A bill to be entitled

An act relating to health care facility market barriers; repealing ss. 154.245 and 154.246, F.S., relating to the issuance of a certificate of need by the Agency for Health Care Administration as a condition to bond validation and project construction; creating s. 381.4066, F.S.; establishing local health councils under ch. 381, F.S.; providing for the appointment of members; providing powers and duties; designating health service planning districts; providing for funding; requiring the agency to establish rules relating to the imposition of fees and financial accountability; requiring the agency to coordinate the planning of health care services in the state and develop and maintain a comprehensive health care database; requiring the Department of Health to contract with local health councils for specified services; amending s. 395.003, F.S.; removing a provision requiring that certain hospital beds be specified as general beds for licensure; removing provisions relating to the prohibition of licensure for hospitals that treat specific populations; amending s. 395.1055, F.S.; removing provisions requiring the agency to adopt rules relating to data for certificate-of-need reviews; revising provisions

relating to appointments to a technical advisory panel for certain pediatric cardiovascular programs; requiring the agency to adopt rules establishing licensure standards for providers of adult cardiovascular services; requiring such providers to comply with specified national standards; repealing s. 395.6025, F.S., relating to rural hospital replacement facilities; repealing ss. 408.031, 408.032, 408.033, 408.034, 408.035, 408.036, 408.0361, 408.037, 408.038, 408.039, 408.040, 408.041, 408.042, 408.043, 408.044, 408.045, and 408.0455, F.S., relating to the Health Facility and Services Development Act; amending ss. 159.27, 186.503, 189.08, 220.1845, 376.30781, 376.86, 383.216, 395.0191, 395.1065, 400.071, 400.606, 400.6085, 408.07, 408.806, 408.808, 408.810, and 408.820, F.S.; conforming provisions to changes made by the act and conforming cross-references; repealing s. 651.118, F.S., relating to the issuance of certificates of need by the Agency for Health Care Administration for nursing home beds; providing an effective date.

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

Section 1. Sections 154.245 and 154.246, Florida Statutes,

are repealed.

Section 2. Subsection (16) of section 159.27, Florida Statutes, is amended to read:

159.27 Definitions.—The following words and terms, unless the context clearly indicates a different meaning, shall have the following meanings:

(16) "Health care facility" means property operated in the private sector, whether operated for profit or not, used for or useful in connection with the diagnosis, treatment, therapy, rehabilitation, housing, or care of or for aged, sick, ill, injured, infirm, impaired, disabled, or handicapped persons, without discrimination among such persons due to race, religion, or national origin; or for the prevention, detection, and control of disease, including, without limitation thereto, hospital, clinic, emergency, outpatient, and intermediate care, including, but not limited to, facilities for the elderly such as assisted living facilities, facilities defined in s. 154.205(8), day care and share-a-home facilities, nursing homes, and the following related property when used for or in connection with the foregoing: laboratory; research; pharmacy; laundry; health personnel training and lodging; patient, guest, and health personnel food service facilities; and offices and office buildings for persons engaged in health care professions or services~~; provided, if required by ss. 400.601-400.611 and ss. 408.031-408.045, a certificate of need therefor is obtained~~

~~prior to the issuance of the bonds~~.

Section 3. Subsection (7) of section 186.503, Florida Statutes, is amended to read:

186.503 Definitions relating to Florida Regional Planning Council Act.—As used in this act, the term:

(7) "Local health council" means a council ~~a regional agency~~ established pursuant to s. 381.4066 ~~s. 408.033~~.

Section 4. Subsection (3) of section 189.08, Florida Statutes, is amended to read:

189.08 Special district public facilities report.—

~~(3) A special district proposing to build, improve, or expand a public facility which requires a certificate of need pursuant to chapter 408 shall elect to notify the appropriate local general-purpose government of its plans either in its 7-year plan or at the time the letter of intent is filed with the Agency for Health Care Administration pursuant to s. 408.039.~~

Section 5. Paragraph (k) of subsection (2) of section 220.1845, Florida Statutes, is amended to read:

220.1845 Contaminated site rehabilitation tax credit.—

(2) AUTHORIZATION FOR TAX CREDIT; LIMITATIONS.—

(k) In order to encourage the construction and operation of a new health care facility as defined in ~~s. 408.032 or~~ s. 408.07, or a health care provider as defined in s. 408.07, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs,

not to exceed $500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a license or certificate has been issued for the operation of the health care facility or health care provider.

