1 A bill to be entitled
2 An act relating to health care facilities; creating s.
3 400.244, F.S.; allowing nursing homes to convert beds to
4 alternative uses as specified; providing restrictions on
5 uses of funding under assisted-living Medicaid waivers;
6 providing procedures; providing for the applicability of
7 certain fire and life safety codes; providing
8 applicability of certain laws; requiring a nursing home to
9 submit to the Agency for Health Care Administration a
10 written request for permission to convert beds to
11 alternative uses; providing conditions for disapproving
12 such a request; providing for periodic review; providing
13 for retention of nursing home licensure for converted
14 beds; providing for reconversion of the beds; providing
15 applicability of licensure fees; requiring quarterly
16 reports to the agency relating to patient days; amending
17 s. 400.021, F.S.; redefining the term "resident care
18 plan," as used in part II of ch. 400, F.S.; amending s.
19 400.23, F.S.; providing that certain information from the
20 Agency for Health Care Administration must reflect the
21 most current agency actions; amending s. 400.211, F.S.;
22 revising inservice training requirements for persons
23 employed as nursing assistants in a nursing home facility;
24 amending s. 408.032, F.S.; revising the definition of
25 "tertiary health service" under the Health Facility and
26 Services Development Act; amending s. 408.034, F.S.;
27 requiring the nursing-home-bed-need methodology
28 established by the Agency for Health Care Administration
29 by rule to include a goal of maintaining a specified
30 district average occupancy rate; amending s. 408.036,

31 F.S., relating to health-care-related projects subject to
32 review for a certificate of need; removing shared services
33 contracts or projects from expedited review; revising
34 expedited review requirements for transfer of a
35 certificate of need and conversion of beds for mental
36 health services or general acute care; subjecting projects
37 relating to replacement of a nursing home and relocation
38 of nursing home beds to expedited review; removing the
39 exemption from review for establishment of certain
40 specialty hospitals and a satellite facility; revising
41 requirements for certain projects that are exempt from
42 review; exempting from review projects relating to
43 provision of percutaneous coronary intervention,
44 replacement of a statutory rural hospital, and conversion
45 of mental health services beds; amending s. 408.038, F.S.;
46 increasing fees of the certificate-of-need program;
47 amending s. 408.039, F.S.; providing for approval of
48 recommended orders of the Division of Administrative
49 Hearings when the Agency for Health Care Administration
50 fails to take action on an application for a certificate
51 of need within a specified time period; providing for
52 payment of attorney's fees and costs when a hospital is
53 the losing party; providing for review of an application
54 for a certificate of need pending on the effective date of
55 the act; creating the Hospital Statutory and Regulatory
56 Reform Council; providing legislative intent; providing
57 for membership and duties of the council; providing for
58 construction of the act in pari materia with laws enacted
59 during the 2003 Regular Session of the Legislature;
60 providing an effective date.

61
62 Be It Enacted by the Legislature of the State of Florida:
63
64 Section 1. Section 400.244, Florida Statutes, is created
65 to read:
66 400.244 Alternative uses of nursing home beds; funding
67 limitations; applicable codes and requirements; procedures;
68 reconversion; quarterly reports.--
69 (1) It is the intent of the Legislature to allow nursing
70 home facilities to use licensed nursing home facility beds for
71 alternative uses other than nursing home care for extended
72 periods of time exceeding 48 hours.
73 (2) A nursing home may use a contiguous portion of the
74 nursing home facility to meet the needs of the elderly through
75 the use of less restrictive and less institutional methods of
76 long-term care, including, but not limited to, adult day care,
77 assisted living, extended congregate care, or limited nursing
78 services.
79 (3) Funding under assisted-living Medicaid waivers for
80 nursing home facility beds that are used to provide extended
81 congregate care or limited nursing services under this section
82 may be provided only for residents who have resided in the
83 nursing home facility for a minimum of 90 consecutive days.
84 (4) Nursing home facility beds that are used in providing
85 alternative services may share common areas, services, and staff
86 with beds that are designated for nursing home care. Fire codes
87 and life safety codes applicable to nursing home facilities also
88 apply to beds used for alternative purposes under this section.
89 Any alternative use must meet other requirements specified by
90 law for that use.

