A bill to be entitled

An act relating to health care; amending s. 395.002, F.S.; providing definitions applicable to provisions regulating hospitals and other licensed facilities; conforming cross references; amending s. 395.003, F.S.; specifying that only the applicant is entitled to an administrative hearing on its application; conforming a cross reference; creating s. 395.0095, F.S.; establishing licensing criteria for cardiac programs; requiring reporting; amending s. 408.034, F.S.; providing a nursing-home-bed need methodology that has a goal of maintaining a specified district average occupancy rate; amending s. 408.036, F.S., relating to health-care-related projects subject to review for a certificate of need; deleting hospice inpatient facilities from the projects subject to review; deleting shared services contracts or projects from expedited review; modifying circumstances requiring transfer of a certificate of need; providing expedited review for replacement of a nursing home and for relocation of a portion of a nursing home's beds; adding or revising exemptions for addition of acute care beds, hospital-based distinct part skilled nursing unit beds, comprehensive medical rehabilitation beds, Level II or Level III neonatal intensive care beds, mental health services beds, and nursing home beds; adding exemptions for conversion of mental health services beds, replacement of a statutory rural hospital, establishment of a Level II neonatal intensive care unit, replacement of a licensed nursing home, consolidation or combination of nursing homes or transfer of beds between nursing homes by

providers that operate multiple nursing homes, and establishment of certain adult open-heart programs; deleting exemptions relating to establishment of certain specialty hospitals and a satellite facility for new medical technologies; amending s. 408.037, F.S.; allowing a consolidated audit of a parent company; providing that the acquisition of a licensed hospital includes acquisition of any pending certificate-of-need application; amending s. 408.038, F.S.; increasing fees to fund the activities of the certificate-of-need program; amending s. 408.039, F.S.; eliminating the right of existing health care facilities to initiate or intervene in an administrative hearing pertaining to the issuance or denial of a certificate of need; providing that without agency action within a specified time period the recommended order of the Division of Administrative Hearings becomes the final order; removing the requirement that the court must find a complete absence of a judiciable issue of law or fact prior to awarding attorney's fees and costs; requiring a hospital that is the losing party in a judicial review to pay the reasonable attorney's fees and costs of the prevailing hospital; amending s. 408.043, F.S.; deleting a provision requiring a certificate of need for a hospice inpatient facility, to conform to changes made by the act; amending s. 408.05, F.S.; providing quality outcome measure reporting requirements and standards for cardiac programs; amending s. 52, ch. 2001-45, Laws of Florida; establishing criteria for which the imposed moratorium on certificates of need for nursing homes does not apply; amending ss.

383.50, 394.4787, 395.602, 395.701, 400.051, 409.905, 468.505, 766.316, and 812.014, F.S.; conforming cross references; providing a grandfather clause for cardiac programs; amending s. 408.043, F.S.; including the additional beds at certain acute care hospitals in high growth counties in the inventory of hospital beds used in the calculation of the fixed-bed-need pool for acute care hospitals; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 395.002, Florida Statutes, is amended to read:

395.002 Definitions.--As used in this chapter:

(1) "Accrediting organizations" means the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care, Inc.

(2) "Adult" mean a person who is 18 years of age or older.

(3)~~(2)~~ "Agency" means the Agency for Health Care Administration.

(4)~~(3)~~ "Ambulatory surgical center" or "mobile surgical facility" means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office

maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, shall be construed to be a mobile surgical facility.

(5)~~(4)~~ "Applicant" means an individual applicant, or any officer, director, or agent, or any partner or shareholder having an ownership interest equal to a 5-percent or greater interest in the corporation, partnership, or other business entity.

(6)~~(5)~~ "Biomedical waste" means any solid or liquid waste as defined in s. 381.0098(2)(a).

(7) "Cardiac surgery program" means a health service that is provided by or on behalf of a health care facility in which surgical procedures occur that treat conditions such as congenital heart defects and heart and coronary artery diseases, including replacement of heart valves, cardiac vascularization, and cardiac trauma. One cardiac surgery operation equals one patient admission to the hospital during which one or more cardiac surgeries are performed. Cardiac surgery operations are classified under the following Medicare diagnostic-related groups: 104, 105, 106, 107, 108, and 109.

(8)~~(6)~~ "Clinical privileges" means the privileges granted to a physician or other licensed health care practitioner to

render patient care services in a hospital, but does not include the privilege of admitting patients.

(9)~~(7)~~ "Department" means the Department of Health.

(10) "Diagnostic cardiac catheterization program" means a health service that is provided by or on behalf of a health care facility, that consists of one or more laboratories comprised of a room or suite of rooms, and that has the equipment and staff required to perform diagnostic cardiac catheterization serving inpatients and outpatients.

(11)~~(8)~~ "Director" means any member of the official board of directors as reported in the organization's annual corporate report to the Florida Department of State, or, if no such report is made, any member of the operating board of directors. The term excludes members of separate, restricted boards that serve only in an advisory capacity to the operating board.

(12) "Elective percutaneous coronary care program" means a health service that is provided by or on behalf of a health care facility for cardiac patients with procedures involving the use of a coronary artery catheter that is for more than diagnostic purposes. Such procedures include, but are not limited to, rotational atherectomy, directional atherectomy, extraction of atherectomy, laser angioplasty, ablation, and implementation of intracoronary stents. Each elective percutaneous coronary care program shall have a formal agreement for offsite surgical backup.

