1 CHAMBER ACTION
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6 The Committee on Health Care recommends the following:
7
8 **Committee Substitute**
9 Remove the entire bill and insert:
10 A bill to be entitled
11 An act relating to health care facilities; amending s.
12 408.032, F.S.; revising the definition of "tertiary health
13 service" under the Health Facility and Services
14 Development Act; amending s. 408.033, F.S.; providing for
15 the level of funding for local health councils; amending
16 s. 408.036, F.S., relating to health-care-related projects
17 subject to review for a certificate of need; removing
18 certain projects from expedited review and revising
19 requirements for other projects subject to expedited
20 review; removing the exemption from review for certain
21 projects; revising requirements for certain projects that
22 are exempt from review; exempting certain projects from
23 review; amending s. 408.038, F.S.; increasing fees of the
24 certificate-of-need program; amending s. 408.039, F.S.;
25 providing for approval of recommended orders of the
26 Division of Administrative Hearings when the Agency for
27 Health Care Administration fails to take action on an
28 application for a certificate of need within a specified

29 time period; amending s. 400.021, F.S.; revising the
30 definition of "resident care plan"; amending s. 400.121,
31 F.S.; deleting a provision authorizing the overcoming of
32 agency action by a preponderance of the evidence; amending
33 s. 400.141, F.S.; narrowing the responsibilities for a
34 nursing assistant to maintain medical records only for
35 residents who are at high risk for malnutrition or
36 dehydration as ordered by the resident's physician;
37 amending s. 400.147, F.S.; revising the definition of
38 "adverse incident" to eliminate certain events from the
39 term; revising reporting requirements; amending s. 400.19,
40 F.S.; revising the agency's authority to enter and inspect
41 a nursing home based on final agency action that a
42 facility has a deficiency cited; amending s. 400.195,
43 F.S.; conforming a cross reference; amending s. 400.211,
44 F.S.; requiring nursing assistants to meet certain
45 inservice training requirements to maintain certification;
46 amending s. 400.23, F.S.; revising requirements regarding
47 rules, evaluation and deficiencies, and licensure status
48 of nursing homes; creating s. 400.244, F.S.; allowing
49 nursing homes to convert beds to alternative uses as
50 specified; providing restrictions on uses of funding under
51 assisted-living Medicaid waivers; providing procedures;
52 providing for the applicability of certain fire and life
53 safety codes; providing applicability of certain laws;
54 requiring a nursing home to submit to the Agency for
55 Health Care Administration a written request for
56 permission to convert beds to alternative uses; providing

57 conditions for disapproving such a request; providing for
58 periodic review; providing for retention of nursing home
59 licensure for converted beds; providing for reconversion
60 of the beds; providing applicability of licensure fees;
61 requiring a report to the agency; creating the Hospital
62 Statutory and Regulatory Reform Council; providing
63 legislative intent; providing for membership and duties of
64 the council; providing an effective date.
65
66 Be It Enacted by the Legislature of the State of Florida:
67
68 Section 1. Subsection (17) of section 408.032, Florida
69 Statutes, is amended to read:
70 408.032 Definitions relating to Health Facility and
71 Services Development Act.--As used in ss. 408.031-408.045, the
72 term:
73 (17) "Tertiary health service" means a health service
74 which, due to its high level of intensity, complexity,
75 specialized or limited applicability, and cost, should be
76 limited to, and concentrated in, a limited number of hospitals
77 to ensure the quality, availability, and cost-effectiveness of
78 such service. Examples of such service include, but are not
79 limited to, organ transplantation, adult and pediatric open
80 heart surgery, specialty burn units, neonatal intensive care
81 units, comprehensive rehabilitation, and medical or surgical
82 services which are experimental or developmental in nature to
83 the extent that the provision of such services is not yet
84 contemplated within the commonly accepted course of diagnosis or

85 treatment for the condition addressed by a given service. The
86 agency shall establish by rule a list of all tertiary health
87 services.
88 Section 2. Paragraph (g) is added to subsection (2) of
89 section 408.033, Florida Statutes, to read:
90 408.033 Local and state health planning.--
91 (2) FUNDING.--
92 <u>(g) Effective July 1, 2003, funding for the local health</u>
93 <u>councils shall be at the level provided on July 1, 2002.</u>
94 Section 3. Section 408.036, Florida Statutes, is amended
95 to read:
96 408.036 Projects subject to review; exemptions.--
97 (1) APPLICABILITY.--Unless exempt under subsection (3),
98 all health-care-related projects, as described in paragraphs
99 (a)-(h), are subject to review and must file an application for
100 a certificate of need with the agency. The agency is exclusively
101 responsible for determining whether a health-care-related
102 project is subject to review under ss. 408.031-408.045.
103 (a) The addition of beds by new construction or
104 alteration.
105 (b) The new construction or establishment of additional
106 health care facilities, including a replacement health care
107 facility when the proposed project site is not located on the
108 same site as the existing health care facility.
109 (c) The conversion from one type of health care facility
110 to another.
111 (d) An increase in the total licensed bed capacity of a
112 health care facility.

113 (e) The establishment of a hospice or hospice inpatient
114 facility, except as provided in s. 408.043.
115 (f) The establishment of inpatient health services by a
116 health care facility, or a substantial change in such services.
117 (g) An increase in the number of beds for acute care,
118 nursing home care beds, specialty burn units, neonatal intensive
119 care units, comprehensive rehabilitation, mental health
120 services, or hospital-based distinct part skilled nursing units,
121 or at a long-term care hospital.
122 (h) The establishment of tertiary health services.
123 (2) PROJECTS SUBJECT TO EXPEDITED REVIEW.--Unless exempt
124 pursuant to subsection (3), projects subject to an expedited
125 review shall include, but not be limited to:
126 (a) Research, education, and training programs.
127 ~~(b) Shared services contracts or projects.~~
128 (b)~~(c)~~ A transfer of a certificate of need, except when an
129 existing hospital is acquired by a purchaser, in which case all
130 pending certificates of need filed by the existing hospital and
131 all approved certificates of need owned by that hospital would
132 be acquired by the purchaser.
133 (c)~~(d)~~ A 50-percent increase in nursing home beds for a
134 facility incorporated and operating in this state for at least
135 60 years on or before July 1, 1988, which has a licensed nursing
136 home facility located on a campus providing a variety of
137 residential settings and supportive services. The increased
138 nursing home beds shall be for the exclusive use of the campus
139 residents. ~~Any application on behalf of an applicant meeting~~

~~this requirement shall be subject to the base fee of $5,000 provided in s. 408.038.~~

(d)~~(c)~~ Replacement of a health care facility when the proposed project site is located in the same district and within a 1-mile radius of the replaced health care facility.

(e)~~(f)~~ The conversion of mental health services beds licensed under chapter 395 ~~or hospital-based distinct part skilled nursing unit beds~~ to general acute care beds~~; the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services;~~ or the conversion of general acute care beds to beds for mental health services.