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91 (5) In order to take beds out of service for nursing home
92 care and use them to provide alternative services under this
93 section, a nursing home must submit a written request for
94 approval to the Agency for Health Care Administration in a
95 format specified by the agency. The agency shall approve the
96 request unless it determines that such action will adversely
97 affect access to nursing home care in the geographical area in
98 which the nursing home is located. The agency shall, in its
99 review, consider a district average occupancy of 94 percent or
100 greater at the time of the application as an indicator of an
101 adverse impact. The agency shall review the request for
102 alternative use at each annual license renewal.
103 (6) A nursing home facility that converts beds to an
104 alternative use under this section retains its license for all
105 of the nursing home facility beds and may return those beds to
106 nursing home operation upon 60 days' written notice to the
107 agency unless notice requirements are specified elsewhere in
108 law. The nursing home facility shall continue to pay all
109 licensure fees as required by s. 400.062 and applicable rules
110 but is not required to pay any other state licensure fee for the
111 alternative use.
112 (7) Within 45 days after the end of each calendar quarter,
113 each facility that has nursing home facility beds licensed under
114 this chapter shall report to the agency or its designee the
115 total number of patient days that occurred in each month of the
116 quarter and the number of such days that were Medicaid patient
117 days.
118 Section 2. Subsection (17) of section 400.021, Florida
119 Statutes, is amended to read:

120 400.021 Definitions.--When used in this part, unless the
121 context otherwise requires, the term:
122 (17) "Resident care plan" means a written plan developed,
123 maintained, and reviewed not less than quarterly by a registered
124 nurse, with participation from other facility staff and the
125 resident or his or her designee or legal representative, which
126 includes a comprehensive assessment of the needs of an
127 individual resident; the type and frequency of services required
128 to provide the necessary care for the resident to attain or
129 maintain the highest practicable physical, mental, and
130 psychosocial well-being; a listing of services provided within
131 or outside the facility to meet those needs; and an explanation
132 of service goals. The resident care plan must be signed by the
133 director of nursing or another registered nurse employed by the
134 facility to whom institutional responsibilities have been
135 delegated and by the resident, the resident's designee, or the
136 resident's legal representative. The facility may not use an
137 agency or temporary registered nurse to satisfy the foregoing
138 requirement and must document the institutional responsibilities
139 that have been delegated to the registered nurse.
140 Section 3. Subsection (10) is added to section 400.23,
141 Florida Statutes, to read:
142 400.23 Rules; evaluation and deficiencies; licensure
143 status.--
144 (10) Agency records, reports, ranking systems, Internet
145 information, and publications must reflect the most current
146 agency actions.
147 Section 4. Subsection (4) of section 400.211, Florida
148 Statutes, is amended to read:

149 400.211 Persons employed as nursing assistants;
150 certification requirement.--
151 (4) When employed by a nursing home facility for a 12-
152 month period or longer, a nursing assistant, to maintain
153 certification, shall submit to a performance review every 12
154 months and must receive regular inservice education based on the
155 outcome of such reviews. The inservice training must:
156 (a) Be sufficient to ensure the continuing competence of
157 nursing assistants and must meet the standard specified in s.
158 464.203(7), must be at least 18 hours per year, and may include
159 hours accrued under s. 464.203(8);
160 (b) Include, at a minimum:
161 1. Techniques for assisting with eating and proper
162 feeding;
163 2. Principles of adequate nutrition and hydration;
164 3. Techniques for assisting and responding to the
165 cognitively impaired resident or the resident with difficult
166 behaviors;
167 4. Techniques for caring for the resident at the end-of-
168 life; and
169 5. Recognizing changes that place a resident at risk for
170 pressure ulcers and falls; and
171 (c) Address areas of weakness as determined in nursing
172 assistant performance reviews and may address the special needs
173 of residents as determined by the nursing home facility staff.
174
175 Costs associated with this training may not be reimbursed from
176 additional Medicaid funding through interim rate adjustments.
177 Section 5. Subsection (17) of section 408.032, Florida
178 Statutes, is amended to read:

179 408.032 Definitions relating to Health Facility and
180 Services Development Act.--As used in ss. 408.031-408.045, the
181 term:
182 (17) "Tertiary health service" means a health service
183 which, due to its high level of intensity, complexity,
184 specialized or limited applicability, and cost, should be
185 limited to, and concentrated in, a limited number of hospitals
186 to ensure the quality, availability, and cost-effectiveness of
187 such service. Examples of such service include, but are not
188 limited to, organ transplantation, adult and pediatric open
189 heart surgery, specialty burn units, neonatal intensive care
190 units, comprehensive rehabilitation, and medical or surgical
191 services which are experimental or developmental in nature to
192 the extent that the provision of such services is not yet
193 contemplated within the commonly accepted course of diagnosis or
194 treatment for the condition addressed by a given service. The
195 agency shall establish by rule a list of all tertiary health
196 services.
197 Section 6. Subsection (5) of section 408.034, Florida
198 Statutes, is amended to read:
199 408.034 Duties and responsibilities of agency; rules.--
200 (5) The agency shall establish by rule a nursing-home-bed-
201 need methodology that has a goal of maintaining a district
202 average occupancy rate of 94 percent and that reduces the
203 community nursing home bed need for the areas of the state where
204 the agency establishes pilot community diversion programs
205 through the Title XIX aging waiver program.
206 Section 7. Section 408.036, Florida Statutes, is amended
207 to read:
208 408.036 Projects subject to review; exemptions.--

209 (1) APPLICABILITY.--Unless exempt under subsection (3),
210 all health-care-related projects, as described in paragraphs
211 (a)-(h), are subject to review and must file an application for
212 a certificate of need with the agency. The agency is exclusively
213 responsible for determining whether a health-care-related
214 project is subject to review under ss. 408.031-408.045.
215 (a) The addition of beds by new construction or
216 alteration.
217 (b) The new construction or establishment of additional
218 health care facilities, including a replacement health care
219 facility when the proposed project site is not located on the
220 same site as the existing health care facility.
221 (c) The conversion from one type of health care facility
222 to another.
223 (d) An increase in the total licensed bed capacity of a
224 health care facility.
225 (e) The establishment of a hospice or hospice inpatient
226 facility, except as provided in s. 408.043.
227 (f) The establishment of inpatient health services by a
228 health care facility, or a substantial change in such services.
229 (g) An increase in the number of beds for acute care,
230 nursing home care beds, specialty burn units, neonatal intensive
231 care units, comprehensive rehabilitation, mental health
232 services, or hospital-based distinct part skilled nursing units,
233 or at a long-term care hospital.
234 (h) The establishment of tertiary health services.
235 (2) PROJECTS SUBJECT TO EXPEDITED REVIEW.--Unless exempt
236 pursuant to subsection (3), projects subject to an expedited
237 review shall include, but not be limited to:
238 (a) Research, education, and training programs.

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

240 (b)~~(c)~~ A transfer of a certificate of need, except when an
241 existing hospital is acquired by a purchaser, in which case all
242 pending certificates of need filed by the existing hospital and
243 all approved certificates of need owned by that hospital would
244 be acquired by the purchaser.

245 (c)~~(d)~~ A 50-percent increase in nursing home beds for a
246 facility incorporated and operating in this state for at least
247 60 years on or before July 1, 1988, which has a licensed nursing
248 home facility located on a campus providing a variety of
249 residential settings and supportive services. The increased
250 nursing home beds shall be for the exclusive use of the campus
251 residents. ~~Any application on behalf of an applicant meeting~~
252 ~~this requirement shall be subject to the base fee of $5,000~~
253 ~~provided in s. 408.038.~~

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

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

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

267 2. Beds converted under this paragraph must be licensed
268 and operational for at least 12 months before the hospital may
269 apply for additional conversion affecting beds of the same type.
270 (f) Replacement of a nursing home within the same
271 district, provided the proposed project site is located within a
272 geographic area that contains at least 65 percent of the
273 facility's current residents and is within a 30-mile radius of
274 the replaced nursing home.
275 (g) Relocation of a portion of a nursing home's licensed
276 beds to a replacement facility within the same district,
277 provided the relocation is within a 30-mile radius of the
278 existing facility and the total number of nursing home beds in
279 the district does not increase.
280
281 The agency shall develop rules to implement the provisions for
282 expedited review, including time schedule, application content
283 which may be reduced from the full requirements of s.
284 408.037(1), and application processing.
285 (3) EXEMPTIONS.--Upon request, the following projects are
286 subject to exemption from the provisions of subsection (1):
287 (a) For replacement of a licensed health care facility on
288 the same site, provided that the number of beds in each licensed
289 bed category will not increase.
290 (b) For hospice services or for swing beds in a rural
291 hospital, as defined in s. 395.602, in a number that does not
292 exceed one-half of its licensed beds.
293 (c) For the conversion of licensed acute care hospital
294 beds to Medicare and Medicaid certified skilled nursing beds in
295 a rural hospital, as defined in s. 395.602, so long as the
296 conversion of the beds does not involve the construction of new