Section 6. Paragraph (f) of subsection (3) of section 376.30781, Florida Statutes, is amended to read:

376.30781 Tax credits for rehabilitation of drycleaning-solvent-contaminated sites and brownfield sites in designated brownfield areas; application process; rulemaking authority; revocation authority.—

(3)

(f) In order to encourage the construction and operation of a new health care facility or a health care provider, as defined in ~~s. 408.032 or~~ s. 408.07, on a brownfield site, an applicant for a tax credit may claim an additional 25 percent of the total site rehabilitation costs, not to exceed $500,000, if the applicant meets the requirements of this paragraph. In order to receive this additional tax credit, the applicant must provide documentation indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a

license or certificate has been issued for the operation of the health care facility or health care provider.

Section 7. Subsection (1) of section 376.86, Florida Statutes, is amended to read:

376.86 Brownfield Areas Loan Guarantee Program.—

(1) The Brownfield Areas Loan Guarantee Council is created to review and approve or deny, by a majority vote of its membership, the situations and circumstances for participation in partnerships by agreements with local governments, financial institutions, and others associated with the redevelopment of brownfield areas pursuant to the Brownfields Redevelopment Act for a limited state guaranty of up to 5 years of loan guarantees or loan loss reserves issued pursuant to law. The limited state loan guaranty applies only to 50 percent of the primary lenders loans for redevelopment projects in brownfield areas. If the redevelopment project is for affordable housing, as defined in s. 420.0004, in a brownfield area, the limited state loan guaranty applies to 75 percent of the primary lender's loan. If the redevelopment project includes the construction and operation of a new health care facility or a health care provider, as defined in ~~s. 408.032 or~~ s. 408.07, on a brownfield site and the applicant has obtained documentation in accordance with s. 376.30781 indicating that the construction of the health care facility or health care provider by the applicant on the brownfield site has received a certificate of occupancy or a

license or certificate has been issued for the operation of the health care facility or health care provider, the limited state loan guaranty applies to 75 percent of the primary lender's loan. A limited state guaranty of private loans or a loan loss reserve is authorized for lenders licensed to operate in the state upon a determination by the council that such an arrangement would be in the public interest and the likelihood of the success of the loan is great.

Section 8. Section 381.4066, Florida Statutes, is created to read:

381.4066 Local and state health planning.—

(1) LOCAL HEALTH COUNCILS.—

(a) Local health councils are hereby established as public or private nonprofit agencies serving the counties of a health service planning district. The members of each council shall be appointed in an equitable manner by the county commissions having jurisdiction in the respective district. Each council shall be composed of a number of persons equal to one and one half times the number of counties which compose the district or 12 members, whichever is greater. Each county commission in a district shall be entitled to appoint at least one member on the council. The balance of the membership of the council shall be allocated among the counties of the district on the basis of population rounded to the nearest whole number, except that in a district composed of only two counties, each county shall have

at least four members. The appointees shall be representatives of health care providers, health care purchasers, and nongovernmental health care consumers, not excluding elected government officials. The members representing nongovernmental health care consumers shall include a representative number of persons 60 years of age or older. A majority of council members shall consist of health care purchasers and nongovernmental health care consumers. The local health council shall provide each county commission a schedule for appointing council members to ensure that council membership complies with the requirements of this paragraph. The members of the council shall elect a chair. Members shall serve for terms of 2 years and may be eligible for reappointment.

(b) Health service planning districts are composed of the following counties:

1. District 1.—Escambia, Santa Rosa, Okaloosa, and Walton Counties.

2. District 2.—Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties.

3. District 3.—Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties.

4. District 4.—Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties.

5. District 5.—Pasco and Pinellas Counties.

6. District 6.—Hillsborough, Manatee, Polk, Hardee, and Highlands Counties.

7. District 7.—Seminole, Orange, Osceola, and Brevard Counties.

8. District 8.—Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties.

9. District 9.—Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.

10. District 10.—Broward County.

11. District 11.—Miami-Dade and Monroe Counties.

(c) Each local health council may:

1. Develop a district area health plan that permits each local health council to develop strategies and set priorities for implementation based on its unique local health needs.