1. Conversion under this paragraph shall not establish a new licensed bed category at the hospital but shall apply only to categories of beds licensed at that hospital.

2. Beds converted under this paragraph must be licensed and operational for at least 12 months before the hospital may apply for additional conversion affecting beds of the same type.

The agency shall develop rules to implement the provisions for expedited review, including time schedule, application content which may be reduced from the full requirements of s. 408.037(1), and application processing.

(3) EXEMPTIONS.--Upon request, the following projects are subject to exemption from the provisions of subsection (1):

(a) For replacement of a licensed health care facility on the same site, provided that the number of beds in each licensed bed category will not increase.

168 (b) For hospice services or for swing beds in a rural
169 hospital, as defined in s. 395.602, in a number that does not
170 exceed one-half of its licensed beds.
171 (c) For the conversion of licensed acute care hospital
172 beds to Medicare and Medicaid certified skilled nursing beds in
173 a rural hospital, as defined in s. 395.602, so long as the
174 conversion of the beds does not involve the construction of new
175 facilities. The total number of skilled nursing beds, including
176 swing beds, may not exceed one-half of the total number of
177 licensed beds in the rural hospital as of July 1, 1993.
178 Certified skilled nursing beds designated under this paragraph,
179 excluding swing beds, shall be included in the community nursing
180 home bed inventory. A rural hospital which subsequently
181 decertifies any acute care beds exempted under this paragraph
182 shall notify the agency of the decertification, and the agency
183 shall adjust the community nursing home bed inventory
184 accordingly.
185 (d) For the addition of nursing home beds at a skilled
186 nursing facility that is part of a retirement community that
187 provides a variety of residential settings and supportive
188 services and that has been incorporated and operated in this
189 state for at least 65 years on or before July 1, 1994. All
190 nursing home beds must not be available to the public but must
191 be for the exclusive use of the community residents.
192 (e) For an increase in the bed capacity of a nursing
193 facility licensed for at least 50 beds as of January 1, 1994,
194 under part II of chapter 400 which is not part of a continuing
195 care facility if, after the increase, the total licensed bed

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196 capacity of that facility is not more than 60 beds and if the
197 facility has been continuously licensed since 1950 and has
198 received a superior rating on each of its two most recent
199 licensure surveys.
200 (f) For an inmate health care facility built by or for the
201 exclusive use of the Department of Corrections as provided in
202 chapter 945. This exemption expires when such facility is
203 converted to other uses.
204 (g) For the termination of an inpatient health care
205 service, upon 30 days' written notice to the agency.
206 (h) For the delicensure of beds, upon 30 days' written
207 notice to the agency. A request for exemption submitted under
208 this paragraph must identify the number, the category of beds,
209 and the name of the facility in which the beds to be delicensed
210 are located.
211 (i) For the provision of adult inpatient diagnostic
212 cardiac catheterization services in a hospital.
213 1. In addition to any other documentation otherwise
214 required by the agency, a request for an exemption submitted
215 under this paragraph must comply with the following criteria:
216 a. The applicant must certify it will not provide
217 therapeutic cardiac catheterization pursuant to the grant of the
218 exemption.
219 b. The applicant must certify it will meet and
220 continuously maintain the minimum licensure requirements adopted
221 by the agency governing such programs pursuant to subparagraph
222 2.

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223 c. The applicant must certify it will provide a minimum of
224 2 percent of its services to charity and Medicaid patients.
225 2. The agency shall adopt licensure requirements by rule
226 which govern the operation of adult inpatient diagnostic cardiac
227 catheterization programs established pursuant to the exemption
228 provided in this paragraph. The rules shall ensure that such
229 programs:
230 a. Perform only adult inpatient diagnostic cardiac
231 catheterization services authorized by the exemption and will
232 not provide therapeutic cardiac catheterization or any other
233 services not authorized by the exemption.
234 b. Maintain sufficient appropriate equipment and health
235 personnel to ensure quality and safety.
236 c. Maintain appropriate times of operation and protocols
237 to ensure availability and appropriate referrals in the event of
238 emergencies.
239 d. Maintain appropriate program volumes to ensure quality
240 and safety.
241 e. Provide a minimum of 2 percent of its services to
242 charity and Medicaid patients each year.
243 3.a. The exemption provided by this paragraph shall not
244 apply unless the agency determines that the program is in
245 compliance with the requirements of subparagraph 1. and that the
246 program will, after beginning operation, continuously comply
247 with the rules adopted pursuant to subparagraph 2. The agency
248 shall monitor such programs to ensure compliance with the
249 requirements of subparagraph 2.

250 b.(I) The exemption for a program shall expire immediately
251 when the program fails to comply with the rules adopted pursuant
252 to sub-subparagraphs 2.a., b., and c.
253 (II) Beginning 18 months after a program first begins
254 treating patients, the exemption for a program shall expire when
255 the program fails to comply with the rules adopted pursuant to
256 sub-subparagraphs 2.d. and e.
257 (III) If the exemption for a program expires pursuant to
258 sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the
259 agency shall not grant an exemption pursuant to this paragraph
260 for an adult inpatient diagnostic cardiac catheterization
261 program located at the same hospital until 2 years following the
262 date of the determination by the agency that the program failed
263 to comply with the rules adopted pursuant to subparagraph 2.
264 (j) For the provision of percutaneous coronary
265 intervention for patients presenting with emergency myocardial
266 infarctions in a hospital without an approved adult open heart
267 surgery program. In addition to any other documentation required
268 by the agency, a request for an exemption submitted under this
269 paragraph must comply with the following:
270 1. The applicant must certify that it will meet and
271 continuously maintain the requirements adopted by the agency for
272 the provision of these services. These licensure requirements
273 are to be adopted by rule pursuant to ss. 120.536(1) and 120.54
274 and are to be consistent with the guidelines published by the
275 American College of Cardiology and the American Heart
276 Association for the provision of percutaneous coronary

277 interventions in hospitals without adult open heart services. At
278 a minimum, the rules shall require the following:
279 a. Cardiologists must be experienced interventionalists
280 who have performed a minimum of 75 interventions within the
281 previous 12 months.
282 b. The hospital must provide a minimum of 36 emergency
283 interventions annually in order to continue to provide the
284 service.
285 c. The hospital must offer sufficient physician, nursing,
286 and laboratory staff to provide the services 24 hours a day, 7
287 days a week.
288 d. Nursing and technical staff must have demonstrated
289 experience in handling acutely ill patients requiring
290 intervention based on previous experience in dedicated
291 interventional laboratories or surgical centers.
292 e. Cardiac care nursing staff must be adept in hemodynamic
293 monitoring and Intra-aortic Balloon Pump (IABP) management.
294 f. Formalized written transfer agreements must be
295 developed with a hospital with an adult open heart surgery
296 program, and written transport protocols must be in place to
297 ensure safe and efficient transfer of a patient within 60
298 minutes. Transfer and transport agreements must be reviewed and
299 tested, with appropriate documentation maintained at least every
300 3 months.
301 g. Hospitals implementing the service must first undertake
302 a training program of 3 to 6 months which includes establishing
303 standards, testing logistics, creating quality assessment and