297 facilities. The total number of skilled nursing beds, including
298 swing beds, may not exceed one-half of the total number of
299 licensed beds in the rural hospital as of July 1, 1993.
300 Certified skilled nursing beds designated under this paragraph,
301 excluding swing beds, shall be included in the community nursing
302 home bed inventory. A rural hospital which subsequently
303 decertifies any acute care beds exempted under this paragraph
304 shall notify the agency of the decertification, and the agency
305 shall adjust the community nursing home bed inventory
306 accordingly.
307 (d) For the addition of nursing home beds at a skilled
308 nursing facility that is part of a retirement community that
309 provides a variety of residential settings and supportive
310 services and that has been incorporated and operated in this
311 state for at least 65 years on or before July 1, 1994. All
312 nursing home beds must not be available to the public but must
313 be for the exclusive use of the community residents.
314 (e) For an increase in the bed capacity of a nursing
315 facility licensed for at least 50 beds as of January 1, 1994,
316 under part II of chapter 400 which is not part of a continuing
317 care facility if, after the increase, the total licensed bed
318 capacity of that facility is not more than 60 beds and if the
319 facility has been continuously licensed since 1950 and has
320 received a superior rating on each of its two most recent
321 licensure surveys.
322 (f) For an inmate health care facility built by or for the
323 exclusive use of the Department of Corrections as provided in
324 chapter 945. This exemption expires when such facility is
325 converted to other uses.

326 (g) For the termination of an inpatient health care
327 service, upon 30 days' written notice to the agency.
328 (h) For the delicensure of beds, upon 30 days' written
329 notice to the agency. A request for exemption submitted under
330 this paragraph must identify the number, the category of beds,
331 and the name of the facility in which the beds to be delicensed
332 are located.
333 (i) For the provision of adult inpatient diagnostic
334 cardiac catheterization services in a hospital.
335 1. In addition to any other documentation otherwise
336 required by the agency, a request for an exemption submitted
337 under this paragraph must comply with the following criteria:
338 a. The applicant must certify it will not provide
339 therapeutic cardiac catheterization pursuant to the grant of the
340 exemption.
341 b. The applicant must certify it will meet and
342 continuously maintain the minimum licensure requirements adopted
343 by the agency governing such programs pursuant to subparagraph
344 2.
345 c. The applicant must certify it will provide a minimum of
346 2 percent of its services to charity and Medicaid patients.
347 2. The agency shall adopt licensure requirements by rule
348 which govern the operation of adult inpatient diagnostic cardiac
349 catheterization programs established pursuant to the exemption
350 provided in this paragraph. The rules shall ensure that such
351 programs:
352 a. Perform only adult inpatient diagnostic cardiac
353 catheterization services authorized by the exemption and will
354 not provide therapeutic cardiac catheterization or any other
355 services not authorized by the exemption.

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356 b. Maintain sufficient appropriate equipment and health
357 personnel to ensure quality and safety.
358 c. Maintain appropriate times of operation and protocols
359 to ensure availability and appropriate referrals in the event of
360 emergencies.
361 d. Maintain appropriate program volumes to ensure quality
362 and safety.
363 e. Provide a minimum of 2 percent of its services to
364 charity and Medicaid patients each year.
365 3.a. The exemption provided by this paragraph shall not
366 apply unless the agency determines that the program is in
367 compliance with the requirements of subparagraph 1. and that the
368 program will, after beginning operation, continuously comply
369 with the rules adopted pursuant to subparagraph 2. The agency
370 shall monitor such programs to ensure compliance with the
371 requirements of subparagraph 2.
372 b.(I) The exemption for a program shall expire immediately
373 when the program fails to comply with the rules adopted pursuant
374 to sub-subparagraphs 2.a., b., and c.
375 (II) Beginning 18 months after a program first begins
376 treating patients, the exemption for a program shall expire when
377 the program fails to comply with the rules adopted pursuant to
378 sub-subparagraphs 2.d. and e.
379 (III) If the exemption for a program expires pursuant to
380 sub-sub-subparagraph (I) or sub-sub-subparagraph (II), the
381 agency shall not grant an exemption pursuant to this paragraph
382 for an adult inpatient diagnostic cardiac catheterization
383 program located at the same hospital until 2 years following the
384 date of the determination by the agency that the program failed
385 to comply with the rules adopted pursuant to subparagraph 2.

