless waived by all parties.

(d) The failure of a hospital to request a hearing within 14 days of the receipt of the preliminary findings of the staff constitutes a waiver of the right of the hospital to contest the final decision of the board, and the board is authorized to enter a final order consistent with the staff's preliminary findings without further proceedings.

(e) During the pendency of any hearing or any appeal of a final order of the board, no hospital shall operate at a level of expenditures and revenues which exceeds the maximum allowable rate of increase minus 1 percentage point, unless a higher rate of increase has been approved by the board. However, a hospital with banked percentage points requesting a rate of increase which exceeds the maximum allowable rate of increase plus the banked percentage points shall not operate at a level of expenditures or revenues in excess of 1 percentage point below the maximum allowable rate of increase plus the banked percentage points.

(10) The board may publish its findings in connection with any review conducted under this section in the newspaper of the largest circulation in the county in which the hospital is located.

(11) Notwithstanding any other provisions of this part:

(a) Any hospital operated by the Department of Health and Rehabilitative Services or the Department of Corrections, any comprehensive rehabilitative hospital as defined in s. 407.002(24), any rural hospital as defined in s. 407.002(24), and the Florida Elks Children's Hospital located in West Palm Beach shall be exempt from filing a budget, shall be exempt from

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budget review and approval for exceeding the maximum allowable
rate of increase, and shall be exempt from any penalties
arising therefrom. However, each such hospital shall be
required to submit to the board its audited actual experience,
as required by s. 407.05(7).

(b) In addition, the board shall exempt any hospital
from filing a budget, from budget review and approval for
exceeding the maximum allowable rate of increase, and from any
penalties arising therefrom, upon a finding of the board that
the hospital, during the hospital's most recent audited actual
experience, had a prospective payment system, as defined in s.
407.13(2), which contained all of the elements set forth in s.
407.13(4)(a)-(e) for at least 90 percent of the hospital's
admissions, exclusive of Medicare, Medicaid, and any other
patients which meet the board's definition for charity care.

Such exception shall be on a year-to-year basis, upon a
finding by the board that the hospital has met the
requirements of this subsection each year. Each hospital
exempted from budget review pursuant to this paragraph shall
submit to the board its audited actual experience, as required
by s. 407.05(7). This paragraph is repealed, and shall be
subject to review by the Legislature pursuant to s. 11.61,
upon a finding by the board that at least 25 percent of
hospitals which would have otherwise been subject to budget
review are excluded from budget review pursuant to this
paragraph. Such repeal shall take effect on July 1 following
the date on which the board makes a finding that the 25-
percent level, as set forth in this paragraph, has been
reached.

(12) The review and approval of hospital budgets
pursuant to this act shall apply to hospital budgets for

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fiscal years which begin on or after February 1, 1989.
Notwithstanding any other provision in this act to the
contrary, any budget or budget amendment for fiscal years
beginning prior to February 1, 1989, shall be filed and
reviewed pursuant to chapter 84-35, Laws of Florida, and rules
adopted by the board pursuant thereto.

Section 47. Section 395.5094, Florida Statutes, is
renumbered as section 407.51, Florida Statutes, and amended to
read:

407.51 395-5094 Exceeding approved budget or previous
year's actual experience by more than maximum rate of
increase; allowing or authorizing operating revenue or
expenditures to exceed amount in approved budget; penalties.—

(1) The board shall annually compare the audited
actual experience of each hospital to the audited actual
experience of that hospital for the previous year.

(a) For hospitals submitting budget letters, if the
board determines that the audited actual experience of a
hospital exceeded its previous year's audited actual
experience by more than the maximum allowable rate of increase
as certified in the budget letter, the amount of such excess
shall be determined by the board and a penalty shall be levied
against such hospital pursuant to subsection (2).

(b) For hospitals subject to budget review, if the
board determines that the audited actual experience of a
hospital or exceeded its previous year's audited actual
experience by more than the most recent approved budget or the
most recent approved budget as amended the-projected-budget-as
approved-by-the-board,-whichever-is-greater, the amount of
such excess shall be determined by the board, and a penalty

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shall be levied against such hospital pursuant to subsection
based-thereon-as-follows:
(c) For hospitals submitting a budget letter and for
hospitals subject to budget review, the board shall annually
compare each hospital's audited actual experience for net
revenues per adjusted admission to the hospital's audited
actual experience for net revenues per adjusted admission for
the previous year. If the rate of increase in net revenues
per adjusted admission between the previous year and the
current year was less than the market basket index plus 2
percentage points, the hospital may carry forward the
difference and earn up to a cumulative maximum of 3 banked net
revenue percentage points. Such banked net revenue percentage
points shall be available to the hospital to offset in any
future-year penalties for exceeding the approved budget or the
maximum allowable rate of increase as set forth in subsection
(f.). Nothing in this paragraph shall be used by a hospital to
justify the approval of a budget or a budget amendment by the
board in excess of the maximum allowable rate of increase
pursuant to s. 407.50.

(2) Penalties shall be assessed as follows:
(a) For the first occurrence within a 5-year period,
the board shall prospectively reduce the current budget of the
hospital by the amount of the excess up to 5 percent; and, if
such excess is greater than 5 percent over the maximum
allowable rate of increase, any amount in excess of 5 percent
shall be levied by the board as a fine against such hospital,
to be deposited in the Public Medical Assistance Trust Fund,
as created in s. 409.2662.
(b) For the second occurrence within the 5-year period
following the first occurrence as set forth in paragraph (a),
the board shall prospectively reduce the current budget of the
hospital by the amount of the excess up to 2 percent; and, if
such excess is greater than 2 percent over the maximum
allowable rate of increase, any amount in excess of 2 percent
shall be levied by the board as a fine against such hospital,
to be deposited in the Public Medical Assistance Trust Fund.

(c) For the third occurrence within the 5-year period
following the first occurrence as set forth in paragraph (a),
the board shall:

1. Levy a fine against the hospital in the total
amount of the excess, to be deposited in the Public Medical
Assistance Trust Fund.

2. Notify the Department of Health and Rehabilitative
Services of the violation, whereupon, the department shall not
accept any application for a certificate of need pursuant to
ss. 381.701-381.7155 381.701-381.715 from or on behalf of such
hospital until such time as the hospital has demonstrated, to
the satisfaction of the board, that, following the date the
penalty was imposed under subparagraph 1., the hospital has
stayed within its projected or amended budget or its
applicable maximum allowable rate of increase for a period of
at least 1 year. However, this provision does not apply with
respect to a certificate-of-need application filed to satisfy
a life or safety code violation.