(13)~~(9)~~ "Emergency medical condition" means:

(a) A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to patient health, including a pregnant woman or fetus.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

(b) With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery;

2. That a transfer may pose a threat to the health and safety of the patient or fetus; or

3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

(14) "Emergency/primary percutaneous coronary intervention program" means a health service that is provided by or on behalf of a health care facility providing cardiac care, which includes procedures involving the use of a coronary artery catheter that is for more than diagnostic purposes, and that is applicable only to patients presenting with an acute myocardial infarction or similar condition in an emergency department. Such procedures include, but are not limited to, rotational atherectomy, directional atherectomy, extraction of atherectomy, laser angioplasty, ablation, and implementation of intracoronary stents for patients with an emergency condition. Each emergency/primary percutaneous coronary intervention program shall have in place a transfer agreement to a facility with a licensed cardiac surgery program.

(15)~~(10)~~ "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care,

treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

(16)~~(11)~~ "General hospital" means any facility which meets the provisions of subsection (18) ~~(13)~~ and which regularly makes its facilities and services available to the general population.

(17)~~(12)~~ "Governmental unit" means the state or any county, municipality, or other political subdivision, or any department, division, board, or other agency of any of the foregoing.

(18)~~(13)~~ "Hospital" means any establishment that:

(a) Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and

(b) Regularly makes available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment of similar extent.

However, the provisions of this chapter do not apply to any institution conducted by or for the adherents of any well-recognized church or religious denomination that depends exclusively upon prayer or spiritual means to heal, care for, or treat any person. For purposes of local zoning matters, the term "hospital" includes a medical office building located on the same premises as a hospital facility, provided the land on which the medical office building is constructed is zoned for use as a

hospital; provided the premises were zoned for hospital purposes on January 1, 1992.

(19)~~(14)~~ "Hospital bed" means a hospital accommodation which is ready for immediate occupancy, or is capable of being made ready for occupancy within 48 hours, excluding provision of staffing, and which conforms to minimum space, equipment, and furnishings standards as specified by rule of the agency for the provision of services specified in this section to a single patient.

(20)~~(15)~~ "Initial denial determination" means a determination by a private review agent that the health care services furnished or proposed to be furnished to a patient are inappropriate, not medically necessary, or not reasonable.

(21)~~(16)~~ "Intensive residential treatment programs for children and adolescents" means a specialty hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations which provides 24-hour care and which has the primary functions of diagnosis and treatment of patients under the age of 18 having psychiatric disorders in order to restore such patients to an optimal level of functioning.

(22)~~(17)~~ "Licensed facility" means a hospital, ambulatory surgical center, or mobile surgical facility licensed in accordance with this chapter.

(23)~~(18)~~ "Lifesafety" means the control and prevention of fire and other life-threatening conditions on a premises for the purpose of preserving human life.

(24)~~(19)~~ "Managing employee" means the administrator or other similarly titled individual who is responsible for the daily operation of the facility.

(25)~~(20)~~ "Medical staff" means physicians licensed under chapter 458 or chapter 459 with privileges in a licensed facility, as well as other licensed health care practitioners with clinical privileges as approved by a licensed facility's governing board.

(26)~~(21)~~ "Medically necessary transfer" means a transfer made necessary because the patient is in immediate need of treatment for an emergency medical condition for which the facility lacks service capability or is at service capacity.

(27)~~(22)~~ "Mobile surgical facility" is a mobile facility in which licensed health care professionals provide elective surgical care under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957 and in which inmate patients are admitted to and discharged from said facility within the same working day and are not permitted to stay overnight. However, mobile surgical facilities may only provide health care services to the inmate patients of the Department of Corrections, or inmate patients of a private correctional facility operating pursuant to chapter 957, and not to the general public.

(28) "Pediatric patient" means a patient who is under 18 years of age.

(29) "Percutaneous coronary intervention" means any procedure involving the use of a coronary artery catheter that is for more than diagnostic purposes. Such procedures include, but are not limited to, rotational atherectomy, directional atherectomy, extraction of atherectomy, laser angioplasty, ablation, and implementation of intracoronary stents.

(30)~~(23)~~ "Person" means any individual, partnership, corporation, association, or governmental unit.

(31)~~(24)~~ "Premises" means those buildings, beds, and equipment located at the address of the licensed facility and all other buildings, beds, and equipment for the provision of hospital, ambulatory surgical, or mobile surgical care located in such reasonable proximity to the address of the licensed facility as to appear to the public to be under the dominion and control of the licensee. For any licensee that is a teaching hospital as defined in s. 408.07(44), reasonable proximity includes any buildings, beds, services, programs, and equipment under the dominion and control of the licensee that are located at a site with a main address that is within 1 mile of the main address of the licensed facility; and all such buildings, beds, and equipment may, at the request of a licensee or applicant, be included on the facility license as a single premises.

(32)~~(25)~~ "Private review agent" means any person or entity which performs utilization review services for third-party payors on a contractual basis for outpatient or inpatient services. However, the term shall not include full-time employees, personnel, or staff of health insurers, health maintenance organizations, or hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, when performing utilization review for their respective hospitals, health maintenance organizations, or insureds of the same insurance group. For this purpose, health insurers, health maintenance organizations, and hospitals, or wholly owned subsidiaries thereof or affiliates under common ownership, include such entities engaged as administrators of self-insurance as defined in s. 624.031.

(33)~~(26)~~ "Service capability" means all services offered by the facility where identification of services offered is

evidenced by the appearance of the service in a patient's medical record or itemized bill.

(34)~~(27)~~ "At service capacity" means the temporary inability of a hospital to provide a service which is within the service capability of the hospital, due to maximum use of the service at the time of the request for the service.

(35)~~(28)~~ "Specialty bed" means a bed, other than a general bed, designated on the face of the hospital license for a dedicated use.

(36)~~(29)~~ "Specialty hospital" means any facility which meets the provisions of subsection (18) ~~(13)~~, and which regularly makes available either:

(a) The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population;

(b) A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or

(c) Intensive residential treatment programs for children and adolescents as defined in subsection (21) ~~(16)~~.