2. Advise the Agency for Health Care Administration on health care issues and resource allocations.

3. Promote public awareness of community health needs, emphasizing health promotion and cost-effective health service selection.

4. Collect data and conduct analyses and studies related to health care needs of the district, including the needs of medically indigent persons, and assist the Agency for Health Care Administration and other state agencies in carrying out

data collection activities that relate to the functions in this subsection.

5. Advise and assist any regional planning councils within the district which have elected to address health issues in their strategic regional policy plans with the development of the health element of the plans to address the health goals and policies in the State Comprehensive Plan.

6. Advise and assist local governments within the district on the development of an optional health plan element of the comprehensive plan provided in chapter 163, to ensure compatibility with the health goals and policies in the State Comprehensive Plan and the district health plan. To facilitate the implementation of this section, the local health council shall annually provide the local governments in its service area, upon request, with:

a. A copy and appropriate updates of the district health plan.

b. A report of hospital and nursing home utilization statistics for facilities within the local government jurisdiction.

7. Monitor and evaluate the adequacy, appropriateness, and effectiveness, within the district, of local, state, federal, and private funds distributed to meet the needs of the medically indigent and other underserved population groups.

8. In conjunction with the Department of Health, plan for the provision of services at the local level for persons infected with the human immunodeficiency virus.

9. Provide technical assistance to encourage and support activities by providers, purchasers, and consumers and local, regional, and state agencies in meeting the health care goals, objectives, and policies adopted by the local health council.

(d) Each local health council shall enter into a memorandum of agreement with each regional planning council in its district that elects to address health issues in its strategic regional policy plan. In addition, each local health council shall enter into a memorandum of agreement with each local government that includes an optional health element in its comprehensive plan. The memorandum of agreement must specify the manner in which each local government, regional planning council, and local health council will coordinate its activities to ensure a unified approach to health planning and implementation efforts.

(e) Local health councils may employ personnel or contract for staffing services with persons who possess appropriate qualifications to carry out the councils' purposes. Such personnel are not state employees.

(f) Personnel of the local health councils shall provide to council members an annual orientation about council member responsibilities.

(g) Each local health council may accept and receive, in furtherance of its health planning functions, funds, grants, and services from governmental agencies and from private or civic sources to perform studies related to local health planning in exchange for such funds, grants, or services. Each council shall, no later than January 30 of each year, render to the Department of Health an accounting of the receipt and disbursement of such funds received.

(2) FUNDING.—

(a) The Legislature intends that the cost of local health councils be borne by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration, including abortion clinics, assisted living facilities, ambulatory surgical centers, birth centers, home health agencies, hospices, hospitals, intermediate care facilities for the developmentally disabled, nursing homes, health care clinics, and multiphasic testing centers and by assessments on organizations subject to certification by the agency pursuant to part III of chapter 641, including health maintenance organizations and prepaid health clinics. Fees assessed may be collected prospectively at the time of licensure renewal and prorated for the licensure period.

(b)1. A hospital licensed under chapter 395, a nursing home facility licensed under chapter 400, and an assisted living

facility licensed under chapter 429 shall be assessed an annual fee based on the number of beds in such facilities.

2. All other facilities and organizations listed in paragraph (a) shall each be assessed an annual fee of $150.

3. Facilities operated by the Department of Children and Families, the Department of Health, or the Department of Corrections and a rural hospital as defined in s. 395.602 are exempt from the assessment required in this subsection.

(c) The agency shall, by rule, establish:

1. Fees for hospitals and nursing homes based on an assessment of $2 per bed. However, such facilities may not be assessed more than a total of $500 under this subsection.

2. Fees for assisted living facilities based on an assessment of $1 per bed. However, such facilities may not be assessed more than a total of $150 under this subsection.

3. An annual fee of $150 for all other facilities and organizations listed in paragraph (a).

(d) The agency shall, by rule, establish a facility billing and collection process for the billing and collection of the health facility fees authorized by this subsection.