304 error management practices, and formalizing patient selection
305 criteria.
306 2. The applicant must certify that it will utilize at all
307 times the patient selection criteria for the performance of
308 primary angioplasty at hospitals without adult open heart
309 surgery programs issued by the American College of Cardiology
310 and the American Heart Association. At a minimum, these criteria
311 would provide for the following:
312 a. Avoidance of interventions in hemodynamically stable
313 patients presenting with identified symptoms or medical
314 histories.
315 b. Transfer of patients presenting with a history of
316 coronary disease and clinical presentation of hemodynamic
317 instability.
318 3. The applicant must agree to submit a quarterly report
319 to the agency detailing patient characteristics, treatment, and
320 outcomes for all patients receiving emergency percutaneous
321 coronary interventions pursuant to this paragraph. This report
322 must be submitted within 15 days after the close of each
323 calendar quarter.
324 4. The exemption provided by this paragraph shall not
325 apply unless the agency determines that the hospital has taken
326 all necessary steps to be in compliance with all requirements of
327 this paragraph, including the training program required pursuant
328 to sub-subparagraph 1.g.
329 5. Failure of the hospital to continuously comply with the
330 requirements of sub-subparagraphs 1.c.-f. and subparagraphs 2.

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331 and 3. will result in the immediate expiration of this
332 exemption.
333 6. Failure of the hospital to meet the volume requirements
334 of sub-subparagraphs 1.a.-b. within 18 months after the program
335 begins offering the service will result in the immediate
336 expiration of the exemption.
337 7. If the exemption for this service expires pursuant to
338 subparagraph 5. or subparagraph 6., the agency shall not grant
339 another exemption for this service to the same hospital for a
340 period of 2 years and then only upon a showing that the hospital
341 will remain in compliance with the requirements of this
342 paragraph through a demonstration of corrections to the
343 deficiencies which caused expiration of the exemption.
344 Compliance with the requirements of this paragraph includes
345 compliance with the rules adopted pursuant to this paragraph.
346 (k)~~(j)~~ For mobile surgical facilities and related health
347 care services provided under contract with the Department of
348 Corrections or a private correctional facility operating
349 pursuant to chapter 957.
350 (l)~~(k)~~ For state veterans' nursing homes operated by or on
351 behalf of the Florida Department of Veterans' Affairs in
352 accordance with part II of chapter 296 for which at least 50
353 percent of the construction cost is federally funded and for
354 which the Federal Government pays a per diem rate not to exceed
355 one-half of the cost of the veterans' care in such state nursing
356 homes. These beds shall not be included in the nursing home bed
357 inventory.

358 (m) ~~(l)~~ For combination within one nursing home facility of
359 the beds or services authorized by two or more certificates of
360 need issued in the same planning subdistrict. An exemption
361 granted under this paragraph shall extend the validity period of
362 the certificates of need to be consolidated by the length of the
363 period beginning upon submission of the exemption request and
364 ending with issuance of the exemption. The longest validity
365 period among the certificates shall be applicable to each of the
366 combined certificates.
367 (n) ~~(m)~~ For division into two or more nursing home
368 facilities of beds or services authorized by one certificate of
369 need issued in the same planning subdistrict. An exemption
370 granted under this paragraph shall extend the validity period of
371 the certificate of need to be divided by the length of the
372 period beginning upon submission of the exemption request and
373 ending with issuance of the exemption.
374 (o) ~~(n)~~ For the addition of hospital beds licensed under
375 chapter 395 for acute care~~, mental health services,~~ or a
376 hospital-based distinct part skilled nursing unit in a number
377 that may not exceed 30 ~~10~~ total beds or 10 percent of the
378 licensed capacity of the bed category being expanded, whichever
379 is greater; for the addition of medical rehabilitation beds
380 licensed under chapter 395 in a number that may not exceed eight
381 total beds or 10 percent of capacity, whichever is greater; or
382 for the addition of mental health services beds licensed under
383 chapter 395 in a number that may not exceed 10 total beds or 10
384 percent of the licensed capacity of the bed category being
385 expanded, whichever is greater. Beds for specialty burn units

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386 or~~,~~ neonatal intensive care units~~, or comprehensive~~
387 ~~rehabilitation~~, or at a long-term care hospital, may not be
388 increased under this paragraph.
389 1. In addition to any other documentation otherwise
390 required by the agency, a request for exemption submitted under
391 this paragraph must:
392 a. Certify that the prior 12-month average occupancy rate
393 for the category of licensed beds being expanded at the facility
394 meets or exceeds 75 ~~80~~ percent or, for a hospital-based distinct
395 part skilled nursing unit, the prior 12-month average occupancy
396 rate meets or exceeds 96 percent or, for medical rehabilitation
397 beds, the prior 12-month average occupancy rate meets or exceeds
398 90 percent.
399 b. Certify that any beds of the same type authorized for
400 the facility under this paragraph before the date of the current
401 request for an exemption have been licensed and operational for
402 at least 12 months.
403 2. The timeframes and monitoring process specified in s.
404 408.040(2)(a)-(c) apply to any exemption issued under this
405 paragraph.
406 3. The agency shall count beds authorized under this
407 paragraph as approved beds in the published inventory of
408 hospital beds until the beds are licensed.
409 (p)~~(o)~~ For the addition of acute care beds, as authorized
410 by rule consistent with s. 395.003(4), in a number that may not
411 exceed 30 ~~10~~ total beds or 10 percent of licensed bed capacity,
412 whichever is greater, for temporary beds in a hospital that has
413 experienced high seasonal occupancy within the prior 12-month

414 period or in a hospital that must respond to emergency
415 circumstances.
416 (q)~~(p)~~ For the addition of nursing home beds licensed
417 under chapter 400 in a number not exceeding 10 total beds or 10
418 percent of the number of beds licensed in the facility being
419 expanded, whichever is greater.
420 1. In addition to any other documentation required by the
421 agency, a request for exemption submitted under this paragraph
422 must:
423 a. Effective until June 30, 2001, certify that the
424 facility has not had any class I or class II deficiencies within
425 the 30 months preceding the request for addition.
426 b. Effective on July 1, 2001, certify that the facility
427 has been designated as a Gold Seal nursing home under s.
428 400.235.
429 c. Certify that the prior 12-month average occupancy rate
430 for the nursing home beds at the facility meets or exceeds 96
431 percent.
432 d. Certify that any beds authorized for the facility under
433 this paragraph before the date of the current request for an
434 exemption have been licensed and operational for at least 12
435 months.
436 2. The timeframes and monitoring process specified in s.
437 408.040(2)(a)-(c) apply to any exemption issued under this
438 paragraph.
439 3. The agency shall count beds authorized under this
440 paragraph as approved beds in the published inventory of nursing
441 home beds until the beds are licensed.