(37)~~(30)~~ "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the patient from a hospital.

(38) "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Such services include, and are limited to, organ

transplantation, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and cardiac surgery.

(39)~~(31)~~ "Utilization review" means a system for reviewing the medical necessity or appropriateness in the allocation of health care resources of hospital services given or proposed to be given to a patient or group of patients.

(40)~~(32)~~ "Utilization review plan" means a description of the policies and procedures governing utilization review activities performed by a private review agent.

(41)~~(33)~~ "Validation inspection" means an inspection of the premises of a licensed facility by the agency to assess whether a review by an accrediting organization has adequately evaluated the licensed facility according to minimum state standards.

Section 2. Paragraph (e) of subsection (2) of section 395.003, Florida Statutes, is amended, and subsection (9) is added to said section, to read:

395.003 Licensure; issuance, renewal, denial, modification, suspension, and revocation.--

(2)

(e) The agency shall, at the request of a licensee that is a teaching hospital as defined in s. 408.07(44), issue a single license to a licensee for facilities that have been previously licensed as separate premises, provided such separately licensed facilities, taken together, constitute the same premises as defined in s. 395.002(31)~~(24)~~. Such license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph

shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

(9) In administrative proceedings on an application to license any health care facility or program or to provide any service or take any other action requiring health care facility licensure authority, only the applicant is entitled to an administrative hearing on its application. No other person may initiate or intervene in any action to determine whether such an application should be approved or denied.

Section 3. Section 395.0095, Florida Statutes, is created to read:

395.0095 Licensed cardiac programs.--

(1) LICENSED CARDIAC PROGRAMS.--The following inpatient services when provided by a hospital licensed under this chapter shall be subject to the requirements as specified in this section and in ss. 395.003 and 408.05 and shall be separately listed on the hospital license and specify whether the service is for adults or pediatric patients for:

(a) Diagnostic cardiac catheterization programs.

(b) Emergency/primary percutaneous coronary intervention programs.

(c) Elective percutaneous coronary intervention programs.

(d) Cardiac surgery programs.

(2) REQUIRMENTS FOR LICENSED CARDIAC PROGRAMS.--Each hospital providing diagnostic cardiac catheterization, emergency/primary percutaneous coronary interventions, elective percutaneous interventions, or cardiac surgery shall be subject to the following provisions:

(a) The hospital shall document for each program it provides that sufficient numbers of properly trained personnel

shall be available for the specific service offered to ensure quality of care and patient safety, providing services 24 hours a day, 7 days a week, in accordance with the guidelines established by the American College of Cardiology and the American Heart Association.

(b) The hospital shall be fully accredited by the Joint Commission on Accreditation of Health Care Organizations in accordance with evidence-based standards and core measures for cardiac programs.

(c) The hospital shall ensure that each program it provides shall possess the capability for emergency services, which includes rapid mobilization of the surgical and medical support teams for emergency cases, 24 hours a day, 7 days a week.

(3) MINIMUM STANDARDS FOR QUALITY OUTCOME MEASURES AND PUBLIC REPORTING.--Beginning January 1, 2004, each hospital with a cardiac program as defined in this section shall submit the data elements required by s. 408.05(9). As of July 1, 2005, each hospital with a cardiac program as defined in this section shall be subject to the quality outcome standards established pursuant to s. 408.05(9).

(a) After July 1, 2006, and before December 30, 2006, all hospitals with cardiac programs shall be notified by the department of their standing in the various quality measures.

(b) Any hospital whose service or services fail to achieve an acceptable rating pursuant to s. 408.05, when adjusted for, but not limited to, age, sex, and severity of patients, shall be directed by the agency, within 30 days after its receipt of the hospital's quality outcome scores, to submit a plan for quality improvements within 60 days.

(4) REQUIREMENTS FOR DIAGNOSTIC CARDIAC CATHETERIZATION PROGRAMS.--

(a) Each diagnostic cardiac catheterization program shall:

1. Have the capability of providing immediate endocardiac catheter pacemaking, in case of cardiac arrest or heart failure, and pressure recording for monitoring and evaluating valvular disease.

2. Provide a full range of noninvasive cardiac or circulatory diagnostic services within the hospital itself.

3. Have the capability of rapid mobilization of the study team within 30 minutes after emergency procedures, 24 hours a day, 7 days a week.

4. Provide a minimum of 500 catheterizations annually.

(b) Diagnostic cardiac catheterization programs licensed in a facility not licensed for a cardiac surgery program must submit, as part of their licensure application, a written protocol for the transfer of emergency patients to a hospital providing cardiac surgery that is within 30 minutes' travel time via air or ground transportation vehicle under average travel conditions.

(c) Pediatric cardiac catheterization programs must be located in a hospital in which pediatric cardiac surgery is being performed.

(5) REQUIRMENTS FOR EMERGENCY/PRIMARY PERCUTANEOUS CORONARY INTERVENTION PROGRAMS.--

(a) Each hospital providing emergency/primary percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital without an operational cardiac surgery program must comply with the following:

1. Provide a cardiologist or cardiovascular surgeon who is

an experienced interventionalist who has performed a minimum of 75 interventions within the previous 12 months.

2. Provide a minimum of 36 emergency interventions annually, in order to continue to provide the service.

3. Provide nursing and technical staff who have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers and cardiac care nursing staff who are adept in hemodynamic monitoring and Intra Aortic Balloon Pump (IABP) management.

4. Provide formalized written transfer agreements, developed with a hospital with an adult cardiac surgery program, and put in place written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes. Transfer and transport agreements must be reviewed and tested, with appropriate documentation maintained at least every 3 months.