(e) A health facility that is assessed a fee under this subsection is subject to a fine of $100 per day for each day in which the facility is late in submitting its annual fee up to the maximum of the annual fee owed by the facility. A facility

that refuses to pay the fee or fine is subject to the forfeiture of its license.

(f) The agency shall deposit all health care facility assessments that are assessed under this subsection in the Health Care Trust Fund and shall transfer such funds to the Department of Health for funding of the local health councils.

(3) DUTIES AND RESPONSIBILITIES OF THE AGENCY FOR HEALTH CARE ADMINISTRATION.—

(a) The agency is responsible for the coordinated planning of health care services in the state.

(b) The agency shall develop and maintain a comprehensive health care database. The agency or its contractor is authorized to require the submission of information from health facilities, health service providers, and licensed health professionals which is determined by agency rule to be necessary for meeting the agency's responsibilities as established in this section.

(c) The Department of Health shall contract with the local health councils for the services specified in subsection (1). All contract funds shall be distributed according to an allocation plan developed by the department. The department may withhold funds from a local health council or cancel its contract with a local health council that does not meet performance standards agreed upon by the department and local health councils.

Section 9. Subsection (1) of section 383.216, Florida

Statutes, is amended to read:

383.216 Community-based prenatal and infant health care.—

(1) The Department of Health shall cooperate with localities which wish to establish prenatal and infant health care coalitions, and shall acknowledge and incorporate, if appropriate, existing community children's services organizations, pursuant to this section within the resources allocated. The purpose of this program is to establish a partnership among the private sector, the public sector, state government, local government, community alliances, and maternal and child health care providers, for the provision of coordinated community-based prenatal and infant health care. The prenatal and infant health care coalitions must work in a coordinated, nonduplicative manner with local health planning councils established pursuant to s. 381.4066 ~~s. 408.033~~.

Section 10. Subsection (4), paragraph (b) of subsection (6), and subsections (8), (9), and (10) of section 395.003, Florida Statutes, are amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(4) The agency shall issue a license that ~~which~~ specifies the service categories and the number of hospital beds in each bed category for which a license is received. Such information shall be listed on the face of the license. ~~All beds which are not covered by any specialty-bed-need methodology shall be specified as general beds.~~ A licensed facility shall not operate

a number of hospital beds greater than the number indicated by the agency on the face of the license without approval from the agency under conditions established by rule.

(6)

(b) A specialty-licensed children's hospital that has licensed neonatal intensive care unit beds and is located in District 5 or District 11, as defined in s. 381.4066 ~~s. 408.032~~, as of January 1, 2018, may provide obstetrical services, in accordance with the pertinent guidelines promulgated by the American College of Obstetricians and Gynecologists and with verification of guidelines and compliance with internal safety standards by the Voluntary Review for Quality of Care Program of the American College of Obstetricians and Gynecologists and in compliance with the agency's rules pertaining to the obstetrical department in a hospital and offer healthy mothers all necessary critical care equipment, services, and the capability of providing up to 10 beds for labor and delivery care, which services are restricted to the diagnosis, care, and treatment of pregnant women of any age who have documentation by an examining physician that includes information regarding:

1. At least one fetal characteristic or condition diagnosed intra-utero that would characterize the pregnancy or delivery as high risk including structural abnormalities of the digestive, central nervous, and cardiovascular systems and disorders of genetic malformations and skeletal dysplasia, acute

metabolic emergencies, and babies of mothers with rheumatologic disorders; or

2. Medical advice or a diagnosis indicating that the fetus may require at least one perinatal intervention.

This paragraph shall not preclude a specialty-licensed children's hospital from complying with s. 395.1041 or the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. s. 1395dd.