3. Upon a determination that the hospital knowingly
and willfully generated such excess, notify the Department of
Health and Rehabilitative Services, whereupon the department
shall initiate disciplinary proceedings to deny, modify,
suspend, or revoke the license of such hospital or impose an
administrative fine on such hospital not to exceed $20,000.

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The determination of the amount of any such excess shall be based upon net revenues per adjusted admission excluding funds distributed to the hospital pursuant to s. 409.266(7) or s. 409.2663. However, in making such determination, the board shall appropriately reduce the amount of the excess by the total amount of the assessment paid by such hospital pursuant to s. 395.101 minus the amount of revenues received by the hospital through the operation of s. 409.266(7) or s. 409.2663. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, its entitlement to such reduction. It is the intent of the Legislature that the Health Care Hospital Cost Containment Board, in levying any penalty imposed against a hospital for exceeding its maximum allowable rate of increase or its approved budget pursuant to this subsection, consider the effect of changes in the case mix of the hospital. It is the responsibility of the hospital to demonstrate, to the satisfaction of the board, any change in its case mix. For psychiatric hospitals, the board shall also reduce the amount of excess by utilizing as a proxy for case mix the change in a hospital's audited actual average length of stay as compared to the previous year's audited actual average length of stay without any thresholds or limitations.

(3) The following factors may be used by the board to reduce the amount of excess of the hospital as determined pursuant to this section:

(a) Unforeseen and unforeseeable events which affect the net revenue per adjusted admission and which are beyond the control of the hospital, such as prior-year Medicare cost report settlements, retroactive changes in Medicare

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If the board finds that any hospital chief executive officer, or any person who is in charge of hospital administration or operations, has knowingly and willfully allowed or authorized actual operating revenues or expenditures that are in excess of projected operating revenues or expenditures in the hospital's approved hospital budget as approved by the board, the board shall order such officer or person to pay an administrative fine not to exceed $5,000.
Section 50. Section 395.5092, Florida Statutes, is renumbered as section 407.54, Florida Statutes, and amended to read:

407.54  395.5092  Budget review proceedings; duty of Public Counsel.—Notwithstanding any other provisions of this chapter or part, it shall be the duty of the Public Counsel to represent the general public of the state in any proceeding before the board or its advisory panels, in any administrative hearing conducted pursuant to the provisions of s. 120.57, or before any other state and federal agencies and courts, in any issue related to budget review. With respect to any such proceeding, the Public Counsel is subject to the provisions of ss. 350.061-350.0614.

Section 51. Section 395.52, Florida Statutes, is renumbered as section 407.70, Florida Statutes, and amended to read:

407.70 395.52  Information relating to physician's charges.—

(1) The Health Care Cost Containment Board may, in its discretion, require the submission by hospitals of information relating to charges made by a physician with respect to hospital services. However, any physician who provides services within a hospital is exempt from the provisions of this section if he bills his services independently of the hospital.

(2) The board shall publish, based on information provided by insurers, an annual report containing available physician charge comparisons, profiles, and related information, and shall disseminate the report in the manner provided in s. 407.09. Each health insurer regulated pursuant

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section 52. The board shall contract with the State University System for an 18-month study. Within the established time frame, the study shall determine the following:

(a) By February 1, 1990, a recommendation to the board for a Florida-specific measure of changes in hospital input prices, which shall include consideration of the need for regional-specific adjustments to reflect geographic differences between Florida hospitals. The Florida Hospital Input Price Index (FHPI) shall consider and include, but not be limited to, the components of the National Hospital Input Price Index weighted for Florida-specific experience, as well as other expense components not currently included in the National Hospital Input Price Index. The study is directed to consider expense trends during the past 8 years, as well as unusual expense increases such as for nurses. By February 1, 1990, the contractor shall also recommend to the board a methodology and reporting system to measure the impact annually of changes in reimbursement methodologies and changes in reimbursement levels from all government payers and increases in uncompensated care, including bad debts. The board shall submit the results of these two parts of the study.
to the Legislature along with recommendations as to
application by March 1, 1990.

(2) By January 1, 1999, a recommendation to the board
as to a statistical measure or index for severity of illness.
The board shall submit the results of this part of the study
to the Legislature along with recommendations as to
application by March 1, 1990.

(3) By February 1, 1999, a recommendation to the board
for the development of a severity index for psychiatric
hospitals. The board shall submit the results of this part of
the study to the Legislature along with its recommendations as
to application by March 1, 1990.

Section 53. 11. The Health Care Cost Containment
Board shall conduct a special study of the shortage in the
supply of registered nurses in, and the demand for registered
nurses by, hospitals, nursing homes, and other providers of
health care in Florida. The study shall include, but not
necessarily confine itself to, the following issues:

(a) The extent of the shortage as it relates to
different types of providers of health care and specialties of
nursing care.

(b) The causes of the shortage, including, but not
restricted to, the effects of considerations of salary,
benefits, working conditions, and career development.

(c) The impact of the labor shortage on the
availability, quality, and costs of services provided by
hospitals, nursing homes, and other providers, such as
physicians, home health agencies, and hospices.

(d) The impact of the labor shortage on the increased
use of temporary nursing pool agencies by institutional
providers; the influence of this trend on the availability,

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quality, and costs of services provided; and the costs and
benefits of potential regulation of such nursing pool agencies
in light of the shortage.

(e) Comparisons of the extent and effects of said
shortage in Florida to similar features of the experiences of
other states and of national trends.

(f) The need for and the feasibility of various
measures to enhance the image of the nursing profession and
the recruitment of individuals into the profession, including
nurse recruitment centers, human services counseling efforts
directed towards students at the junior and senior high school
level, educational outreach, and job placement programs.

(g) The implications of the shortage as it relates to
the supply of and need for related para-professionals and other
health care workers, such as licensed practical nurses,
certified nurses' aides, and nursing assistants.

(h) The feasibility of allocating loans, grants, and
scholarships for the purpose of providing greater incentive
for and access to the study of nursing in Florida, and the
probable effects of such efforts.

(i) The desirability of demonstration projects
designed to test innovative and alternative models of nursing
practice, roles, and responsibilities, and wage and benefit
structures; and methods for the application of successful
models for the purpose of addressing causes of the shortage.