386 (j) For the provision of percutaneous coronary
387 intervention for patients presenting with emergency myocardial
388 infarctions in a hospital without an approved adult open heart
389 surgery program. In addition to any other documentation required
390 by the agency, a request for an exemption submitted under this
391 paragraph must comply with the following:
392 1. The applicant must certify that it will meet and
393 continuously maintain the requirements adopted by the agency for
394 the provision of these services. These licensure requirements
395 are to be adopted by rule pursuant to ss. 120.536(1) and 120.54
396 and are to be consistent with the guidelines published by the
397 American College of Cardiology and the American Heart
398 Association for the provision of percutaneous coronary
399 interventions in hospitals without adult open heart services. At
400 a minimum, the rules shall require the following:
401 a. Cardiologists must be experienced interventionalists
402 who have performed a minimum of 75 interventions within the
403 previous 12 months.
404 b. The hospital must provide a minimum of 36 emergency
405 interventions annually in order to continue to provide the
406 service.
407 c. The hospital must offer sufficient physician, nursing,
408 and laboratory staff to provide the services 24 hours a day, 7
409 days a week.
410 d. Nursing and technical staff must have demonstrated
411 experience in handling acutely ill patients requiring
412 intervention based on previous experience in dedicated
413 interventional laboratories or surgical centers.
414 e. Cardiac care nursing staff must be adept in hemodynamic
415 monitoring and intra-aortic balloon pump (IABP) management.

416 f. Formalized written transfer agreements must be
417 developed with a hospital with an adult open heart surgery
418 program, and written transport protocols must be in place to
419 ensure safe and efficient transfer of a patient within 60
420 minutes. Transfer and transport agreements must be reviewed and
421 tested, with appropriate documentation maintained at least every
422 3 months.
423 g. Hospitals implementing the service must first undertake
424 a training program of 3 to 6 months that includes establishing
425 standards, testing logistics, creating quality assessment and
426 error management practices, and formalizing patient selection
427 criteria.
428 2. The applicant must certify that it will utilize at all
429 times the patient selection criteria for the performance of
430 primary angioplasty at hospitals without adult open heart
431 surgery programs issued by the American College of Cardiology
432 and the American Heart Association. At a minimum, these criteria
433 would provide for the following:
434 a. Avoidance of interventions in hemodynamically stable
435 patients presenting with identified symptoms or medical
436 histories.
437 b. Transfer of patients presenting with a history of
438 coronary disease and clinical presentation of hemodynamic
439 instability.
440 3. The applicant must agree to submit a quarterly report
441 to the agency detailing patient characteristics, treatment, and
442 outcomes for all patients receiving emergency percutaneous
443 coronary interventions pursuant to this paragraph. This report
444 must be submitted within 15 days after the close of each
445 calendar quarter.

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446 4. The exemption provided by this paragraph shall not
447 apply unless the agency determines that the hospital has taken
448 all necessary steps to be in compliance with all requirements of
449 this paragraph, including the training program required pursuant
450 to sub-subparagraph 1.g.
451 5. Failure of the hospital to continuously comply with the
452 requirements of sub-subparagraphs 1.c.-f. and subparagraphs 2.
453 and 3. will result in the immediate expiration of this
454 exemption.
455 6. Failure of the hospital to meet the volume requirements
456 of sub-subparagraphs 1.a.-b. within 18 months after the program
457 begins offering the service will result in the immediate
458 expiration of the exemption.
459 7. If the exemption for this service expires pursuant to
460 subparagraph 5. or subparagraph 6., the agency shall not grant
461 another exemption for this service to the same hospital for a
462 period of 2 years and then only upon a showing that the hospital
463 will remain in compliance with the requirements of this
464 paragraph through a demonstration of corrections to the
465 deficiencies that caused expiration of the exemption. Compliance
466 with the requirements of this paragraph includes compliance with
467 the rules adopted pursuant to this paragraph.
468 (k)~~(j)~~ For mobile surgical facilities and related health
469 care services provided under contract with the Department of
470 Corrections or a private correctional facility operating
471 pursuant to chapter 957.
472 (l)~~(k)~~ For state veterans' nursing homes operated by or on
473 behalf of the Florida Department of Veterans' Affairs in
474 accordance with part II of chapter 296 for which at least 50
475 percent of the construction cost is federally funded and for