~~(8) A hospital may not be licensed or relicensed if:~~

~~(a) The diagnosis-related groups for 65 percent or more of the discharges from the hospital, in the most recent year for which data is available to the Agency for Health Care Administration pursuant to s. 408.061, are for diagnosis, care, and treatment of patients who have:~~

~~1. Cardiac-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 5;~~

~~2. Orthopedic-related diseases and disorders classified as diagnosis-related groups in major diagnostic category 8;~~

~~3. Cancer-related diseases and disorders classified as discharges in which the principal diagnosis is neoplasm or carcinoma or is for an admission for radiotherapy or antineoplastic chemotherapy or immunotherapy; or~~

~~4. Any combination of the above discharges.~~

~~(b) The hospital restricts its medical and surgical~~

~~services to primarily or exclusively cardiac, orthopedic, surgical, or oncology specialties.~~

~~(c) A hospital classified as an exempt cancer center hospital pursuant to 42 C.F.R. s. 412.23(f) as of December 31, 2005, is exempt from the licensure restrictions of this subsection.~~

~~(9) A hospital licensed as of June 1, 2004, shall be exempt from subsection (8) as long as the hospital maintains the same ownership, facility street address, and range of services that were in existence on June 1, 2004. Any transfer of beds, or other agreements that result in the establishment of a hospital or hospital services within the intent of this section, shall be subject to subsection (8). Unless the hospital is otherwise exempt under subsection (8), the agency shall deny or revoke the license of a hospital that violates any of the criteria set forth in that subsection.~~

~~(10) The agency may adopt rules implementing the licensure requirements set forth in subsection (8). Within 14 days after rendering its decision on a license application or revocation, the agency shall publish its proposed decision in the Florida Administrative Register. Within 21 days after publication of the agency's decision, any authorized person may file a request for an administrative hearing. In administrative proceedings challenging the approval, denial, or revocation of a license pursuant to subsection (8), the hearing must be based on the~~

~~facts and law existing at the time of the agency's proposed agency action. Existing hospitals may initiate or intervene in an administrative hearing to approve, deny, or revoke licensure under subsection (8) based upon a showing that an established program will be substantially affected by the issuance or renewal of a license to a hospital within the same district or service area.~~

Section 11. Subsection (10) of section 395.0191, Florida Statutes, is amended to read:

395.0191 Staff membership and clinical privileges.—

~~(10) Nothing herein shall be construed by the agency as requiring an applicant for a certificate of need to establish proof of discrimination in the granting of or denial of hospital staff membership or clinical privileges as a precondition to obtaining such certificate of need under the provisions of s. 408.043.~~

Section 12. Subsection (12) of section 395.1055, Florida Statutes, is renumbered as subsection (15), paragraph (f) of subsection (1) and paragraph (b) of subsection (9) are amended, and new subsections (12), (13), and (14) are added to that section, to read:

395.1055 Rules and enforcement.—

(1) The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this part, which shall include reasonable and fair minimum standards for

ensuring that:

~~(f) All hospitals submit such data as necessary to conduct certificate-of-need reviews required under part I of chapter 408. Such data shall include, but shall not be limited to, patient origin data, hospital utilization data, type of service reporting, and facility staffing data. The agency may not collect data that identifies or could disclose the identity of individual patients. The agency shall utilize existing uniform statewide data sources when available and shall minimize reporting costs to hospitals.~~

(9) The agency shall establish a technical advisory panel, pursuant to s. 20.052, to develop procedures and standards for measuring outcomes of pediatric cardiac catheterization programs and pediatric cardiovascular surgery programs.

(b) Voting members of the panel shall include: 3 at-large members, including 1 cardiologist who is board certified in caring for adults with congenital heart disease and 2 board-certified pediatric cardiologists, neither of whom may be employed by any of the hospitals specified in subparagraphs 1.-10. or their affiliates, each of whom is appointed by the Secretary of Health Care Administration, and 10 members, and an alternate for each member, each of whom is a pediatric cardiologist or a pediatric cardiovascular surgeon, each appointed by the chief executive officer of the following hospitals:

1. Johns Hopkins All Children's Hospital in St. Petersburg.

2. Arnold Palmer Hospital for Children in Orlando.

3. Joe DiMaggio Children's Hospital in Hollywood.

4. Nicklaus Children's Hospital in Miami.

5. St. Joseph's Children's Hospital in Tampa.

6. University of Florida Health Shands Hospital in Gainesville.

7. University of Miami Holtz Children's Hospital in Miami.

8. Wolfson Children's Hospital in Jacksonville.

9. Florida Hospital for Children in Orlando.

10. Nemours Children's Hospital in Orlando.

Appointments made under subparagraphs 1.-10. are contingent upon ~~the hospital's maintenance of pediatric certificates of need and~~ the hospital's compliance with this section and rules adopted thereunder, as determined by the Secretary of Health Care Administration. A member appointed under subparagraphs 1.-10. whose hospital fails to ~~maintain such certificates or~~ comply with such standards may serve only as a nonvoting member until the hospital ~~restores such certificates or~~ complies with such standards.