(j) The need for promoting educational articulation
efforts designed to facilitate the transition between
different types of nursing education programs.

(2) The study of the shortage in the supply of
registered nurses shall be conducted by the Health Care Cost
Containment Board through the use of a special technical

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assistance panel convened for the purposes of this study. The
panel shall reflect representation from each of the following
groups:

1. The nursing profession, including at least one
representative from the temporary nursing pool industry.

2. The hospital industry.

3. The nursing home industry.

4. Nursing education professionals representing at a
minimum, baccalaureate and associate degree programs.

5. Other parties as deemed appropriate by the board.

Stimulation of the roles and responsibilities of the technical
assistance panel in satisfying the provisions of this section,
as well as the panel's exact composition, shall be at the
discretion of the Health Care Cost Containment Board, subject
to the following:

1. The Health Care Cost Containment Board shall
complete an interim report detailing the progress of the study
by March 15, 1990; shall complete the final version of the
study, along with specific data-based conclusions and
recommendations for alleviating the shortage of the supply of
nurses in Florida, on or before February 1, 1990; and shall
file copies of the interim and final versions of same with the
Legislature and the Governor.

2. Money shall be appropriated to the Health Care
Cost Containment Board from the Health Care Cost Containment
Trust Fund for the purpose of satisfying the provisions of
this section. These funds may be used for the hiring of
consultants or contracting with members of the State
University System to conduct certain aspects of the study at
the discretion of the Health Care Cost Containment Board.
(5) This section shall take effect upon becoming a law.

Section 54. (1) The Health Care Cost Containment Board is directed to undertake a study of the impact on hospitals in Florida of providing health care services to migrant and rural farmworkers. Further, the board, in consultation with the Department of Health and Rehabilitative Services, the Office of Medicaid Services of the department, and the appropriations committees of the Senate and House of Representatives, shall recommend in the study methods of reimbursement for hospitals providing services, including obstetrical services, to migrant and rural farmworkers. This study shall be presented to the chairman of the appropriations committee no later than January 31, 1988.

(2) This section shall take effect upon becoming a law.

Section 55. Subsections (7) and (8) of section 409.266, Florida Statutes, are amended, and subsection (18) is added to said section, to read:

409.266 Medical assistance.--

(7) The Department of Health and Rehabilitative Services shall, within the intent of this section, expand payment for medical services to additional eligible persons as provided herein:

(a) The department shall, by rule, increase the Medicaid outpatient hospital services cap from $500 to $1,000, effective October 1, 1987.

(b) Beginning July 1, 1984, the department is authorized to use up to $10 million from the Public Medical Assistance Trust Fund, as created in s. 409.2662, to establish a primary care system programs for Medicaid clients and other

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low-income persons by developing primary care programs contracted through the county public health units pursuant to s. 154.011.

(c) Beginning July 1, 1987, the department is authorized to use up to $20 million from the Public Medical Assistance Trust Fund in addition to the moneys authorized in paragraph (b), for a total of $30 million for fiscal year 1987-1988, in order to expand primary care programs for low-income persons to each county pursuant to s. 154.011.

(d) Beginning July 1, 1985, the department shall provide by rule for the delivery of Medicaid services to:

1. Financially eligible individuals under age 21 who are children in intact families;
2. Financially eligible unemployed parents and their children who are under age 18; and
3. Financially eligible married pregnant women.

Financial eligibility shall be based on the income and resource standards for Aid to Families with Dependent Children. The definition of the term "unemployed" shall be based on federal regulations.

(e) The department shall provide, by rule, for the delivery of federally approved Medicaid services to qualified elderly persons and disabled persons whose family incomes are below 100 percent of the federal nonfarm poverty level.

(f) Beginning October 1, 1987, the department shall provide, by rule, for the delivery of Medicaid services as specified in paragraph (j) to qualified pregnant women whose family incomes are below 100 percent of the federal nonfarm poverty level.

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(g) Beginning October 1, 1987, the department shall provide, by rule, for the delivery of federally approved Medicaid services to qualified infants and children under 5 years of age, whose family incomes are below 100 percent of the federal nonfarm poverty level, and shall phase in additional age limits as follows:

1. Beginning October 1, 1988, Medicaid benefits shall be extended to cover eligible children under the age of 3.

2. Beginning October 1, 1989, Medicaid benefits shall be extended to cover eligible children under the age of 4.

3. Beginning October 1, 1990, Medicaid benefits shall be extended to cover eligible children under the age of 5.

(h) The department is prohibited from applying a resource test to those pregnant women or children who are made eligible for Medicaid services under paragraph (f) or paragraph (g), unless such persons also receive Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) benefits.

(i) Beginning October 1, 1987, the department is directed to implement the federal option of presumptive eligibility in accordance with 42 U.S.C., ss. 1396(a)(47) and 1396r, for all Medicaid-eligible pregnant women who affirm their family income to be within the Medicaid eligibility standards.

(j) The specific Medicaid services referred to be provided in paragraphs (e) through (i) shall be those authorized by the Federal Sixth Omnibus Budget Reconciliation

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Act or the Federal Seventh Omnibus Budget Reconciliation Act

and provided for in the General Appropriations Act.

(k) Beginning July 1, 1986, the department shall
establish, by rule, a Medicaid medically needy program that
will provide services for which categorically eligible persons
are entitled, except for long-term institutional services.
These services shall be provided to persons who meet
categorical eligibility requirements, other than requirements
relating to income limitations. The maximum income
eligibility for services through the medically needy program
shall be set at up to 133 1/3 percent of the payment standard
for eligibility for Aid to Families with Dependent Children,
the percentage to be set by the department in consultation
with the appropriations committees of the Senate and the House
of Representatives and based upon recurring funds available.

2. On or before March 1, 1987, the department shall
submit to the President of the Senate, the Senate Minority
Leader, the Speaker of the House of Representatives, and the
Minority Leader of the House of Representatives, a report on
the status of the Medicaid medically needy program and any of
the other Medicaid programs which expand eligibility to
national groups and which are funded from the Public Medical
Assistance Trust Fund. The report shall include, but need not
be limited to, the following:

a. The amounts reimbursed to providers, arranged by
major types of providers, and the amount hospitals were
assessed for the Public Medical Assistance Trust Fund.

b. Any evidence of a shift in the burden of
uncompensated care among hospitals, based on hospital
assessments and reimbursements from the Public Medical
Assistance Trust Fund.