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442 ~~(q) For establishment of a specialty hospital offering a~~
443 ~~range of medical service restricted to a defined age or gender~~
444 ~~group of the population or a restricted range of services~~
445 ~~appropriate to the diagnosis, care, and treatment of patients~~
446 ~~with specific categories of medical illnesses or disorders,~~
447 ~~through the transfer of beds and services from an existing~~
448 ~~hospital in the same county.~~
449 (r) For the conversion of hospital-based Medicare and
450 Medicaid certified skilled nursing beds to acute care beds, if
451 the conversion does not involve the construction of new
452 facilities.
453 (s) <u>For the replacement of a statutory rural hospital when</u>
454 <u>the proposed project site is located in the same district and</u>
455 <u>within 10 miles of the existing facility and within the current</u>
456 <u>primary service area, defined as the least number of zip codes</u>
457 <u>comprising 75 percent of the hospital's inpatient admissions.</u>
458 ~~For fiscal year 2001-2002 only, for transfer by a health care~~
459 ~~system of existing services and not more than 100 licensed and~~
460 ~~approved beds from a hospital in district 1, subdistrict 1, to~~
461 ~~another location within the same subdistrict in order to~~
462 ~~establish a satellite facility that will improve access to~~
463 ~~outpatient and inpatient care for residents of the district and~~
464 ~~subdistrict and that will use new medical technologies,~~
465 ~~including advanced diagnostics, computer assisted imaging, and~~
466 ~~telemedicine to improve care. This paragraph is repealed on July~~
467 ~~1, 2002.~~

468 (t) For the conversion of mental health services beds
469 between or among the licensed bed categories defined as beds for
470 mental health services.
471 (u) For the creation of at least a 10-bed Level II
472 neonatal intensive care unit upon demonstrating to the agency
473 that the applicant hospital had a minimum of 1,500 live births
474 during the previous 12 months.
475 (v) For the addition of Level II or Level III neonatal
476 intensive care beds in a number not to exceed six beds or 10
477 percent of licensed capacity in that category, whichever is
478 greater, provided that the hospital certifies that the prior 12-
479 month average occupancy rate for the category of licensed
480 neonatal intensive care beds meets or exceeds 75 percent.
481 (4) A request for exemption under subsection (3) may be
482 made at any time and is not subject to the batching requirements
483 of this section. The request shall be supported by such
484 documentation as the agency requires by rule. The agency shall
485 assess a fee of $250 for each request for exemption submitted
486 under subsection (3).
487 Section 4. Section 408.038, Florida Statutes, is amended
488 to read:
489 408.038 Fees.--The agency shall assess fees on
490 certificate-of-need applications. Such fees shall be for the
491 purpose of funding the functions of the local health councils
492 and the activities of the agency and shall be allocated as
493 provided in s. 408.033. The fee shall be determined as follows:
494 (1) A minimum base fee of $10,000 ~~$5,000~~.

495 (2) In addition to the base fee of $10,000 ~~$5,000~~, 0.015
496 of each dollar of proposed expenditure, except that a fee may
497 not exceed $50,000 ~~$22,000~~.
498 Section 5. Paragraph (e) of subsection (5) and paragraph
499 (c) of subsection (6) of section 408.039, Florida Statutes, are
500 amended to read:
501 408.039 Review process.--The review process for
502 certificates of need shall be as follows:
503 (5) ADMINISTRATIVE HEARINGS.--
504 (e) The agency shall issue its final order within 45 days
505 after receipt of the recommended order. If the agency fails to
506 take action within 45 days, the recommended order of the
507 Division of Administrative Hearings is deemed approved ~~such~~
508 ~~time, or as otherwise agreed to by the applicant and the agency,~~
509 ~~the applicant may take appropriate legal action to compel the~~
510 ~~agency to act~~. When making a determination on an application for
511 a certificate of need, the agency is specifically exempt from
512 the time limitations provided in s. 120.60(1).
513 (6) JUDICIAL REVIEW.--
514 (c) The court, in its discretion, may award reasonable
515 attorney's fees and costs to the prevailing party if the court
516 finds that there was a complete absence of a justiciable issue
517 of law or fact raised by the losing party. If the losing party
518 is a hospital, the court shall order it to pay the reasonable
519 attorney's fees and costs, which shall include fees and costs
520 incurred as a result of the administrative hearing and the
521 judicial appeal, of the prevailing hospital party.

522 Section 6. Subsection (17) of section 400.021, Florida
523 Statutes, is amended to read:
524 400.021 Definitions.--When used in this part, unless the
525 context otherwise requires, the term:
526 (17) "Resident care plan" means a written plan developed,
527 maintained, and reviewed not less than quarterly by a registered
528 nurse, with participation from other facility staff and the
529 resident or his or her designee or legal representative, which
530 includes a comprehensive assessment of the needs of an
531 individual resident; the type and frequency of services required
532 to provide the necessary care for the resident to attain or
533 maintain the highest practicable physical, mental, and
534 psychosocial well-being; a listing of services provided within
535 or outside the facility to meet those needs; and an explanation
536 of service goals. The resident care plan must be signed by the
537 director of nursing or another registered nurse employed by the
538 facility to whom institutional responsibilities have been
539 delegated and by the resident, the resident's designee, or the
540 resident's legal representative.
541 Section 7. Subsections (9) and (10) of section 400.121,
542 Florida Statutes, are amended to read:
543 400.121 Denial, suspension, revocation of license;
544 moratorium on admissions; administrative fines; procedure; order
545 to increase staffing.--
546 (9) ~~Notwithstanding any other provision of law to the~~
547 ~~contrary, agency action in an administrative proceeding under~~
548 ~~this section may be overcome by the licensee upon a showing by a~~
549 ~~preponderance of the evidence to the contrary.~~

550 ~~(10)~~ In addition to any other sanction imposed under this
551 part, in any final order that imposes sanctions, the agency may
552 assess costs related to the investigation and prosecution of the
553 case. Payment of agency costs shall be deposited into the Health
554 Care Trust Fund.
555 Section 8. Subsection (21) of section 400.141, Florida
556 Statutes, is amended to read:
557 400.141 Administration and management of nursing home
558 facilities.--Every licensed facility shall comply with all
559 applicable standards and rules of the agency and shall:
560 (21) Maintain in the medical record for each resident a
561 daily chart of certified nursing assistant services provided to
562 residents who are at high risk for malnutrition or dehydration
563 as ordered by the resident's physician ~~the resident~~. The
564 certified nursing assistant who is caring for the resident must
565 complete this record by the end of his or her shift. This record
566 must indicate assistance with activities of daily living,
567 assistance with eating, and assistance with drinking, and must
568 record each offering of nutrition and hydration for those
569 residents ~~whose plan of care or assessment indicates a risk for~~
570 ~~malnutrition or dehydration~~.
571
572 Facilities that have been awarded a Gold Seal under the program
573 established in s. 400.235 may develop a plan to provide
574 certified nursing assistant training as prescribed by federal
575 regulations and state rules and may apply to the agency for
576 approval of their program.