(12) Each provider of diagnostic cardiac catheterization services shall comply with rules adopted by the agency that establish licensure standards governing the operation of adult

inpatient diagnostic cardiac catheterization programs. The rules shall ensure that such programs:

(a) Comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories.

(b) Perform only adult inpatient diagnostic cardiac catheterization services and will not provide therapeutic cardiac catheterization or any other cardiology services.

(c) Maintain sufficient appropriate equipment and health care personnel to ensure quality and safety.

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

(e) Demonstrate a plan to provide services to Medicaid and charity care patients.

(13) Each provider of adult cardiovascular services or operator of a burn unit shall comply with rules adopted by the agency which establish licensure standards that govern the provision of adult cardiovascular services or the operation of a burn unit. Such rules shall consider, at a minimum, staffing, equipment, physical plant, operating protocols, the provision of services to Medicaid and charity care patients, accreditation, licensure period and fees, and enforcement of minimum standards.

(14) In establishing rules for adult cardiovascular

services, the agency shall include provisions that allow for:

(a) Establishment of two hospital program licensure levels: a Level I program authorizing the performance of adult percutaneous cardiac intervention without onsite cardiac surgery and a Level II program authorizing the performance of percutaneous cardiac intervention with onsite cardiac surgery.

(b)1. For a hospital seeking a Level I program, demonstration that, for the most recent 12-month period as reported to the agency, the hospital has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease and that it has a formalized, written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient within 60 minutes.

2.a. A hospital located more than 100 road miles from the closest Level II adult cardiovascular services program does not need to meet the diagnostic cardiac catheterization volume and ischemic heart disease diagnosis volume requirements in subparagraph 1. if the hospital demonstrates that it has, for the most recent 12-month period as reported to the agency, provided a minimum of 100 adult inpatient and outpatient diagnostic cardiac catheterizations or that, for the most recent

12-month period, it has discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease.

b. A hospital located more than 100 road miles from the closest Level II adult cardiovascular services program does not need to meet the 60-minute transfer time protocol requirement in subparagraph 1. if the hospital demonstrates that it has a formalized, written transfer agreement with a hospital that has a Level II program. The agreement must include written transport protocols to ensure the safe and efficient transfer of a patient, taking into consideration the patient's clinical and physical characteristics, road and weather conditions, and viability of ground and air ambulance service to transfer the patient.

3. At a minimum, the rules for adult cardiovascular services must require nursing and technical staff to have demonstrated experience in handling acutely ill patients requiring intervention, based on the staff member's previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open heart surgery program, the staff member's previous experience qualifies only if, at the time the staff member acquired his or her experience, the dedicated cardiac interventional laboratory:

a. Had an annual volume of 500 or more percutaneous

cardiac intervention procedures.

b. Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures.

c. Experienced a complication rate of less than 5 percent for percutaneous cardiac intervention procedures.

d. Performed diverse cardiac procedures, including, but not limited to, balloon angioplasty and stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.

(c) For a hospital seeking a Level II program, demonstration that, for the most recent 12-month period as reported to the agency, the hospital has performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

(d) Compliance with the most recent guidelines of the American College of Cardiology and American Heart Association guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria to ensure patient quality and safety.

(e) Establishment of appropriate hours of operation and protocols to ensure availability and timely referral in the event of emergencies.

(f) Demonstration of a plan to provide services to

Medicaid and charity care patients.

Section 13. Subsection (5) of section 395.1065, Florida Statutes, is amended to read:

395.1065 Criminal and administrative penalties; moratorium.—

(5) The agency shall impose a fine of $500 for each instance of the facility's failure to provide the information required by rules adopted pursuant to s. 395.1055(1)(g) ~~s. 395.1055(1)(h)~~.

Section 14. Section 395.6025, Florida Statutes, is repealed.