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c. The impact in the eligibility for and the
reimbursements from the expanded Medicaid eligibility programs
on the budgets of county public health units and the
children's medical services budget.
d. Caseload information concerning Aid to Families
With Dependent Children and Supplemental Security Income
clients who were screened and determined eligible, as a
result of the medically needy eligibility determination
process.
e. Information relating to attrition rates at the
various stages of the application process.
f. An assessment of the impact of the payment level
for clients receiving Aid to Families With Dependent Children
on the average medically needy spend-down payment level.
g. Recommendations for program improvements, including
recommendations relating to administrative issues, additional
services to be offered, interface with providers, and possible
funding mechanisms.
h. Projections of caseloads for the next 3 fiscal
years for programs funded from the Public Medical Assistance
Trust Fund and projections of any surplus or deficit resulting
from those caseload projections.
(8) The department shall, within the intent of this
section, expand payment for Medicaid services as follows:
(a) Beginning October 1, 1987, the department is
directed to increase all Medicaid physician reimbursement up
to a minimum of the Medicare 50th percentile as published in
the 1986 Medicare Part B Procedure Codes and Prevailing
Allowances, to be phased in over a 5-year period, except,
however, effective October 1, 1987:

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1. The department shall increase the Medicaid physician reimbursement rate for office visits to the Medicare 50th percentile.

2. Reimbursement fees to physicians for providing total obstetrical services to Medicaid recipients, which include prenatal, delivery, and postpartum care, shall be at least $800 per delivery for a pregnant woman with low medical risk and at least $1,200 per delivery for a pregnant woman with high medical risk. Nurse midwives licensed under chapter 464 and chapter 467 shall be paid at no less than 80 percent of the low medical risk fee. The department shall by rule determine, for the purpose of this paragraph, what constitutes a high or low medical risk pregnant woman. Such determination shall not include a consideration of whether a caesarean section was performed. The department shall by rule determine a pro-rated payment for obstetrical services in cases where only part of the total prenatal, delivery, or postpartum care was performed. The department shall review these reimbursement fees annually in relation to the actual cost of providing the obstetrical care, and shall make recommendations to the Legislature for appropriate increases as necessary.

3. Reimbursement per day per patient to a physician licensed under chapter 458 or chapter 459, who is certified or is eligible for certification by an appropriate board to practice neonatal-perinatal medicine or pediatric critical care medicine, shall be limited to no more than 10 percent of the total obstetrical service delivery rate for a high medical risk pregnant woman. The department may by rule establish a graduated fee schedule which is based on the complexity and severity of the infant's medical problems. However, in no

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instance shall the physician's daily reimbursement per patient
be set at less than $50.

(b) The department shall phase in increases to the
Medicaid physician reimbursement rates up to a minimum of the
Medicare 50th percentile, utilizing the Florida Medicare Area
B allowances, as follows:

1. Beginning October 1, 1988, the department shall
increase fees for all remaining physician visits, including
critical care visits, hospital visits, and nursing home
visits, and for services rendered within the 25 most frequent
surgical procedure code groups as determined by the
department, and for those surgical procedures performed on
children by physicians licensed under chapter 458 or chapter
459 who are certified or eligible for certification by an
appropriate board to practice pediatric surgery.

2. Beginning October 1, 1989, the department shall
increase fees for anesthesiologist procedures.

3. Beginning October 1, 1990, the department shall
increase fees for radiology and pathology procedures.

4. Beginning October 1, 1991, the department shall
increase fees for the remaining surgical procedures and for
all remaining procedures not previously increased.

(c) Consistent with the legislative intent to
emphasize primary and preventive health services as they apply
to children, beginning October 1, 1987, the department is
directed to provide, by rule, for the expansion of Medicaid
coverage to increase provider fees for early periodic
screening, diagnosis and treatment of Medicaid-eligible
children up to a minimum of $30 per unit. The department
shall review provider fees annually in relation to the actual
cost of providing the screening, diagnosis, and treatment, and

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1. shall make recommendations to the Legislature for appropriate
2. increases as necessary.
3. (d) Beginning October 1, 1987, the department shall
4. provide, by rule, for a 100-percent increase in Medicaid
5. provider fees for home health care services, up to a maximum
6. of 55 percent of the Medicare maximum allowance; however,
7. licensed practical nurses shall be reimbursed 15 percent less
8. than registered nurses.
9. (e) Beginning October 1, 1987, the department shall
10. reimburse physicians $35 per unit to provide annual health
11. screening and diagnostic services for Medicaid-eligible
12. adults. The department shall review provider fees annually in
13. relation to the actual cost of providing the screening and
14. diagnosis, and shall make recommendations to the Legislature
15. for appropriate increases as necessary.
16. (f) Beginning October 1, 1987, the department shall
17. increase access to primary dental care by increasing Medicaid
18. dental fees to 100 percent of the October 1, 1984,
19. departmental fee schedule for non-Medicaid clients as
20. determined by the advisory Dental Fee Committee.
21. (g) The department is directed to pursue alternatives
22. with the Federal Health Care Financing Administration to
23. extend the limit on inpatient hospitalization to 90 days
24. beginning October 1, 1988, for all Medicaid-eligible neonates
25. receiving services in regional perinatal intensive care
26. centers as defined in s. 393.16(3), or in affiliated centers
27. as defined in s. 393.16(4). If by January 1, 1989, the
28. department is unable to reach agreement with the Health Care
29. Financing Administration to extend the length of inpatient
30. hospital days for such neonates, then the department is
31. directed to extend the length of stay for inpatient hospital

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services to 90 days for all eligible children under 21, which
participate in the Medicaid Early Periodic Screening,
Diagnosis, and Treatment Program. Notwithstanding the
provisions of § 409.267, counties shall be exempt from
contributing towards the cost of this extension from the 46th
to the 90th day. The provisions of this subsection shall be
funded by an appropriation to the department from the Public
Medical Assistance Trust Fund pursuant to § 409.2661.

Section 56. Subsections (1) and (6) of section
409.2661, Florida Statutes, are amended to read:

409.2661 Medically indigent demonstration projects.--
Beginning July 1, 1987, the department is directed to plan for
and establish medically indigent demonstration projects and to
evaluate the impact of each on improving access to services by
persons who are medically underserved.