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577 Section 9. Section 400.147, Florida Statutes, is amended
578 to read:
579 400.147 Internal risk management and quality assurance
580 program.--
581 (1) Every facility shall, as part of its administrative
582 functions, establish an internal risk management and quality
583 assurance program, the purpose of which is to assess resident
584 care practices; review facility quality indicators, facility
585 incident reports, deficiencies cited by the agency, and resident
586 grievances; and develop plans of action to correct and respond
587 quickly to identified quality deficiencies. The program must
588 include:
589 (a) A designated person to serve as risk manager, who is
590 responsible for implementation and oversight of the facility's
591 risk management and quality assurance program as required by
592 this section.
593 (b) A risk management and quality assurance committee
594 consisting of the facility risk manager, the administrator, the
595 director of nursing, the medical director, and at least three
596 other members of the facility staff. The risk management and
597 quality assurance committee shall meet at least monthly.
598 (c) Policies and procedures to implement the internal risk
599 management and quality assurance program, which must include the
600 investigation and analysis of the frequency and causes of
601 general categories and specific types of adverse incidents to
602 residents.
603 (d) The development and implementation of an incident
604 reporting system based upon the affirmative duty of all health

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605 care providers and all agents and employees of the licensed
606 health care facility to report adverse incidents to the risk
607 manager, or to his or her designee, within 3 business days after
608 their occurrence.
609 (e) The development of appropriate measures to minimize
610 the risk of adverse incidents to residents, including, but not
611 limited to, education and training in risk management and risk
612 prevention for all nonphysician personnel, as follows:
613 1. Such education and training of all nonphysician
614 personnel must be part of their initial orientation; and
615 2. At least 1 hour of such education and training must be
616 provided annually for all nonphysician personnel of the licensed
617 facility working in clinical areas and providing resident care.
618 (f) The analysis of resident grievances that relate to
619 resident care and the quality of clinical services.
620 (2) The internal risk management and quality assurance
621 program is the responsibility of the facility administrator.
622 (3) In addition to the programs mandated by this section,
623 other innovative approaches intended to reduce the frequency and
624 severity of adverse incidents to residents and violations of
625 residents' rights shall be encouraged and their implementation
626 and operation facilitated.
627 (4) Each internal risk management and quality assurance
628 program shall include the use of incident reports to be filed
629 with the risk manager and the facility administrator. The risk
630 manager shall have free access to all resident records of the
631 licensed facility. The incident reports are part of the
632 workpapers of the attorney defending the licensed facility in

633 litigation relating to the licensed facility and are subject to
634 discovery, but are not admissible as evidence in court. A person
635 filing an incident report is not subject to civil suit by virtue
636 of such incident report. As a part of each internal risk
637 management and quality assurance program, the incident reports
638 shall be used to develop categories of incidents which identify
639 problem areas. Once identified, procedures shall be adjusted to
640 correct the problem areas.

641 (5) For purposes of reporting to the agency under this
642 section, the term "adverse incident" means~~:~~

643 ~~(a)~~ an event over which facility personnel could exercise
644 control and which is associated in whole or in part with the
645 facility's intervention, rather than the condition for which
646 such intervention occurred, and which results in one of the
647 following injuries:

648 (a)~~1.~~ Death;

649 (b)~~2.~~ Brain or spinal damage;

650 (c)~~3.~~ Permanent disfigurement;

651 (d)~~4.~~ Fracture or dislocation of bones or joints;

652 (e)~~5.~~ A resulting limitation of neurological, physical, or
653 sensory function which is expected to be irreversible;

654 (f)~~6.~~ Any injurious condition that required medical
655 attention to which the resident has not given his or her
656 informed consent, including failure to honor advanced
657 directives; or

658 (g)~~7.~~ Any condition that required the transfer of the
659 resident, within or outside the facility, to a unit providing a

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660 more acute level of care due to the adverse incident, rather
661 than the resident's condition prior to the adverse incident~~;~~
662 ~~(b) Abuse, neglect, or exploitation as defined in s.~~
663 ~~415.102;~~
664 ~~(c) Abuse, neglect and harm as defined in s. 39.01;~~
665 ~~(d) Resident elopement; or~~
666 ~~(e) An event that is reported to law enforcement~~.
667 (6) The internal risk manager of each licensed facility
668 shall:
669 (a) Investigate every allegation of sexual misconduct
670 which is made against a member of the facility's personnel who
671 has direct patient contact when the allegation is that the
672 sexual misconduct occurred at the facility or at the grounds of
673 the facility.~~;~~
674 (b) Report every allegation of sexual misconduct to the
675 administrator of the licensed facility.~~; and~~
676 (c) Notify the resident representative or guardian of the
677 victim that an allegation of sexual misconduct has been made and
678 that an investigation is being conducted.
679 ~~(7) The facility shall initiate an investigation and shall~~
680 ~~notify the agency within 1 business day after the risk manager~~
681 ~~or his or her designee has received a report pursuant to~~
682 ~~paragraph (1)(d). The notification must be made in writing and~~
683 ~~be provided electronically, by facsimile device or overnight~~
684 ~~mail delivery. The notification must include information~~
685 ~~regarding the identity of the affected resident, the type of~~
686 ~~adverse incident, the initiation of an investigation by the~~
687 ~~facility, and whether the events causing or resulting in the~~

688 ~~adverse incident represent a potential risk to any other~~
689 ~~resident. The notification is confidential as provided by law~~
690 ~~and is not discoverable or admissible in any civil or~~
691 ~~administrative action, except in disciplinary proceedings by the~~
692 ~~agency or the appropriate regulatory board. The agency may~~
693 ~~investigate, as it deems appropriate, any such incident and~~
694 ~~prescribe measures that must or may be taken in response to the~~
695 ~~incident. The agency shall review each incident and determine~~
696 ~~whether it potentially involved conduct by the health care~~
697 ~~professional who is subject to disciplinary action, in which~~
698 ~~case the provisions of s. 456.073 shall apply.~~
699 (7)~~(8)~~(a) Each facility shall complete the investigation
700 and submit an adverse incident report to the agency for each
701 adverse incident within 15 calendar days after its occurrence.
702 If, after a complete investigation, the risk manager determines
703 that the incident was not an adverse incident as defined in
704 subsection (5), the facility shall include this information in
705 the report. The agency shall develop a form for reporting this
706 information.
707 (b) The information reported to the agency pursuant to
708 paragraph (a) which relates to persons licensed under chapter
709 458, chapter 459, chapter 461, or chapter 466 shall be reviewed
710 by the agency. The agency shall determine whether any of the
711 incidents potentially involved conduct by a health care
712 professional who is subject to disciplinary action, in which
713 case the provisions of s. 456.073 shall apply.
714 (c) The report submitted to the agency must also contain
715 the name of the risk manager of the facility.