476 which the Federal Government pays a per diem rate not to exceed
477 one-half of the cost of the veterans' care in such state nursing
478 homes. These beds shall not be included in the nursing home bed
479 inventory.
480 (m)~~(l)~~ For combination within one nursing home facility of
481 the beds or services authorized by two or more certificates of
482 need issued in the same planning subdistrict. An exemption
483 granted under this paragraph shall extend the validity period of
484 the certificates of need to be consolidated by the length of the
485 period beginning upon submission of the exemption request and
486 ending with issuance of the exemption. The longest validity
487 period among the certificates shall be applicable to each of the
488 combined certificates.
489 (n)~~(m)~~ For division into two or more nursing home
490 facilities of beds or services authorized by one certificate of
491 need issued in the same planning subdistrict. An exemption
492 granted under this paragraph shall extend the validity period of
493 the certificate of need to be divided by the length of the
494 period beginning upon submission of the exemption request and
495 ending with issuance of the exemption.
496 (o)~~(n)~~ For the addition of hospital beds licensed under
497 chapter 395 for acute care~~, mental health services,~~ or a
498 hospital-based distinct part skilled nursing unit in a number
499 that may not exceed 10 total beds or 10 percent of the licensed
500 capacity of the bed category being expanded, whichever is
501 greater; for the addition of medical rehabilitation beds
502 licensed under chapter 395 in a number that may not exceed eight
503 total beds or 10 percent of capacity, whichever is greater; or
504 for the addition of mental health services beds licensed under
505 chapter 395 in a number that may not exceed 10 total beds or 10

506 percent of the licensed capacity of the bed category being
507 expanded, whichever is greater. Beds for specialty burn units
508 or~~,~~ neonatal intensive care units~~, or comprehensive~~
509 ~~rehabilitation,~~ or at a long-term care hospital~~,~~ may not be
510 increased under this paragraph.
511 1. In addition to any other documentation otherwise
512 required by the agency, a request for exemption submitted under
513 this paragraph must:
514 a. Certify that the prior 12-month average occupancy rate
515 for the category of licensed beds being expanded at the facility
516 meets or exceeds 75 ~~80~~ percent or, for a hospital-based distinct
517 part skilled nursing unit, the prior 12-month average occupancy
518 rate meets or exceeds 96 percent or, for medical rehabilitation
519 beds, the prior 12-month average occupancy rate meets or exceeds
520 90 percent.
521 b. Certify that any beds of the same type authorized for
522 the facility under this paragraph before the date of the current
523 request for an exemption have been licensed and operational for
524 at least 12 months.
525 2. The timeframes and monitoring process specified in s.
526 408.040(2)(a)-(c) apply to any exemption issued under this
527 paragraph.
528 3. The agency shall count beds authorized under this
529 paragraph as approved beds in the published inventory of
530 hospital beds until the beds are licensed.
531 (p)~~(o)~~ For the addition of acute care beds, as authorized
532 by rule consistent with s. 395.003(4), in a number that may not
533 exceed 30 ~~10~~ total beds or 10 percent of licensed bed capacity,
534 whichever is greater, for temporary beds in a hospital that has
535 experienced high seasonal occupancy within the prior 12-month

period or in a hospital that must respond to emergency circumstances.