(1) The department shall contract to assist in funding
two one rural and two one urban demonstration primary care
health training project which links the provision of primary
care services to low-income persons with the education of
medical students, interns, and residents. Such program shall
at a minimum:

(a) Be sponsored by state-approved medical schools
which shall be responsible for the clinical training and
supervision.

(b) Cover large geographical areas and large numbers
of patients.

(c) Utilize a multidisciplinary approach with
appropriate medical supervision.

Nothing in this subsection shall preclude a primary care
health training demonstration project from utilizing current:

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community resources such as county public health units,
primary care programs, or other established cooperative
agreements. Each primary care health training demonstration
project shall be eligible for up to $1 million of funds
appropriated pursuant to subsection (6).

(6) Not more than $5 million in total shall be
appropriated for the medically indigent demonstration
projects; provided, however, that each demonstration project
shall be awarded no more than $1 million to cover service,
administration, and start-up costs. This money shall be
derived exclusively from the Public Medical Assistance Trust
Fund.

Section 57. Subsection (4) of section 409.2662,
Florida Statutes, is amended to read:
409.2662 Public Medical Assistance Trust Fund,--
(4) Moneys deposited into the Public Medical
Assistance Trust Fund shall be used solely for the purposes
set out in this section, in s. 14, chapter 87-92, Laws of
Florida, and in ss. 240.4067, 381.703(3), 409.266(7), 118,
and 19, 409.2661, 409.2663, and 409.701,
Section 58. Effective July 1, 1988, or upon becoming a
law, whichever occurs later, section 409.2663, Florida
Statutes, is amended to read:
409.2663 Redistribution of funds in the Public Medical
Assistance Trust Fund,--
(1) LEGISLATIVE INTENT.--The Legislature finds that
the Public Medical Assistance Trust Fund was created for the
purpose of providing equity among hospitals in the provision
of indigent health care services. The Legislature further
finds that at this time, the Medicaid medically needy program
and the categorical expansion of the Medicaid program are
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The Legislature concludes that additional mechanisms for the redistribution of funds in the Public Medical Assistance Trust Fund are needed in order to accomplish the original intent, including a direct redistribution of trust fund dollars to hospitals which are major providers of indigent care. However, a redistribution formula is considered appropriate only for the short term until other, more appropriate, mechanisms for equalizing the indigent care burden among hospitals can be established. Further, it is the intent of the Legislature that local governments or tax districts county-governments shall not reduce county contributions to hospitals for-indigent-care as a result of funds redistributed to hospitals pursuant to this section and shall provide, at a minimum, the same level of funding as provided for during the last fiscal year in that county.

(2) DEFINITIONS.--As used in this section:

(a) "Adjusted patient day" means the sum of acute patient days and intensive care patient days divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues.

(b) "Audited actual data" or "audited actual experience" means data contained within financial statements examined by an independent, Florida-licensed, certified public accountant, in accordance with generally accepted auditing standards.

(c) "Bad-debts" means that portion of hospital charges for-care-provided-to-a-patient-whose-family-income-fails-to qualify-him-for-charity-care-and-for-which-there-is-no

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(g) "Board" means the Health Care Hospital Containment Board as established in s. 407.01395.003.

(d) "Charity care" means that portion of hospital charges reported to the board for which there is no compensation for care provided to a patient whose family income for the 12 months preceding the determination is less than or equal to below 150 percent of the federal nonfarm poverty level unless the amount of hospital charges due from the patient exceeds 25 percent of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four times the federal nonfarm poverty level for a family of four be considered charity, and for which there is no compensation. Charity care, for the purposes of this section, shall not include administrative or courtesy discounts, contractual allowances to third-party payers, or failure of a hospital to collect full per diem charges from Medicare or Medicaid sponsored patients; failure to collect full charges due to grants or partial payment by government programs or charity care reported to comply with the requirements of the Hill-Burton Hospital and Medical Facilities Construction Plan.

(f) "Charity care days" means the sum of charity care divided by gross revenues per adjusted patient day.

(g) "Department" means the Department of Health and Rehabilitative Services.

(h) "Hospital" means a health care institution as defined in s. 395.002(6).
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(h) "Gross revenue" means the sum of daily hospital
service charges, ambulatory service charges, ancillary service
charges, and other operating revenue. Gross revenues do not
include contributions, donations, legacies, or bequests made
to a hospital without restriction by the donors.

(i) "Public Medical Assistance Trust Fund" or
"trust fund" means the Public Medical Assistance Trust Fund as
established in s. 409.2662.

(t)-"Uncompensated-care" means the sum of charity-care
and-bed-debts.

(t) "Uncompensated-care-days" means the sum of
uncompensated-care-divided-by-gross-revenue-per-adjusted
patient-day.

(3) HOSPITAL REDISTRIBUTION OF PUBLIC MEDICAL
ASSISTANCE TRUST FUND SURPLUS.--The hospital-redistribution-of
surplus-funds-in-the-Public-Medical-Assistance-Trust-Fund
shall-be-based-upon-fiscal-1986-hospital-data-as-reported-to
the-board.

(a) Beginning September 30, 1985, the department shall
distribute, pursuant to this subsection, up to $70 million
from surplus trust funds in four quarterly payments to
hospitals which meet the following criteria:

1. The hospital began contributing to the trust fund
on or before January 1, 1986; and

2. The dollar-volume of charity-care reported to the
board for the quarter for which payment is requested was equal
to or exceeded 2 percent of the hospital's gross-revenues.

(b) Hospitals which meet the criteria of subparagraphs
(a), and 2., and which desire to participate in the
redistributions designated in this subsection, shall submit

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the following data to the board for each reporting period in
which the hospital wishes to participate:

1. Actual gross revenues for the reporting period.

2. Actual documented charity care written off for the
reporting period, based on patients discharged, provided that
the last service rendered to a given charity patient occurred
not more than 60 days prior to the beginning of the reporting
period.

3. One-fourth of its annual budgeted restricted and
unrestricted revenues from local governments or tax districts
as reported to the Health Care Cost Containment Board for the
year or years which comprise the reporting period.

4. For any charity care reported for a patient whose
length of stay exceeded 12 days, the aggregate total charges
associated with the 13th and subsequent days.

(c) Hospitals shall report and be paid based on the
following schedule:

1. For the months of April, May, and June 1988, the
hospital shall report by August 1, 1988, to qualify for a

2. For the months of July, August, and September 1988,
the hospital shall report by November 1, 1988, to qualify for
a quarterly payment due on December 31, 1988.