5. Certify that the facility implementing the service undertook a 3-month to 6-month training program that includes establishing standards, testing logistics, providing quality assessment and error management practices, and formalizing patient selection criteria.

6. Certify that it will utilize at all times at hospitals without adult cardiac surgery programs the patient selection criteria for the performance of primary angioplasty issued by the American College of Cardiology and the American Heart Association.

(b) The applicant must agree to submit a quarterly report to the agency detailing patient characteristics and treatment and outcomes for all patients receiving emergency/primary percutaneous coronary interventions pursuant to this licensure

category. The specialty license provided by this subsection shall not apply unless the agency determines that the hospital has taken all necessary steps to comply with the requirements of this subsection, including the training program required pursuant to subparagraph (a)5.

(6) REQUIRMENTS FOR ELECTIVE PERCUTANEOUS CORONARY INTERVENTION PROGRAMS.--

(a) Each hospital providing elective percutaneous coronary intervention for patients in a hospital without an operational adult cardiac surgery program must comply with the following:

1. Provide a cardiologist or cardiovascular surgeon who is an experienced interventionalist who has performed a minimum of 150 interventions within the previous 12 months.

2. Provide a minimum of 400 elective interventions annually, in order to continue to provide the service.

3. Provide nursing and technical staff who have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers and cardiac care nursing staff who are adept in hemodynamic monitoring and Intra-aortic Balloon Pump (IABP) management.

4. Provide formalized written transfer agreements, developed with a hospital with an adult cardiac surgery program, and put in place written transport protocols to ensure safe and efficient transfer of a patient within 30 minutes. Transfer and transport agreements must be reviewed and tested, with appropriate documentation maintained at least every 3 months.

5. Certify that the facility implementing the service undertook a 3-month to 6-month training program that includes establishing standards, testing logistics, providing quality

assessment and error management practices, and formalizing patient selection criteria.

6. Certify that it will utilize at all times at hospitals without adult cardiac surgery programs the patient selection criteria for the performance of primary angioplasty issued by the American College of Cardiology and the American Heart Association.

(b) The applicant must agree to submit a quarterly report to the agency detailing patient characteristics and treatment and outcomes for all patients receiving elective percutaneous coronary interventions pursuant to this licensure category. This report must be submitted within 45 days after the close of each calendar quarter. The specialty license provided by this subsection shall not apply unless the agency determines that the hospital has taken all necessary steps to comply with the requirements of this subsection, including the training program required pursuant to subparagraph (a)5.

(c) Pediatric percutaneous coronary intervention programs must be located in a hospital in which pediatric cardiac surgery is being performed.

(7) REQUIRMENTS FOR CARDIAC SURGERY PROGRAMS.--

(a) Each hospital providing a cardiac surgery program must have the capability to provide a full range of cardiac surgery operations, including, at a minimum:

1. Repair or replacement of heart valves.

2. Repair of congenital heart defects.

3. Cardiac revascularization.

4. Repair or reconstruction of intrathoracic vessels.

5. Treatment of cardiac trauma.

(b) Each cardiac surgery program must document its ability

to implement and apply circulatory assist devices such as intra-aortic balloon assist and prolonged cardiopulmonary partial bypass.

(c) Each hospital with a cardiac surgery program shall provide the following services:

1. Cardiology, gastroenterology, hematology, nephrology, pulmonary medicine, general surgery, and treatment of infectious diseases.

2. Pathology, including anatomical, clinical, blood bank, and coagulation laboratory services.

3. Anesthesiology, including respiratory therapy.

4. Radiology, including diagnostic nuclear medicine.

5. Neurology.

6. Inpatient cardiac catheterization.

7. Noninvasive cardiographics, including electrocardiography, exercise stress testing, and echocardiography.

8. Intensive care.

9. Emergency care available 24 hours a day, 7 days a week, for cardiac emergencies.

(d) For emergency services:

1. Each cardiac surgery program shall be available for elective cardiac operations 8 hours a day, 5 days a week. Each cardiac surgery program shall possess the capability for rapid mobilization of the surgical and medical support teams for emergency cases, 24 hours a day, 7 days a week.

2. Cardiac surgery shall routinely be available for emergency cardiac surgery operations within a maximum waiting period of 2 hours.

(e) Each cardiac surgery program shall provide a minimum

of 300 cardiac surgeries within the first 3 years of operation and annually thereafter.

(f) Each hospital applying for licensure of a cardiac surgery program must be a licensed general acute care hospital that is in operation for 3 years or more. This section shall not be construed as allowing single-service hospitals to apply for licensure.

(g) Each cardiac surgery program shall provide nursing and technical staff who have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers and cardiac care nursing staff who are adept in hemodynamic monitoring and Intra Aortic Balloon Pump (IABP) management.

Section 4. Subsection (5) of section 408.034, Florida Statutes, is amended to read:

408.034 Duties and responsibilities of agency; rules.--

(5) The agency shall establish by rule a nursing-home-bed-need methodology that has a goal of maintaining a district average occupancy rate of 94 percent and that reduces the community nursing home bed need for the areas of the state where the agency establishes pilot community diversion programs through the Title XIX aging waiver program.

Section 5. Section 408.036, Florida Statutes, is amended to read:

408.036 Projects subject to review; exemptions.--

(1) APPLICABILITY.--Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(h), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively

responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.

(a) The addition of beds by new construction or alteration.

(b) The new construction or establishment of additional health care facilities, including a replacement health care facility when the proposed project site is not located on the same site as the existing health care facility.

(c) The conversion from one type of health care facility to another.

(d) An increase in the total licensed bed capacity of a health care facility.

(e) The establishment of a hospice ~~or hospice inpatient facility~~, except as provided in s. 408.043.

(f) The establishment of inpatient health services by a health care facility, or a substantial change in such services.