(q)~~(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~~

566 ~~group of the population or a restricted range of services~~
567 ~~appropriate to the diagnosis, care, and treatment of patients~~
568 ~~with specific categories of medical illnesses or disorders,~~
569 ~~through the transfer of beds and services from an existing~~
570 ~~hospital in the same county.~~
571 (r) For the conversion of hospital-based Medicare and
572 Medicaid certified skilled nursing beds to acute care beds, if
573 the conversion does not involve the construction of new
574 facilities.
575 (s) <u>For the replacement of a statutory rural hospital, if</u>
576 <u>the proposed project site is located in the same district,</u>
577 <u>within 10 miles of the existing facility, and within the current</u>
578 <u>primary service area, defined as the least number of zip codes</u>
579 <u>comprising 75 percent of the hospital's inpatient admissions.</u>
580 ~~For fiscal year 2001-2002 only, for transfer by a health care~~
581 ~~system of existing services and not more than 100 licensed and~~
582 ~~approved beds from a hospital in district 1, subdistrict 1, to~~
583 ~~another location within the same subdistrict in order to~~
584 ~~establish a satellite facility that will improve access to~~
585 ~~outpatient and inpatient care for residents of the district and~~
586 ~~subdistrict and that will use new medical technologies,~~
587 ~~including advanced diagnostics, computer assisted imaging, and~~
588 ~~telemedicine to improve care. This paragraph is repealed on July~~
589 ~~1, 2002.~~
590 <u>(t) For the conversion of mental health services beds</u>
591 <u>between or among the licensed bed categories defined as beds for</u>
592 <u>mental health services. Beds converted under this paragraph must</u>
593 <u>be licensed and operational for at least 12 months before the</u>
594 <u>hospital may apply for additional conversion affecting beds of</u>
595 <u>the same type.</u>

596 (u) For the creation of at least a 10-bed Level II
597 neonatal intensive care unit upon demonstrating to the agency
598 that the applicant hospital had a minimum of 1,500 live births
599 during the previous 12 months.
600 (v) For the addition of Level II or Level III neonatal
601 intensive care beds in a number not to exceed six beds or 10
602 percent of licensed capacity in that category, whichever is
603 greater, provided that the hospital certifies that the prior 12-
604 month average occupancy rate for the category of licensed
605 neonatal intensive care beds meets or exceeds 75 percent.
606 (w) For replacement of a licensed nursing home on the same
607 site, or within 3 miles of the same site, provided the number of
608 licensed beds does not increase.
609 (x) For consolidation or combination of licensed nursing
610 homes or transfer of beds between licensed nursing homes within
611 the same district, by providers that operate multiple nursing
612 homes within that district, provided there is no increase in the
613 district total of nursing home beds and the relocation does not
614 exceed 30 miles from the original location.
615 (4) A request for exemption under subsection (3) may be
616 made at any time and is not subject to the batching requirements
617 of this section. The request shall be supported by such
618 documentation as the agency requires by rule. The agency shall
619 assess a fee of $250 for each request for exemption submitted
620 under subsection (3).
621 Section 8. Section 408.038, Florida Statutes, is amended
622 to read:
623 408.038 Fees.--The agency shall assess fees on
624 certificate-of-need applications. Such fees shall be for the
625 purpose of funding the functions of the local health councils

626 and the activities of the agency and shall be allocated as
627 provided in s. 408.033. The fee shall be determined as follows:
628 (1) A minimum base fee of $10,000 ~~$5,000~~.
629 (2) In addition to the base fee of $10,000 ~~$5,000~~, 0.015
630 of each dollar of proposed expenditure, except that a fee may
631 not exceed $50,000 ~~$22,000~~.
632 Section 9. Paragraph (e) of subsection (5) and paragraph
633 (c) of subsection (6) of section 408.039, Florida Statutes, are
634 amended to read:
635 408.039 Review process.--The review process for
636 certificates of need shall be as follows:
637 (5) ADMINISTRATIVE HEARINGS.--
638 (e) The agency shall issue its final order within 45 days
639 after receipt of the recommended order. If the agency fails to
640 take action within 45 days, the recommended order of the
641 Division of Administrative Hearings is deemed approved ~~such~~
642 ~~time, or as otherwise agreed to by the applicant and the agency,~~
643 ~~the applicant may take appropriate legal action to compel the~~
644 ~~agency to act~~. When making a determination on an application for
645 a certificate of need, the agency is specifically exempt from
646 the time limitations provided in s. 120.60(1).
647 (6) JUDICIAL REVIEW.--
648 (c) The court, in its discretion, may award reasonable
649 attorney's fees and costs to the prevailing party if the court
650 finds that there was a complete absence of a justiciable issue
651 of law or fact raised by the losing party. If the losing party
652 is a hospital, the court shall order it to pay the reasonable
653 attorney's fees and costs of the prevailing hospital party,
654 which shall include fees and costs incurred as a result of the
655 administrative hearing and the judicial appeal.