3. For the months of October, November, and December
1988, the hospital shall report by February 1, 1989, to
qualify for a quarterly payment due on March 31, 1989.

4. For the months of January, February, and March
1989, the hospital shall report by May 1, 1989, to qualify for
a quarterly payment due on June 30, 1989.

(d) Hospitals which report to the board under the
provisions of paragraph (c) shall maintain documented data on

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each charity care patient's income as determined by rule by
the board. Such documented data shall be subject to periodic
audit by the board.

(e) By the first day of September 1988, December 1988,
March 1989, and June 1989, the board shall determine and
certify to the department for payment the amount of funds to
be redistributed to each hospital, for each eligible quarter,
according to the following formula:

1. For each quarter, the board shall calculate the
dollar amount by which charity care exceeds 2 percent of the
hospital's gross revenues after deducting 50 percent of the
restricted and unrestricted revenues provided to a hospital by
local governments or tax districts, and shall subtract from
such excess the total charges associated with the 13th and
subsequent days. The board then shall convert the difference
remaining from such subtraction into charity care days. For
each such charity care day, the hospital shall earn 80 percent
of the hospital's most recent Medicaid per diem rate, as
determined by the department. Hospitals ineligible to
participate in the Medicaid program shall be reimbursed at 90
percent of their cost per adjusted day as determined from the
most recent audited actual data accepted by the board.

2. If the total quarterly amount due to all hospitals
eligible under this paragraph exceeds $17.5 million, each
hospital's share shall be reduced on a pro rata basis so that
the total dollars redistributed from the trust fund do not
exceed $70 million a year; provided that no hospital shall
earn more than one-third of each quarterly distribution. If
the total $17.5 million dollars is not distributed for any
quarter, the unspent portion shall be rolled forward and shall

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be distributed with any money due on the fourth and final distribution.

(f) From the amount due each hospital as certified by the board, the department shall redistribute surplus trust funds in quarterly payments as provided for in subsection (e).

(g) Each hospital which receives any of the redistribution under this subsection shall, at the end of the hospital's fiscal year in which any redistribution was received, provide audited actual data to the board to substantiate the quarterly reported data on which the redistribution was based. The board shall calculate any overpayment or underpayment owed to the hospital based on this audited data and correct the error in the next scheduled quarterly redistribution. In the event that the hospital does not qualify for the last quarterly redistribution or there is not any future redistribution available, and the hospital received more surplus trust funds than the hospital was entitled to under this section, the hospital shall, as a condition of participating in the redistribution, agree to reimburse the department for the excess. If the department is unable to collect these excess funds from the hospital for any reason, it is authorized to impose administrative fines of up to $500 per day, for each day the hospital fails to pay, for the first 30 days, and up to $5,000 per day for each day the hospital fails to pay thereafter. Neither the department nor the board shall be held liable for any funds underpaid to a hospital after the fourth quarterly payment, once the total $70 million has been redistributed.

COUDING: Words stricken are deletions; words underlined are additions.
(a) During state fiscal year 1967-1968, the department shall redistribute $69.5 million in trust funds to hospitals which meet the following criteria:

1. The hospital began contributing to the trust fund on or before January 1, 1967.

2. The hospital provided at least 2.5 percent of its total inpatient days to Medicaid eligibles or a combination of charity care days and Medicaid days which, when added together, equals at least 5 percent of the total inpatient days during the hospital's 1966 fiscal year.

3. Ineligible to participate in the Medicaid program due to the nature of the services it provides is exempt from this requirement.

4. The dollar value of uncompensated care provided by the hospital during the hospital's 1966 fiscal year exceeded 5 percent of the hospital's gross revenues.

(b) By July 1, 1967, the board shall calculate the first-year redistribution amount for each hospital meeting all criteria of paragraph (a) based on the following formula:

1. The board shall calculate the dollar amount by which uncompensated care exceeded 5 percent of the hospital's gross revenue and then convert the dollar amount of excess revenue into uncompensated care days.

2. For each uncompensated care day provided above the 5 percent of gross revenues level, the hospital shall earn 50 percent of the hospital's Medicaid per diem rate as determined by the department, for up to 12 days per admission.

3. Day-length-of-stay adjustment factor as determined by the indentigent-care-study-conducted pursuant to section 6 of chapter 107.

CODING: Words stricken are deletions; words underlined are additions.
04-35\r\rLaws of Florida is s. 7054; -- The number of uncompensated
1 care-days are to be reduced by this factor.
2\r\r5\r\rFifty percent of the restricted and unrestricted
3 revenues provided to a hospital by local governments or tax
4 districts shall be considered as offsets against uncompensated
5 care.
6\r\r4\r\rNo hospital shall be entitled to receive more than
50 percent of the total amount of trust funds to be
8 distributed.
9\r\r5\r\rIf the total amount earned by all hospitals under
this paragraph exceeds $69.5 million, each hospital's share
shall be reduced on a pro rata basis so that the total dollars
redistributed from the trust fund do not exceed $69.5 million
for the year.
\r\r\r(c) The board shall certify to the department the
amount owed each hospital by July 31, 1987, and the department
shall disburse the funds in quarterly allotments as follows:
\r\r1\r\rOne quarterly payment by July 31, 1987\r\r2\r\rOne quarterly payment by October 31, 1987\r\r3\r\rOne quarterly payment by January 31, 1988\r\r4\r\rOne quarterly payment by April 30, 1988\r\r(4) Funds distributed to a hospital pursuant to this
section shall not be considered as net revenues of such
hospital in determining whether an excess has occurred
pursuant to s. 407.51, 395.5094. However, if an excess occurs,
the amount of the excess shall be reduced by the difference
derived from subtracting such funds shall be included in
determining the reduction of the amount of the excess for the
amount of revenues received by the hospital pursuant to this
section or s. 409.266(7) from the assessment paid by the
hospital pursuant to s. 395.101 minus the amount of revenues

CODING: Words stricken are deletions; words underlined are additions.
received-by-the-hospital-pursuant-to-this-section-or-sr
469:266{76.

{5}--A-hospital-may-correctly-subject-to-verification-by
the-hospitals-independent-certified-auditors,-its-1986-fiscal
year-data-up-until-90-days-after-the-effective-date-of-this
act.--Based-upon-this-corrected-data,-the-board-shall
recalculate-the-distribution-due-under-this-act-no-later-than
October-15,-1987,-and-shall-certify-to-the-department-a
revised-formula-by-October-25,-1987.--Amounts-previously
distributed-may-be-adjusted-based-upon-this-final
determination.