(g) An increase in the number of beds for acute care, nursing home care beds, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, mental health services, or hospital-based distinct part skilled nursing units, or at a long-term care hospital.

(h) The establishment of tertiary health services.

(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:

(a) Research, education, and training programs.

~~(b) Shared services contracts or projects.~~

(b)~~(c)~~ A transfer of a certificate of need, except that when an existing hospital is acquired by a purchaser, all certificates of need issued to the hospital which are not yet

operational shall be acquired by the purchaser without the need for a transfer.

(c)~~(d)~~ 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. ~~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)~~(e)~~ 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.

(f) Replacement of a nursing home within the same district, provided the proposed project site is located within a geographic area that contains at least 65 percent of the

facility's current residents and is within a 30-mile radius of the replaced nursing home.

(g) Relocation of a portion of a nursing home's licensed beds to a replacement facility within the same district, provided the relocation is within a 30-mile radius of the existing facility and the total number of nursing home beds in the district does not increase.

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.

(b) For hospice services or for swing beds in a rural hospital, as defined in s. 395.602, in a number that does not exceed one-half of its licensed beds.

(c) For the conversion of licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, so long as the conversion of the beds does not involve the construction of new facilities. The total number of skilled nursing beds, including swing beds, may not exceed one-half of the total number of licensed beds in the rural hospital as of July 1, 1993. Certified skilled nursing beds designated under this paragraph, excluding swing beds, shall be included in the community nursing home bed inventory. A rural hospital which subsequently

decertifies any acute care beds exempted under this paragraph shall notify the agency of the decertification, and the agency shall adjust the community nursing home bed inventory accordingly.

(d) For the addition of nursing home beds at a skilled nursing facility that is part of a retirement community that provides a variety of residential settings and supportive services and that has been incorporated and operated in this state for at least 65 years on or before July 1, 1994. All nursing home beds must not be available to the public but must be for the exclusive use of the community residents.

(e) For an increase in the bed capacity of a nursing facility licensed for at least 50 beds as of January 1, 1994, under part II of chapter 400 which is not part of a continuing care facility if, after the increase, the total licensed bed capacity of that facility is not more than 60 beds and if the facility has been continuously licensed since 1950 and has received a superior rating on each of its two most recent licensure surveys.

(f) For an inmate health care facility built by or for the exclusive use of the Department of Corrections as provided in chapter 945. This exemption expires when such facility is converted to other uses.

(g) For the termination of an inpatient health care service, upon 30 days' written notice to the agency.

(h) For the delicensure of beds, upon 30 days' written notice to the agency. A request for exemption submitted under this paragraph must identify the number, the category of beds, and the name of the facility in which the beds to be delicensed are located.

(i) For the provision of adult inpatient diagnostic cardiac catheterization services in a hospital.

1. In addition to any other documentation otherwise required by the agency, a request for an exemption submitted under this paragraph must comply with the following criteria:

a. The applicant must certify it will not provide therapeutic cardiac catheterization pursuant to the grant of the exemption.

b. The applicant must certify it will meet and continuously maintain the minimum licensure requirements adopted by the agency governing such programs pursuant to subparagraph 2.

c. The applicant must certify it will provide a minimum of 2 percent of its services to charity and Medicaid patients.

2. The agency shall adopt licensure requirements by rule which govern the operation of adult inpatient diagnostic cardiac catheterization programs established pursuant to the exemption provided in this paragraph. The rules shall ensure that such programs:

a. Perform only adult inpatient diagnostic cardiac catheterization services authorized by the exemption and will not provide therapeutic cardiac catheterization or any other services not authorized by the exemption.

b. Maintain sufficient appropriate equipment and health personnel to ensure quality and safety.

c. Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

d. Maintain appropriate program volumes to ensure quality and safety.

e. Provide a minimum of 2 percent of its services to charity and Medicaid patients each year.

3.a. The exemption provided by this paragraph shall not apply unless the agency determines that the program is in compliance with the requirements of subparagraph 1. and that the program will, after beginning operation, continuously comply with the rules adopted pursuant to subparagraph 2. The agency shall monitor such programs to ensure compliance with the requirements of subparagraph 2.

b.(I) The exemption for a program shall expire immediately when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.a., b., and c.

(II) Beginning 18 months after a program first begins treating patients, the exemption for a program shall expire when the program fails to comply with the rules adopted pursuant to sub-subparagraphs 2.d. and e.

(III) If the exemption for a program expires pursuant to sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the agency shall not grant an exemption pursuant to this paragraph for an adult inpatient diagnostic cardiac catheterization program located at the same hospital until 2 years following the date of the determination by the agency that the program failed to comply with the rules adopted pursuant to subparagraph 2.

(j) For mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957.

(k) For state veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs in accordance with part II of chapter 296 for which at least 50

percent of the construction cost is federally funded and for which the Federal Government pays a per diem rate not to exceed one-half of the cost of the veterans' care in such state nursing homes. These beds shall not be included in the nursing home bed inventory.

(l) For 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. An exemption granted under this paragraph shall extend the validity period of the certificates of need to be consolidated by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption. The longest validity period among the certificates shall be applicable to each of the combined certificates.

(m) For division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificate of need to be divided by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption.

(n) For the addition of hospital beds licensed under chapter 395.

1. Beds in the following licensed categories may be increased under this paragraph:

a. ~~for~~ Acute care beds, ~~mental health services, or a hospital-based distinct part skilled nursing unit~~ in a number that may not exceed 30 ~~10~~ total beds or 10 percent of the licensed capacity of acute care beds ~~the bed category being expanded~~, whichever is greater;

b. Hospital-based distinct part skilled nursing unit beds, in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of skilled nursing unit beds, whichever is greater;

c. Comprehensive medical rehabilitation beds in a number that may not exceed 8 total beds or 10 percent of the licensed capacity of comprehensive medical rehabilitation beds, whichever is greater;

d. Level II or Level III neonatal intensive care beds, in a number that may not exceed 6 total beds or 10 percent of the licensed capacity of Level II or Level III neonatal intensive care beds, whichever is greater; or

e. Mental health services beds, in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of mental health services beds, whichever is greater.