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716 (d) The adverse incident report is confidential as
717 provided by law and is not discoverable or admissible in any
718 civil or administrative action, except in disciplinary
719 proceedings by the agency or the appropriate regulatory board.
720 (8)~~(9)~~ By the 10th of each month, each facility subject to
721 this section shall report any notice received pursuant to s.
722 400.0233(2) and each initial complaint that was filed with the
723 clerk of the court and served on the facility during the
724 previous month by a resident or a resident's family member,
725 guardian, conservator, or personal legal representative. The
726 report must include the name of the resident, the resident's
727 date of birth and social security number, the Medicaid
728 identification number for Medicaid-eligible persons, the date or
729 dates of the incident leading to the claim or dates of
730 residency, if applicable, and the type of injury or violation of
731 rights alleged to have occurred. Each facility shall also submit
732 a copy of the notices received pursuant to s. 400.0233(2) and
733 complaints filed with the clerk of the court. This report is
734 confidential as provided by law and is not discoverable or
735 admissible in any civil or administrative action, except in such
736 actions brought by the agency to enforce the provisions of this
737 part.
738 (9)~~(10)~~ The agency shall review, as part of its licensure
739 inspection process, the internal risk management and quality
740 assurance program at each facility regulated by this section to
741 determine whether the program meets standards established in
742 statutory laws and rules, is being conducted in a manner

743 designed to reduce adverse incidents, and is appropriately
744 reporting incidents as required by this section.
745 (10)~~(11)~~ There is no monetary liability on the part of,
746 and a cause of action for damages may not arise against, any
747 risk manager for the implementation and oversight of the
748 internal risk management and quality assurance program in a
749 facility licensed under this part as required by this section,
750 or for any act or proceeding undertaken or performed within the
751 scope of the functions of such internal risk management and
752 quality assurance program if the risk manager acts without
753 intentional fraud.
754 (11)~~(12)~~ If the agency, through its receipt of the adverse
755 incident reports pursuant to ~~prescribed in~~ subsection (7)~~,~~ or
756 through any investigation, has a reasonable belief that conduct
757 by a staff member or employee of a facility is grounds for
758 disciplinary action by the appropriate regulatory board, the
759 agency shall report this fact to the regulatory board. The
760 agency must use the report required under subsection (7) to
761 fulfill this reporting requirement. This subsection does not
762 require dual reporting nor additional, new documentation and
763 reporting by the facility to the appropriate regulatory board.
764 (12)~~(13)~~ The agency may adopt rules to administer this
765 section.
766 (13)~~(14)~~ The agency shall annually submit to the
767 Legislature a report on nursing home adverse incidents. The
768 report must include the following information arranged by
769 county:
770 (a) The total number of adverse incidents.

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771 (b) A listing, by category, of the types of adverse
772 incidents, the number of incidents occurring within each
773 category, and the type of staff involved.
774 (c) A listing, by category, of the types of injury caused
775 and the number of injuries occurring within each category.
776 (d) Types of liability claims filed based on an adverse
777 incident or reportable injury.
778 (e) Disciplinary action taken against staff, categorized
779 by type of staff involved.
780 (14) ~~(15)~~ Information gathered by a credentialing
781 organization under a quality assurance program is not
782 discoverable from the credentialing organization. This
783 subsection does not limit discovery of, access to, or use of
784 facility records, including those records from which the
785 credentialing organization gathered its information.
786 Section 10. Subsections (3) and (4) of section 400.19,
787 Florida Statutes, are amended to read:
788 400.19 Right of entry and inspection.--
789 (3) The agency shall every 15 months conduct at least one
790 unannounced inspection to determine compliance by the licensee
791 with statutes, and with rules promulgated under the provisions
792 of those statutes, governing minimum standards of construction,
793 quality and adequacy of care, and rights of residents. The
794 survey shall be conducted every 6 months for the next 2-year
795 period if it is determined by final agency action that the
796 facility has ~~been cited for~~ a class I deficiency, ~~has been cited~~
797 ~~for~~ two or more class II deficiencies arising from separate
798 surveys or investigations within a 60-day period, or ~~has had~~

799 three or more substantiated complaints within a 6-month period,
800 each resulting in at least one class I or class II deficiency.
801 In addition to any other fees or fines in this part, the agency
802 shall assess a fine for each facility that is subject to the 6-
803 month survey cycle. The fine for the 2-year period shall be
804 $6,000, one-half to be paid at the completion of each survey.
805 The agency may adjust this fine by the change in the Consumer
806 Price Index, based on the 12 months immediately preceding the
807 increase, to cover the cost of the additional surveys. The
808 agency shall verify through subsequent inspection that any
809 deficiency identified during the annual inspection is corrected.
810 However, the agency may verify the correction of a class III or
811 class IV deficiency unrelated to resident rights or resident
812 care without reinspecting the facility if adequate written
813 documentation has been received from the facility, which
814 provides assurance that the deficiency has been corrected. The
815 giving or causing to be given of advance notice of such
816 unannounced inspections by an employee of the agency to any
817 unauthorized person shall constitute cause for suspension of not
818 fewer than 5 working days according to the provisions of chapter
819 110.
820 (4) The agency shall conduct unannounced onsite facility
821 reviews following written verification of licensee noncompliance
822 in instances in which a long-term care ombudsman council,
823 pursuant to ss. 400.0071 and 400.0075, has received a complaint
824 and has documented deficiencies in resident care or in the
825 physical plant of the facility that threaten the health, safety,
826 or security of residents, or when the agency documents through

827 inspection that conditions in a facility present a direct or
828 indirect threat to the health, safety, or security of residents.
829 However, the agency shall conduct unannounced onsite reviews
830 every 3 months of each facility while the facility has a
831 conditional license as a result of final agency action.
832 Deficiencies related to physical plant do not require followup
833 reviews after the agency has determined that correction of the
834 deficiency has been accomplished and that the correction is of
835 the nature that continued compliance can be reasonably expected.
836 Section 11. Paragraph (d) of subsection (1) of section
837 400.195, Florida Statutes, is amended to read:
838 400.195 Agency reporting requirements.--
839 (1) For the period beginning June 30, 2001, and ending
840 June 30, 2005, the Agency for Health Care Administration shall
841 provide a report to the Governor, the President of the Senate,
842 and the Speaker of the House of Representatives with respect to
843 nursing homes. The first report shall be submitted no later than
844 December 30, 2002, and subsequent reports shall be submitted
845 every 6 months thereafter. The report shall identify facilities
846 based on their ownership characteristics, size, business
847 structure, for-profit or not-for-profit status, and any other
848 characteristics the agency determines useful in analyzing the
849 varied segments of the nursing home industry and shall report:
850 (d) Information regarding deficiencies cited, including
851 information used to develop the Nursing Home Guide WATCH LIST
852 pursuant to s. 400.191, and applicable rules, a summary of data
853 generated on nursing homes by Centers for Medicare and Medicaid
854 Services Nursing Home Quality Information Project, and