Section 15. Subsection (3) of section 400.071, Florida Statutes, is amended to read:

400.071 Application for license.—

~~(3) It is the intent of the Legislature that, in reviewing a certificate-of-need application to add beds to an existing nursing home facility, preference be given to the application of a licensee who has been awarded a Gold Seal as provided for in s. 400.235, if the applicant otherwise meets the review criteria specified in s. 408.035.~~

Section 16. Subsections (3), (4), and (5) of section 400.606, Florida Statutes, are amended to read:

400.606 License; application; renewal; conditional license or permit; certificate of need.—

(3) Any hospice initially licensed on or after July 1,

2019, must be accredited by a national accreditation organization that is recognized by the Centers for Medicare and Medicaid Services and the standards of which incorporate comparable licensure regulations required by the state. Such accreditation must be maintained as a requirement of licensure ~~The agency shall not issue a license to a hospice that fails to receive a certificate of need under the provisions of part I of chapter 408. A licensed hospice is a health care facility as that term is used in s. 408.039(5) and is entitled to initiate or intervene in an administrative hearing~~.

(4) A hospice initially licensed on or after July 1, 2019, must establish and maintain a freestanding hospice facility that is engaged in providing inpatient and related services and that is not otherwise licensed as a health care facility ~~shall obtain a certificate of need~~. However, a freestanding hospice facility that has six or fewer beds is not required to comply with institutional standards such as, but not limited to, standards requiring sprinkler systems, emergency electrical systems, or special lavatory devices.

~~(5) The agency may deny a license to an applicant that fails to meet any condition for the provision of hospice care or services imposed by the agency on a certificate of need by final agency action, unless the applicant can demonstrate that good cause exists for the applicant's failure to meet such condition.~~

Section 17. Paragraph (b) of subsection (2) of section

400.6085, Florida Statutes, is amended to read:

400.6085 Contractual services.—A hospice may contract out for some elements of its services. However, the core services, as set forth in s. 400.609(1), with the exception of physician services, shall be provided directly by the hospice. Any contract entered into between a hospice and a health care facility or service provider must specify that the hospice retains the responsibility for planning, coordinating, and prescribing hospice care and services for the hospice patient and family. A hospice that contracts for any hospice service is prohibited from charging fees for services provided directly by the hospice care team that duplicate contractual services provided to the patient and family.

(2) With respect to contractual arrangements for inpatient hospice care:

~~(b) Hospices contracting for inpatient care beds shall not be required to obtain an additional certificate of need for the number of such designated beds. Such beds shall remain licensed to the health care facility and be subject to the appropriate inspections.~~

Section 18. Sections 408.031, 408.032, 408.033, 408.034, 408.035, 408.036, 408.0361, 408.037, 408.038, 408.039, 408.040, 408.041, 408.042, 408.043, 408.044, 408.045, and 408.0455, Florida Statutes, are repealed.

Section 19. Section 408.07, Florida Statutes, is amended

to read:

408.07 Definitions.—As used in this chapter, ~~with the exception of ss. 408.031-408.045,~~ the term:

(1) "Accepted" means that the agency has found that a report or data submitted by a health care facility or a health care provider contains all schedules and data required by the agency and has been prepared in the format specified by the agency, and otherwise conforms to applicable rule or Florida Hospital Uniform Reporting System manual requirements regarding reports in effect at the time such report was submitted, and the data are mathematically reasonable and accurate.

(2) "Adjusted admission" means the sum of acute and intensive care admissions divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues. If a hospital reports only subacute admissions, then "adjusted admission" means the sum of subacute admissions divided by the ratio of total inpatient revenues to gross revenues.

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

(4) "Alcohol or chemical dependency treatment center" means an organization licensed under chapter 397.

(5) "Ambulatory care center" means an organization which employs or contracts with licensed health care professionals to provide diagnosis or treatment services predominantly on a walk-

in basis and the organization holds itself out as providing care on a walk-in basis. Such an organization is not an ambulatory care center if it is wholly owned and operated by five or fewer health care providers.

(6) "Ambulatory surgical center" means a facility licensed as an ambulatory surgical center under chapter 395.