2. Beds for specialty burn units~~, neonatal intensive care units, or comprehensive rehabilitation,~~ or at a long-term care hospital~~,~~ may not be increased under this paragraph.

3.~~1.~~ In addition to any other documentation otherwise required by the agency, a request for exemption submitted under this paragraph must:

a. Certify that the prior 12-month average occupancy rate is at least 75 percent for acute care beds, at least 96 percent ~~for the category of licensed beds being expanded at the facility meets or exceeds 80 percent or,~~ for ~~a~~ hospital-based distinct part skilled nursing unit beds, at least 90 percent for comprehensive medical rehabilitation beds, or at least 75 percent for the level of neonatal intensive care beds being expanded ~~the prior 12-month average occupancy rate meets or exceeds 96 percent~~.

b. Certify that any beds of the same type authorized for the facility under this paragraph before the date of the current request for an exemption have been licensed and operational for at least 12 months.

4.~~2.~~ The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.

5.~~3.~~ The agency shall count beds authorized under this paragraph as approved beds in the published inventory of hospital beds until the beds are licensed.

(o) For the addition of acute care beds, as authorized by rule consistent with s. 395.003(4), in a number that may not exceed 30 ~~10~~ total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.

(p) For the addition of nursing home beds licensed under chapter 400 in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater.

1. In addition to any other documentation required by the agency, a request for exemption submitted under this paragraph must:

a. ~~Effective until June 30, 2001,~~ Certify that the facility has not had any class I or class II deficiencies within the 30 months preceding the request for addition.

~~b. Effective on July 1, 2001, certify that the facility has been designated as a Gold Seal nursing home under s. 400.235.~~

b.~~c.~~ Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 96 percent.

c.~~d.~~ Certify that any beds authorized for the facility under this paragraph before the date of the current request for an exemption have been licensed and operational for at least 12 months.

2. The timeframes and monitoring process specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.

3. The agency shall count beds authorized under this paragraph as approved beds in the published inventory of nursing home beds until the beds are licensed.

~~(q) For establishment of a specialty hospital offering a range of medical service restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county.~~

(q)~~(r)~~ For the conversion of hospital-based Medicare and Medicaid certified skilled nursing beds to acute care beds, if the conversion does not involve the construction of new facilities.

(r) For the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services, provided that 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.

(s) For the replacement of a statutory rural hospital within the same district, provided the proposed project site is within 10 miles of the existing facility and is within the current primary service area, defined as the least number of zip codes comprising 75 percent of the hospital's inpatient admissions.

(t) For the establishment of a Level II neonatal intensive care unit with at least 10 beds, upon documentation to the agency that the applicant hospital had a minimum of 1,500 births during the previous 12 months.

(u) For replacement of a licensed nursing home on the same site, or within 3 miles of the same site, provided the number of licensed beds does not increase.

(v) For consolidation or combination of licensed nursing homes or transfer of beds between licensed nursing homes within the same district, by providers that operate multiple nursing homes within that district, provided there is no increase in the district total of nursing home beds and the relocation does not exceed 30 miles from the original location.

(w) For the establishment of an adult open-heart program in a facility located in a municipality without an open-heart program which has a population of 225,000 or more.

~~(s) For fiscal year 2001-2002 only, for transfer by a health care system of existing services and not more than 100 licensed and approved beds from a hospital in district 1, subdistrict 1, to another location within the same subdistrict in order to establish a satellite facility that will improve access to outpatient and inpatient care for residents of the district and subdistrict and that will use new medical technologies, including advanced diagnostics, computer assisted~~

~~imaging, and telemedicine to improve care. This paragraph is repealed on July 1, 2002.~~

(4) A request for exemption under subsection (3) may be made at any time and is not subject to the batching requirements of this section. The request shall be supported by such documentation as the agency requires by rule. The agency shall assess a fee of $250 for each request for exemption submitted under subsection (3).

Section 6. Paragraph (c) of subsection (1) and subsection (2) of section 408.037, Florida Statutes, are amended to read:

408.037 Application content.--

(1) An application for a certificate of need must contain:

(c) An audited financial statement of the applicant<u>; or, if the applicant is included in a parent company's consolidated audit which details each entity separately, an audited financial statement of the parent company</u>. In an application submitted by an existing health care facility, health maintenance organization, or hospice, financial condition documentation must include, but need not be limited to, a balance sheet and a profit-and-loss statement of the 2 previous fiscal years' operation.

(2) The applicant must certify that it will license and operate the health care facility. For an existing health care facility, the applicant must be the licenseholder of the facility. <u>However, acquisition of a licensed hospital prior to final agency action on its application for a certificate of need shall transfer the application to the new owner and licenseholder.</u>

Section 7. Section 408.038, Florida Statutes, is amended to read:

408.038 Fees.--

(1) The agency shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding ~~the functions of the local health councils and~~ the activities of the agency. Except as otherwise provided in subsection (2), such fees ~~and~~ shall be allocated as provided in s. 408.033. The fee shall be determined as follows:

(a)~~(1)~~ A minimum base fee of $10,000 ~~$5,000~~.

(b)~~(2)~~ In addition to the base fee of $10,000 ~~$5,000~~, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed $50,000 ~~$22,000~~.

(2) The proceeds from half of each minimum base fee under paragraph (1)(a) and the proceeds from each additional amount assessed under paragraph (1)(b) which is in excess of $22,000 shall be used to fund activities of the certificate-of-need program.