855 information collected pursuant to s. 400.147(8)~~(9)~~, relating to
856 litigation.
857 Section 12. Subsection (4) of section 400.211, Florida
858 Statutes, is amended to read:
859 400.211 Persons employed as nursing assistants;
860 certification requirement.--
861 (4) When employed by a nursing home facility for a 12-
862 month period or longer, a nursing assistant, to maintain
863 certification, shall submit to a performance review every 12
864 months and must receive regular inservice education based on the
865 outcome of such reviews. The inservice training must:
866 (a) Be sufficient to ensure the continuing competence of
867 nursing assistants and must meet the standard specified in s.
868 464.203(7).~~, must be at least 18 hours per year, and may include~~
869 ~~hours accrued under s. 464.203(8);~~
870 (b) Include, at a minimum:
871 1. Techniques for assisting with eating and proper
872 feeding.~~;~~
873 2. Principles of adequate nutrition and hydration.~~;~~
874 3. Techniques for assisting and responding to the
875 cognitively impaired resident or the resident with difficult
876 behaviors.~~;~~
877 4. Techniques for caring for the resident at the end-of-
878 life.~~; and~~
879 5. Recognizing changes that place a resident at risk for
880 pressure ulcers and falls.~~; and~~

881 (c) Address areas of weakness as determined in nursing
882 assistant performance reviews and may address the special needs
883 of residents as determined by the nursing home facility staff.
884
885 Costs associated with the ~~this~~ training required by this
886 subsection may not be reimbursed from additional Medicaid
887 funding through interim rate adjustments.
888 Section 13. Paragraphs (b) and (e) of subsection (7) and
889 subsection (8) of section 400.23, Florida Statutes, are amended,
890 and subsection (10) is added to said section, to read:
891 400.23 Rules; evaluation and deficiencies; licensure
892 status.--
893 (7) The agency shall, at least every 15 months, evaluate
894 all nursing home facilities and make a determination as to the
895 degree of compliance by each licensee with the established rules
896 adopted under this part as a basis for assigning a licensure
897 status to that facility. The agency shall base its evaluation on
898 the most recent inspection report, taking into consideration
899 findings from other official reports, surveys, interviews,
900 investigations, and inspections. The agency shall assign a
901 licensure status of standard or conditional to each nursing
902 home.
903 (b) A conditional licensure status means that a facility,
904 due to the presence of one or more class I or class II
905 deficiencies, or class III deficiencies not corrected within the
906 time established by the agency, is not in substantial compliance
907 at the time of the survey with criteria established under this
908 part or with rules adopted by the agency. If the facility has no

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909 class I, class II, or uncorrected class III deficiencies at the
910 time of the followup survey, a standard licensure status shall
911 ~~may~~ be assigned.
912 (e) Each licensee shall post its license, pursuant to
913 final agency action, in a prominent place that is in clear and
914 unobstructed public view at or near the place where residents
915 are being admitted to the facility.
916 (8) The agency shall adopt rules to provide that, when the
917 criteria established under subsection (2) are not met, such
918 deficiencies shall be classified according to the nature and the
919 scope of the deficiency. The scope shall be cited as isolated,
920 patterned, or widespread. An isolated deficiency is a deficiency
921 affecting one or a very limited number of residents, or
922 involving one or a very limited number of staff, or a situation
923 that occurred only occasionally or in a very limited number of
924 locations. A patterned deficiency is a deficiency where more
925 than a very limited number of residents are affected, or more
926 than a very limited number of staff are involved, or the
927 situation has occurred in several locations, or the same
928 resident or residents have been affected by repeated occurrences
929 of the same deficient practice but the effect of the deficient
930 practice is not found to be pervasive throughout the facility. A
931 widespread deficiency is a deficiency in which the problems
932 causing the deficiency are pervasive in the facility or
933 represent systemic failure that has affected or has the
934 potential to affect a large portion of the facility's residents.
935 The agency shall indicate the classification on the face of the
936 notice of deficiencies as follows:

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937 (a) A class I deficiency is a deficiency that the agency
938 determines presents a situation in which immediate corrective
939 action is necessary because the facility's noncompliance creates
940 immediate jeopardy to residents' health or safety. "Immediate
941 jeopardy" exists when the licensee's noncompliance has caused,
942 or is likely to cause, serious injury, harm, impairment, or
943 death to a resident receiving care in a facility. The condition
944 or practice constituting a class I violation shall be abated or
945 eliminated immediately, unless a fixed period of time, as
946 determined by the agency, is required for correction. A class I
947 deficiency is subject to a civil penalty of $10,000 for an
948 isolated deficiency, $12,500 for a patterned deficiency, and
949 $15,000 for a widespread deficiency. The fine amount shall be
950 doubled for each deficiency if the facility was previously cited
951 for one or more class I or class II deficiencies during the last
952 annual inspection or any inspection or complaint investigation
953 since the last annual inspection. A fine must be levied
954 notwithstanding the correction of the deficiency.
955 (b) A class II deficiency is a deficiency that the agency
956 determines has caused actual harm to a resident which is not
957 immediate jeopardy ~~compromised the resident's ability to~~
958 ~~maintain or reach his or her highest practicable physical,~~
959 ~~mental, and psychosocial well-being, as defined by an accurate~~
960 ~~and comprehensive resident assessment, plan of care, and~~
961 ~~provision of services~~. A class II deficiency is subject to a
962 civil penalty of $2,500 for an isolated deficiency, $5,000 for a
963 patterned deficiency, and $7,500 for a widespread deficiency.
964 The fine amount shall be doubled for each deficiency if the

965 facility was previously cited for one or more class I or class
966 II deficiencies during the last annual inspection or any
967 inspection or complaint investigation since the last annual
968 inspection. A fine shall be levied notwithstanding the
969 correction of the deficiency.
970 (c) A class III deficiency is a deficiency that the agency
971 determines has not caused actual harm to residents but presents
972 the potential for more than minimal harm that is not immediate
973 jeopardy ~~will result in no more than minimal physical, mental,~~
974 ~~or psychosocial discomfort to the resident or has the potential~~
975 ~~to compromise the resident's ability to maintain or reach his or~~
976 ~~her highest practical physical, mental, or psychosocial well-~~
977 ~~being, as defined by an accurate and comprehensive resident~~
978 ~~assessment, plan of care, and provision of services~~. A class III
979 deficiency is subject to a civil penalty of $1,000 for an
980 isolated deficiency, $2,000 for a patterned deficiency, and
981 $3,000 for a widespread deficiency. The fine amount shall be
982 doubled for each deficiency if the facility was previously cited
983 for one or more class I or class II deficiencies during the last
984 annual inspection or any inspection or complaint investigation
985 since the last annual inspection. A citation for a class III
986 deficiency must specify the time within which the deficiency is
987 required to be corrected. If a class III deficiency is corrected
988 within the time specified, no civil penalty shall be imposed.
989 (d) A class IV deficiency is a deficiency that the agency
990 determines has the potential for causing no more than minimal
991 harm to ~~a minor negative impact on~~ the resident. If the class IV
992 deficiency is isolated, no plan of correction is required.