656 Section 10. This act does not preclude review and final
657 agency actions on any certificate of need application that was
658 filed with the Agency for Health Care Administration before the
659 effective date of this act.
660 Section 11. Hospital Statutory and Regulatory Reform
661 Council; legislative intent; creation; membership; duties.--
662 (1) It is the intent of the Legislature to provide for the
663 protection of the public health and safety in the establishment,
664 construction, maintenance, and operation of hospitals. However,
665 the Legislature further intends that the police power of the
666 state be exercised toward that purpose only to the extent
667 necessary and that regulation remain current with the ever-
668 changing standard of care and not restrict the introduction and
669 use of new medical technologies and procedures.
670 (2) In order to achieve the purposes expressed in
671 subsection (1), it is necessary that the state establish a
672 mechanism for the ongoing review and updating of laws regulating
673 hospitals. The Hospital Statutory and Regulatory Reform Council
674 is created and located, for administrative purposes only, within
675 the Agency for Health Care Administration. The council shall
676 consist of no more than 15 members, including:
677 (a) Nine members appointed by the Florida Hospital
678 Association who represent acute care, teaching, specialty,
679 rural, government-owned, for-profit, and not-for-profit
680 hospitals.
681 (b) Two members appointed by the Governor who represent
682 patients.
683 (c) Two members appointed by the President of the Senate
684 who represent private businesses that provide health insurance
685 coverage for their employees, one of whom represents small

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

686 private businesses and one of whom represents large private
687 businesses. As used in this paragraph, the term "private
688 business" does not include an entity licensed under chapter 627,
689 Florida Statutes, or chapter 641, Florida Statutes, or otherwise
690 licensed or authorized to provide health insurance services,
691 either directly or indirectly, in this state.
692 (d) Two members appointed by the Speaker of the House of
693 Representatives who represent physicians.
694 (3) Council members shall be appointed to serve 2-year
695 terms and may be reappointed. A member shall serve until his or
696 her successor is appointed. The council shall annually elect
697 from among its members a chair and a vice chair. The council
698 shall meet at least twice a year and shall hold additional
699 meetings as it considers necessary. Members appointed by the
700 Florida Hospital Association may not receive compensation or
701 reimbursement of expenses for their services. Members appointed
702 by the Governor, the President of the Senate, or the Speaker of
703 the House of Representatives may be reimbursed for travel
704 expenses by the agency.
705 (4) The council, as its first priority, shall review
706 chapters 395 and 408, Florida Statutes, and shall make
707 recommendations to the Legislature for the repeal of regulatory
708 provisions that are no longer necessary or that fail to promote
709 cost-efficient, high-quality medicine.
710 (5) The council, as its second priority, shall recommend
711 to the Secretary of Health and the Secretary of Health Care
712 Administration regulatory changes relating to hospital licensure
713 and regulation to assist the Department of Health and the Agency
714 for Health Care Administration in carrying out their duties and

715 to ensure that the intent of the Legislature as expressed in
716 this section is carried out.
717 (6) In determining whether a statute or rule is
718 appropriate or necessary, the council shall consider whether:
719 (a) The statute or rule is necessary to prevent
720 substantial harm, which is recognizable and not remote, to the
721 public health, safety, or welfare.
722 (b) The statute or rule restricts the use of new medical
723 technologies or encourages the implementation of more cost-
724 effective medical procedures.
725 (c) The statute or rule has an unreasonable effect on job
726 creation or job retention in the state.
727 (d) The public is or can be effectively protected by other
728 means.
729 (e) The overall cost-effectiveness and economic effect of
730 the proposed statute or rule, including the indirect costs to
731 consumers, will be favorable.
732 (f) A lower-cost regulatory alternative to the statute or
733 rule could be adopted.
734 Section 12. If any law amended by this act was also
735 amended by a law enacted at the 2003 Regular Session of the
736 Legislature, such laws shall be construed as if they had been
737 enacted at the same session of the Legislature, and full effect
738 shall be given to each if possible.
739 Section 13. This act shall take effect July 1, 2003.