Section 8. Paragraphs (c) and (e) of subsection (5) and paragraph (c) of subsection (6) of section 408.039, Florida Statutes, are amended to read:

408.039 Review process.--The review process for certificates of need shall be as follows:

(5) ADMINISTRATIVE HEARINGS.--

(c) In administrative proceedings challenging the issuance or denial of a certificate of need, only applicants considered by the agency in the same batching cycle are entitled to a comparative hearing on their applications. ~~Existing health care facilities may initiate or intervene in an administrative hearing upon a showing that an established program will be substantially affected by the issuance of any certificate of~~

~~need, whether reviewed under s. 408.036(1) or (2), to a competing proposed facility or program within the same district.~~

(e) The agency shall issue its final order within 45 days after receipt of the recommended order. If the agency fails to take action within 45 days, the recommended order of the Division of Administrative Hearings becomes the agency's final order ~~such time, or as otherwise agreed to by the applicant and the agency, the applicant may take appropriate legal action to compel the agency to act~~. When making a determination on an application for a certificate of need, the agency is specifically exempt from the time limitations provided in s. 120.60(1).

(6) JUDICIAL REVIEW.--

(c) The court, in its discretion, may award reasonable attorney's fees and costs to the prevailing party. If the losing party is a hospital, the court shall order it to pay the reasonable attorney's fees and costs of the prevailing hospital party, which shall include fees and costs incurred as a result of the administrative hearing and the judicial appeal ~~if the court finds that there was a complete absence of a justiciable issue of law or fact raised by the losing party~~.

Section 9. Subsection (2) of section 408.043, Florida Statutes, is amended to read:

408.043 Special provisions.--

(2) HOSPICES.--When an application is made for a certificate of need to establish or to expand a hospice, the need for such hospice shall be determined on the basis of the need for and availability of hospice services in the community. The formula on which the certificate of need is based shall discourage regional monopolies and promote competition. ~~The~~

~~inpatient hospice care component of a hospice which is a freestanding facility, or a part of a facility, which is primarily engaged in providing inpatient care and related services and is not licensed as a health care facility shall also be required to obtain a certificate of need.~~ Provision of hospice care by any current provider of health care is a significant change in service and therefore requires a certificate of need for such services.

Section 10. Subsection (9) of section 408.05, Florida Statutes, is renumbered as subsection (10) and amended, and a new subsection (9) is added to said section, to read:

408.05 State Center for Health Statistics.--

(9) OUTCOME MEASURES.--The agency shall establish, implement, and evaluate scientifically sound and clinically relevant quality outcome measures for cardiac programs in order to reduce unwarranted variation in the delivery of cardiac care, improve the quality of cardiac care, and promote the appropriate utilization of cardiac services.

(a) The agency, in conjunction with the Florida Hospital Association, the Florida Society of Thoracic and Cardiovascular Surgeons, the Florida Chapter of the American College of Cardiology, and the Florida Chapter of the American Heart Association shall develop and adopt by rule state quality outcome measures based on data received pursuant to this subsection, as well as on nationally developed quality outcome measures.

(b) The outcome measures shall be based on the data elements reported by hospitals licensed under s. 395.0095, simultaneously to the Society of Thoracic Surgeons' data base and the agency. The data shall be aggregated to establish

statewide norms for cardiac programs and cardiac surgery. The data shall be adjusted by risk and used to determine morbidity and mortality rates for operative categories by surgical urgency. Other measures shall include, but not be limited to, infection rates, nonfatal myocardial infarctions, lengths of stay, postoperative bleeds, and returns to surgery for operative categories by surgical urgency. Where appropriate, the rates shall be adjusted for age.

(c) Every hospital with a licensed cardiac program, in conjunction with the hospital medical staff, shall produce quality outcome data pursuant to the criteria developed in this subsection. The hospital shall forward such data to the agency in a manner consistent with s. 408.061 on a quarterly basis beginning July 1, 2003. As used in this subsection, "hospital" means an acute care hospital licensed under chapter 395.

(d) The agency shall summarize the quality outcome measures for cardiac procedures by hospital, by district, by region, and across the state. The agency shall make the report available to the public and all hospitals throughout the state on an annual basis beginning December 31, 2006. The agency shall also make detail data submitted pursuant to this subsection available for analysis by others, subject to protection of confidentiality pursuant to s. 408.061.

(e) Parameters developed pursuant to this subsection shall be made available to the public, all hospitals, and health professionals by publication on the agency's website or in writing upon written request.

(f) Procedures shall be instituted which provide for the periodic review and revision of quality outcome measures based on the latest outcome data, research findings, technological

advancements, and clinical experiences, at least once every 2 years.

(10)~~(9)~~ SECTION NOT LIMITING.--Nothing in this section shall limit, restrict, affect, or control the collection, analysis, release, or publication of data by any state agency pursuant to its statutory authority, duties, or responsibilities.

Section 11. Section 52 of chapter 2001-45, Laws of Florida, is amended to read:

Section 52. (1) Notwithstanding the establishment of need as provided for in chapter 408, Florida Statutes, no certificate of need for additional community nursing home beds shall be approved by the agency until July 1, 2006.

(2) The Legislature finds that the continued growth in the Medicaid budget for nursing home care has constrained the ability of the state to meet the needs of its elderly residents through the use of less restrictive and less institutional methods of long-term care. It is therefore the intent of the Legislature to limit the increase in Medicaid nursing home expenditures in order to provide funds to invest in long-term care that is community-based and provides supportive services in a manner that is both more cost-effective and more in keeping with the wishes of the elderly residents of this state.

(3) This moratorium on certificates of need shall not apply to sheltered nursing home beds in a continuing care retirement community certified by the Department of Insurance pursuant to chapter 651, Florida Statutes.