Section 59. Subsection (3) of section 627.9175,
Florida Statutes, is amended to read:
627.9175 Reports of information on health insurance.--
{3}--Each-health-insurer-shall-annually-submit-to-the
department-available-information-related-to-physician-charges;
the-department-shall-provide-by-rule-a-uniform-format-for-the
submission-of-this-information-in-order-to-allow-for
meaningful-comparisons-of-physician-charge-data.--The
department,-in-conjunction-with-the-health-insurance-industry
and-the-Hospital-Cost-Containment-Board,-shall-make-an-initial
report-to-the-1985-regular-session-of-the-legislature-as-to
the-feasibility-of-subdividing-total-physician-charges-by
specialty-and-subdividing-the-most-commonly-used-procedures-by
location-in-this-state.--The-department-shall-provide
information-collected-under-this-subsection-to-the-Hospital
Cost-Containment-Board-for-dissemination-under-the-provisions
of-sr.-395.504(9)(b).

Section 60. Sections 60 through 68 may be cited as the
"Rural Hospital Act of 1988."

Section 61. Legislative findings and intent.--

CODING: Words stricken are deletions; words underlined are additions.
The Legislature finds that rural hospitals are the nucleus or "backbone" of rural health care systems. Public health programs and physicians depend on rural hospitals to meet many of their medical needs. Rural hospitals are usually the only source of emergency medical care in rural areas for life-threatening situations and play a crucial role in attracting physicians to rural areas. The Legislature deems the benefits derived from these features to be truly significant, as rural counties with hospitals have lower accidental death rates and lower incidence of low birth-weight than rural counties without hospitals. In addition, rural hospitals enhance their communities beyond the scope of health care, as they are among the largest employers in rural areas and substantially foster economic development and growth. For these reasons, the Legislature finds that rural hospitals are widely viewed as integral to the welfare of rural communities.

However, the rural health care system is experiencing significant instability as the financial viability of many of these hospitals is threatened. The Legislature finds that sharply declining occupancy rates, increasing dependence on Medicaid and Medicare reimbursements, liability concerns, frequent changes in ownership, high levels of bad debt, greater competition on more sophisticated levels with urban hospitals, and physician and personnel staffing problems threaten the existence of some rural hospitals.

It is the intent of the Legislature to ease the burdens experienced by rural hospitals in personnel staffing by providing financial incentives under the Medical Education Tuition Reimbursement Program in order to increase

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the number of primary care physicians and nurses in rural areas; and

(b) Requiring a study of problems unique to rural hospitals generated by existing licensure and certification requirements for allied health care practitioners in the state.

(3) In addition, it is the intent of the Legislature to ease the severe financial constraints being experienced by some rural hospitals by extending Medicaid reimbursements to rural hospital swing-beds and establishing the full utilization, when feasible, of rural hospital services by departmental primary care programs and programs serving the elderly citizens of the state.

(4) Furthermore, the Legislature encourages the Department of Health and Rehabilitative Services to actively foster the provision of health care services in rural areas and serve as a catalyst for improved health services to citizens in rural areas of the state. Among other considerations, the department is encouraged to:

(a) Promote location and relocation of health care practitioners in rural areas;

(b) Promote the financial viability of rural hospitals and their continued existence in rural counties;

(c) Intervene policies related to physician manpower, hospitals, primary care, and state regulatory functions;

(d) Collect relevant data on rural health care issues for use in departmental policy development;

(e) Propose solutions for problems affecting health care delivery in rural areas.

Section 62. Definitions.—As used in sections 60 through 68:

CODING: Words stricken are deletions; words underlined are additions.
1 (1) "Rural hospital" means an acute care hospital
2 licensed under chapter 395, Florida Statutes, with 65 beds or
3 less, which is:
4 (a) The sole provider within a county with a
5 population density of no greater than 100 persons per square
6 mile;
7 (b) An acute care hospital, in a county with a
8 population density of no greater than 100 persons per square
9 mile, which is at least 30 minutes of travel time, on normally
10 traveled roads under normal traffic conditions, from another
11 acute care hospital within the same county; or
12 (c) A provider supported by a hospital tax district
13 whose boundaries encompass a population of 100 persons or less
14 per square mile.
15 (2) "Rural area health education center" means an area
16 health education center (AHEC), as authorized by Pub. L. No.
17 94-484, which provides services in a county with a population
18 density of no greater than 100 persons per square mile.
19 (3) "Swing-bed" means a bed which can be used
20 interchangeably as either a hospital, skilled nursing facility
21 (SNF), or intermediate care facility (ICF) bed pursuant to the
22 Code of Federal Regulations, Parts 405, 435, 440, 442, and
23 447.
24 Section 63. Paragraph (c) of subsection (1) of section
25 154.011, Florida Statutes, is amended to read:
26 154.011 Primary care services.--
27 (1) It is the intent of the Legislature that all 67
28 counties offer primary care services through contracts, as
29 required by s. 154.011(3), for Medicaid recipients and other
30 qualified low-income persons. Therefore, beginning July 1,
31 1987, the Department of Health and Rehabilitative Services is
32
33 CODING: Words stricken are deletions; words underlined are additions.
directed, to the extent that funds are appropriated, to develop a plan to implement a program in cooperation with each county. The department shall coordinate with the county's primary care panel, as created by s. 154.013, or with the county's governing body if no primary care panel is appointed. Such primary care programs shall be phased-in and made operational as additional resources are appropriated pursuant to s. 409.266(6)(c), and shall be subject to the following:

111. Each primary care program shall conform to the requirements and specifications of the department, and shall

112. Adopt a minimum eligibility standard of at least 100 percent of the federal nonfarm poverty level.

114. Provide a comprehensive mix of preventive and illness care services.

116. Be family oriented and be easily accessible regardless of income, physical status, or geographical location.

119. Ensure 24-hour telephone access and offer evening and weekend clinic services.

121. Offer continuity of care over time.

122. Make maximum use of existing providers to ensure efficient use of resources.

124. Have a sliding fee schedule based on income for eligible persons above 100 percent of the federal nonfarm poverty level.

127. Include quality assurance provisions and procedures for evaluation.

130. Provide early periodic screening diagnostic and treatment services for Medicaid-eligible children.
10. Fully utilize and coordinate with rural hospitals for outpatient services, including contracting for services when advisable in terms of cost-effectiveness and feasibility.