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993 (10) Agency records, reports, ranking systems, Internet
994 information, and publications must reflect final agency actions.
995 Section 14. Section 400.244, Florida Statutes, is created
996 to read:
997 400.244 Alternative uses of nursing home beds; funding
998 limitations; applicable codes and requirements; procedures;
999 reconversion.--
1000 (1) It is the intent of the Legislature to allow nursing
1001 home facilities to use licensed nursing home facility beds for
1002 alternative uses other than nursing home care for extended
1003 periods of time exceeding 48 hours.
1004 (2) A nursing home may use a contiguous portion of the
1005 nursing home facility to meet the needs of the elderly through
1006 the use of less restrictive and less institutional methods of
1007 long-term care, including, but not limited to, adult day care,
1008 assisted living, extended congregate care, or limited nursing
1009 services.
1010 (3) Funding under assisted-living Medicaid waivers for
1011 nursing home facility beds that are used to provide extended
1012 congregate care or limited nursing services under this section
1013 may be provided only for residents who have resided in the
1014 nursing home facility for a minimum of 90 consecutive days.
1015 (4) Nursing home facility beds that are used in providing
1016 alternative services may share common areas, services, and staff
1017 with beds that are designated for nursing home care. Fire codes
1018 and life safety codes applicable to nursing home facilities also
1019 apply to beds used for alternative purposes under this section.

1020 Any alternative use must meet other requirements specified by
1021 law for that use.
1022 (5) In order to take beds out of service for nursing home
1023 care and use them to provide alternative services under this
1024 section, a nursing home must submit a written request for
1025 approval to the Agency for Health Care Administration in a
1026 format specified by the agency. The agency shall approve the
1027 request unless it determines that such action will adversely
1028 affect access to nursing home care in the geographical area in
1029 which the nursing home is located. The agency shall, in its
1030 review, consider a district average occupancy of 94 percent or
1031 greater at the time of the application as an indicator of an
1032 adverse impact. The agency shall review the request for
1033 alternative use at each annual license renewal.
1034 (6) A nursing home facility that converts beds to an
1035 alternative use under this section retains its license for all
1036 of the nursing home facility beds and may return those beds to
1037 nursing home operation upon 60 days' advance notice to the
1038 agency unless notice requirements are specified elsewhere in
1039 law. The nursing home facility shall continue to pay all
1040 licensure fees as required by s. 400.062 and applicable rules
1041 but is not required to pay any other state licensure fee for the
1042 alternative service.
1043 (7) Within 45 days after the end of each calendar quarter,
1044 each facility that has nursing facility beds licensed under this
1045 chapter shall report to the agency or its designee the total
1046 number of patient days which occurred in each month of the

1047 quarter and the number of such days which were Medicaid patient
1048 days.
1049 Section 15. Hospital Statutory and Regulatory Reform
1050 Council; legislative intent; creation; membership; duties.--
1051 (1) It is the intent of the Legislature to provide for the
1052 protection of the public health and safety in the establishment,
1053 construction, maintenance, and operation of hospitals. However,
1054 the Legislature further intends that the police power of the
1055 state be exercised toward that purpose only to the extent
1056 necessary and that regulation remain current with the ever-
1057 changing standard of care and not restrict the introduction and
1058 use of new medical technologies and procedures.
1059 (2) In order to achieve the purposes expressed in
1060 subsection (1), it is necessary that the state establish a
1061 mechanism for the ongoing review and updating of laws regulating
1062 hospitals. The Hospital Statutory and Regulatory Reform Council
1063 is created and located, for administrative purposes only, within
1064 the Agency for Health Care Administration. The council shall
1065 consist of no more than 15 members, including:
1066 (a) Nine members appointed by the Florida Hospital
1067 Association who represent acute care, teaching, specialty,
1068 rural, government-owned, for-profit, and not-for-profit
1069 hospitals.
1070 (b) Two members appointed by the Governor who represent
1071 patients.
1072 (c) Two members appointed by the President of the Senate
1073 who represent private businesses that provide health insurance
1074 coverage for their employees, one of whom represents small

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1075 private businesses and one of whom represents large private
1076 businesses. As used in this paragraph, the term "private
1077 business" does not include an entity licensed under chapter 627,
1078 Florida Statutes, or chapter 641, Florida Statutes, or otherwise
1079 licensed or authorized to provide health insurance services,
1080 either directly or indirectly, in this state.
1081 (d) Two members appointed by the Speaker of the House
1082 of Representatives who represent physicians.
1083 (3) Council members shall be appointed to serve 2-year
1084 terms and may be reappointed. A member shall serve until his or
1085 her successor is appointed. The council shall annually elect
1086 from among its members a chair and a vice chair. The council
1087 shall meet at least twice a year and shall hold additional
1088 meetings as it considers necessary. Members appointed by the
1089 Florida Hospital Association may not receive compensation or
1090 reimbursement of expenses for their services. Members appointed
1091 by the Governor, the President of the Senate, or the Speaker of
1092 the House of Representatives may be reimbursed for travel
1093 expenses by the agency.
1094 (4) The council, as its first priority, shall review
1095 chapters 395 and 408, Florida Statutes, and shall make
1096 recommendations to the Legislature for the repeal of regulatory
1097 provisions that are no longer necessary or that fail to promote
1098 cost-efficient, high-quality medicine.
1099 (5) The council, as its second priority, shall recommend
1100 to the Secretary of Health and the Secretary of Health Care
1101 Administration regulatory changes relating to hospital licensure
1102 and regulation to assist the Department of Health and the Agency

1103 for Health Care Administration in carrying out their duties and
1104 to ensure that the intent of the Legislature as expressed in
1105 this section is carried out.
1106 (6) In determining whether a statute or rule is
1107 appropriate or necessary, the council shall consider whether:
1108 (a) The statute or rule is necessary to prevent
1109 substantial harm, which is recognizable and not remote, to the
1110 public health, safety, or welfare.
1111 (b) The statute or rule restricts the use of new medical
1112 technologies or encourages the implementation of more cost-
1113 effective medical procedures.
1114 (c) The statute or rule has an unreasonable effect on job
1115 creation or job retention in the state.
1116 (d) The public is or can be effectively protected by other
1117 means.
1118 (e) The overall cost-effectiveness and economic effect of
1119 the proposed statute or rule, including the indirect costs to
1120 consumers, will be favorable.
1121 (f) A lower-cost regulatory alternative to the statute or
1122 rule could be adopted.
1123 Section 16. This act shall take effect July 1, 2003.