(4)(a) This moratorium on certificates of need shall not apply, and a certificate of need for additional community nursing home beds may be approved, for a county that meets the following

circumstances:

1. The county has no community nursing home beds.

2. The lack of community nursing home beds occurs because all nursing home beds in the county that were licensed on July 1, 2001, have subsequently closed.

(b) The certificate-of-need review for such circumstances shall be subject to the comparative review process consistent with the provisions of s. 408.039, Florida Statutes, and the number of beds may not exceed the number of beds lost by the county after July 1, 2001.

Section 12. Subsection (4) of section 383.50, Florida Statutes, is amended to read:

383.50 Treatment of abandoned newborn infant.--

(4) Each hospital of this state subject to s. 395.1041 shall, and any other hospital may, admit and provide all necessary emergency services and care, as defined in s. 395.002(15)~~(10)~~, to any newborn infant left with the hospital in accordance with this section. The hospital or any of its licensed health care professionals shall consider these actions as implied consent for treatment, and a hospital accepting physical custody of a newborn infant has implied consent to perform all necessary emergency services and care. The hospital or any of its licensed health care professionals is immune from criminal or civil liability for acting in good faith in accordance with this section. Nothing in this subsection limits liability for negligence.

Section 13. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.--As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(36)~~(29)~~ as a specialty psychiatric hospital.

Section 14. Paragraph (c) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.--

(2) DEFINITIONS.--As used in this part:

(c) "Inactive rural hospital bed" means a licensed acute care hospital bed, as defined in s. 395.002(19)~~(14)~~, that is inactive in that it cannot be occupied by acute care inpatients.

Section 15. Paragraph (c) of subsection (1) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.--

(1) For the purposes of this section, the term:

(c) "Hospital" means a health care institution as defined in s. 395.002(18)~~(13)~~, but does not include any hospital operated by the agency or the Department of Corrections.

Section 16. Paragraph (b) of subsection (1) of section 400.051, Florida Statutes, is amended to read:

400.051 Homes or institutions exempt from the provisions of this part.--

(1) The following shall be exempt from the provisions of this part:

(b) Any hospital, as defined in s. 395.002(16)~~(11)~~, that is licensed under chapter 395.

Section 17. Subsection (8) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(8) NURSING FACILITY SERVICES.--The agency shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined by s. 395.002(16)~~(11)~~, that is licensed under part I of chapter 395, and in accordance with provisions set forth in s. 409.908(2)(a), which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another

nursing facility is not available, the agency must pay for similar services temporarily in a hospital licensed under part I of chapter 395 provided federal funding is approved and available.

Section 18. Paragraph (l) of subsection (1) of section 468.505, Florida Statutes, is amended to read:

468.505 Exemptions; exceptions.--

(1) Nothing in this part may be construed as prohibiting or restricting the practice, services, or activities of:

(l) A person employed by a nursing facility exempt from licensing under s. 395.002(18)~~(13)~~, or a person exempt from licensing under s. 464.022.

Section 19. Section 766.316, Florida Statutes, is amended to read:

766.316 Notice to obstetrical patients of participation in the plan.--Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a patient

when the patient has an emergency medical condition as defined in s. 395.002(13)~~(9)~~(b) or when notice is not practicable.

Section 20. Paragraph (b) of subsection (2) of section 812.014, Florida Statutes, is amended to read:

812.014 Theft.--

(2)

(b)1. If the property stolen is valued at $20,000 or more, but less than $100,000;

2. The property stolen is cargo valued at less than $50,000 that has entered the stream of interstate or intrastate commerce from the shipper's loading platform to the consignee's receiving dock; or

3. The property stolen is emergency medical equipment, valued at $300 or more, that is taken from a facility licensed under chapter 395 or from an aircraft or vehicle permitted under chapter 401,

the offender commits grand theft in the second degree, punishable as a felony of the second degree, as provided in s. 775.082, s. 775.083, or s. 775.084. Emergency medical equipment means mechanical or electronic apparatus used to provide emergency services and care as defined in s. 395.002(15)~~(10)~~ or to treat medical emergencies.

Section 21. (1) A facility authorized by the state to provide services under any of the following authorized programs pursuant to state authorization or a valid certificate of need on June 30, 2003, shall continue to be licensed to provide such service on and after the effective date of this act:

(a) Diagnostic cardiac catheterization program.

(b) Emergency percutaneous coronary intervention program.

(c) Percutaneous coronary intervention program.

(d) Cardiac surgery program.

(2) Facilities applying for relicensure to provide such services pursuant to the provisions of this act are authorized to continue to operate until the Agency for Health Care Administration takes final action on the licensure application.

Section 22. Subsection (5) of section 408.043, Florida Statutes, as created by section 1 of Senate Bill 1568, 2003 Regular Session, is amended to read:

408.043 Special provisions.--

(5) SOLE ACUTE CARE HOSPITALS IN HIGH GROWTH COUNTIES.--Notwithstanding any other provision of law, an acute care hospital licensed under chapter 395 may add up to 180 additional beds without agency review if such hospital is located in a county that has experienced at least a 60-percent growth rate for the most recent 10-year period for which data are available as determined by using the population statistics published in the most recent edition of the Florida Statistical Abstract, is the sole acute care hospital in the county, and is the only acute care hospital within a 10-mile radius of another hospital. A hospital shall provide written notice to the agency that it qualifies under this subsection prior to the addition of beds. Such projects shall not be subject to challenge under s. 408.039 or chapter 120. Acute care beds added under this subsection shall ~~not~~ be included in the inventory of hospital beds used by the agency in the calculation of the fixed-bed-need pool for acute care hospitals.

Section 23. This act shall take effect July 1, 2003.