Section 64. The Legislature shall appropriate from the Public Medical Assistance Trust Fund pursuant to s. 409.266 to the Department of Health and Rehabilitative Services money for the purpose of increasing the number of primary care physicians and nurses in rural areas pursuant to s. 409.4067, Florida Statutes, pertaining to the Medical Education Tuition Reimbursement Program, Reimbursement through the program shall be limited to:

(1) Primary care physicians and nurses employed by or affiliated with rural hospitals, as defined in this act; and

(2) Primary care physicians and nurses employed by or affiliated with rural area health education centers, as defined in this act. Such physicians and nurses shall practice:

(a) In a county with a population density of no greater than 100 persons per square mile; or

(b) Within the boundaries of a hospital tax district which encompasses a population of no greater than 100 persons per square mile.

These funds may be used for federal loan repayment programs which require state matching funds, such as that provided for in section 338, of Pub. L. No. 100-177.

Section 65. Subsection (19) is added to section 409.266, Florida Statutes, to read:

409.266 Medical assistance.—

(19) Medicaid funding shall be extended to intermediate and skilled nursing patients in rural hospitals.
swim-beds, subject to federal financial participation. Such reimbursement shall not be provided for skilled nursing or intermediate care beyond the 30th day of swim-bed service provision, unless the Office of the Deputy Assistant Secretary for Medicaid within the Department of Health and Rehabilitative Services gives prior authorization for a longer length of stay. The provisions of this subsection shall be funded by an appropriation to the department from the Public Medical Assistance Trust Fund pursuant to s. 409.2662.

Section 66. Paragraph (n) is added to subsection (2) of section 410.016, Florida Statutes, to read:

410.016 Elderly population; departmental responsibilities.--

(2) DUTIES AND RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES.--The department shall:

(n) Fully utilize and coordinate with rural hospitals when carrying out activities under this chapter with regard to the need, when advisable in terms of cost-effectiveness and feasibility.

Section 67. Manpower shortage study.--The Department of Health and Rehabilitative Services shall conduct a study of existing state licensure or certification requirements for allied health personnel employed in licensed rural hospitals, and report its findings and recommendations to the Legislature on or before March 1, 1989. The study shall include, but not be limited to, the following:

(1) A review of current licensure or certification requirements for:

(a) Clinical laboratory personnel in accordance with chapter 463, Florida Statutes.

CODING: Words stricken are deletions; words underlined are additions.
(b) Nursing practitioners in accordance with chapter 464, Florida Statutes.

c) Physical therapy practitioners in accordance with chapter 496, Florida Statutes.

d) Radiologic technology practitioners in accordance with chapter 469, Florida Statutes.

e) Respiratory care practitioners in accordance with chapter 468, Florida Statutes.

(f) Any other category of allied health personnel licensed or certified by the state which may be employed in licensed rural hospitals.

(ii) An analysis of problems unique to rural hospitals in this state generated by practice requirements for the personnel enumerated in subsection (1).

(iii) An analysis of the availability of personnel, recruiting problems, supervision problems, and budget or other constraints for rural hospitals in this state.

Section 62. The Department of Health and Rehabilitative Services is hereby authorized to adopt all necessary rules pertaining to the standards of care applicable to rural hospital swing-beds and the criteria whereby swing-bed stays of longer than 30 days shall be authorized. The latter length-of-stay criteria shall include, but not be limited to, the medical needs of the patient, the county of residence of the patient and patient's family, patient preference, proximity to relatives and friends, and distance to available nursing home beds, if any.

Section 69. Notwithstanding the provisions of section 50 of chapter 87-22, Laws of Florida, s. 409.246(7)(k), Florida Statutes, relating to the Medicaid medically needy program shall not stand repealed on October 1, 1988, as
Section 70. Notwithstanding the provisions of section 24 of chapter 82-182, part II of chapter 395, Florida Statutes, relating to the Hospital Cost Containment Board shall not stand repealed on October 1, 1988, as scheduled by such act, but shall continue in full force and effect, as amended and transferred to chapter 407, Florida Statutes, and shall stand repealed on October 1, 1992, subject to review by the Legislature pursuant to s. 11.61, Florida Statutes.

Section 71. Subsection (2) of section 212.055, Florida Statutes, and section 400.342, Florida Statutes, as amended by chapter 86-104, Laws of Florida, are hereby repealed.

Section 72. Effective July 1, 1988, or upon becoming a law, whichever occurs later, there is hereby appropriated, for fiscal year 1988-1989, the following:

(1) From the General Revenue Fund to the Department of Health and Rehabilitative Services, in addition to any matching trust fund dollars, the sum of $555,515 to fund Medicaid fee increases for pediatric surgeons and pediatric critical care specialists as provided for in section 55.

(2) From the Health Care Cost Containment Board Trust Fund as set forth in s. 407.04, Florida Statutes, as amended by this act, to the Health Care Cost Containment Board:

(a) The sum of $121,300 to fund three additional positions necessary to perform the additional responsibilities placed on the Health Care Cost Containment Board as a result of this act.

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(b) The sum of $88,000 to fund the study on the Florida-specific measure of changes in hospital prices and the severity of illness measure as provided for in section 52.

(c) The sum of $100,000 to fund the study of the shortage of registered nurses as provided for in section 53.

Of this amount, $70,000 shall originate from assessments levied against hospitals and $30,000 shall originate from assessments levied against nursing homes.

(3) From the Public Medical Assistance Trust Fund, as set forth in § 395.101, Florida Statutes, to the Department of Health and Rehabilitative Services:

(a) The sum of $2 million to fund two additional primary care health training demonstration projects as provided for in section 56.

(b) The sum of $444,163 to fund Medicaid rural hospital swing-beds as provided for in section 56.

(c) The sum of $4,241,573 to fund the extension of Medicaid length of stay to 90 days as provided for in section 56.

Section 73. In editing manuscript for the next edition of the official Florida Statutes, the Statutory Revision Division of the Joint Legislative Management Committee shall change "Hospital Cost Containment Board" to "Health Care Cost Containment Board" wherever that term appears in the Florida Statutes, and shall exercise its authority under s. 11.24(1)(g), Florida Statutes, to renumber the references to sections and subsections which have been renumbered by this act, so that they will agree with such renumbering.

Section 74. Except as otherwise provided herein, this act shall take effect October 1, 1988.