(7) "Audited actual data" means information contained within financial statements examined by an independent, Florida-licensed, certified public accountant in accordance with generally accepted auditing standards, but does not include data within a financial statement about which the certified public accountant does not express an opinion or issues a disclaimer.

(8) "Birth center" means an organization licensed under s. 383.305.

(9) "Cardiac catheterization laboratory" means a freestanding facility that employs or contracts with licensed health care professionals to provide diagnostic or therapeutic services for cardiac conditions such as cardiac catheterization or balloon angioplasty.

(10) "Case mix" means a calculated index for each health care facility or health care provider, based on patient data, reflecting the relative costliness of the mix of cases to that facility or provider compared to a state or national mix of cases.

(11) "Comprehensive rehabilitative hospital" or

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

(12) "Consumer" means any person other than a person who administers health activities, is a member of the governing body of a health care facility, provides health services, has a fiduciary interest in a health facility or other health agency or its affiliated entities, or has a material financial interest in the rendering of health services.

(13) "Continuing care facility" means a facility licensed under chapter 651.

(14) "Critical access hospital" means a hospital that meets the definition of "critical access hospital" in s. 1861(mm)(1) of the Social Security Act and that is certified by the Secretary of Health and Human Services as a critical access hospital.

(15) "Cross-subsidization" means that the revenues from one type of hospital service are sufficiently higher than the costs of providing such service as to offset some of the costs

of providing another type of service in the hospital. Cross-subsidization results from the lack of a direct relationship between charges and the costs of providing a particular hospital service or type of service.

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

(17) "Diagnostic-imaging center" means a freestanding outpatient facility that provides specialized services for the diagnosis of a disease by examination and also provides radiological services. Such a facility is not a diagnostic-imaging center if it is wholly owned and operated by physicians who are licensed pursuant to chapter 458 or chapter 459 and who practice in the same group practice and no diagnostic-imaging work is performed at such facility for patients referred by any health care provider who is not a member of that same group practice.

(18) "FHURS" means the Florida Hospital Uniform Reporting System developed by the agency.

(19) "Freestanding" means that a health facility bills and receives revenue which is not directly subject to the hospital

assessment for the Public Medical Assistance Trust Fund as described in s. 395.701.

(20) "Freestanding radiation therapy center" means a facility where treatment is provided through the use of radiation therapy machines that are registered under s. 404.22 and the provisions of the Florida Administrative Code implementing s. 404.22. Such a facility is not a freestanding radiation therapy center if it is wholly owned and operated by physicians licensed pursuant to chapter 458 or chapter 459 who practice within the specialty of diagnostic or therapeutic radiology.

(21) "GRAA" means gross revenue per adjusted admission.

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

(23) "Health care facility" means an ambulatory surgical center, a hospice, a nursing home, a hospital, a diagnostic-imaging center, a freestanding or hospital-based therapy center, a clinical laboratory, a home health agency, a cardiac catheterization laboratory, a medical equipment supplier, an alcohol or chemical dependency treatment center, a physical rehabilitation center, a lithotripsy center, an ambulatory care center, a birth center, or a nursing home component licensed

under chapter 400 within a continuing care facility licensed under chapter 651.

(24) "Health care provider" means a health care professional licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter 464, chapter 465, chapter 466, part I, part III, part IV, part V, or part X of chapter 468, chapter 483, chapter 484, chapter 486, chapter 490, or chapter 491.

(25) "Health care purchaser" means an employer in the state, other than a health care facility, health insurer, or health care provider, who provides health care coverage for her or his employees.

(26) "Health insurer" means any insurance company authorized to transact health insurance in the state, any insurance company authorized to transact health insurance or casualty insurance in the state that is offering a minimum premium plan or stop-loss coverage for any person or entity providing health care benefits, any self-insurance plan as defined in s. 624.031, any health maintenance organization authorized to transact business in the state pursuant to part I of chapter 641, any prepaid health clinic authorized to transact business in the state pursuant to part II of chapter 641, any multiple-employer welfare arrangement authorized to transact business in the state pursuant to ss. 624.436-624.45, or any fraternal benefit society providing health benefits to its

members as authorized pursuant to chapter 632.

(27) "Home health agency" means an organization licensed under part III of chapter 400.

(28) "Hospice" means an organization licensed under part IV of chapter 400.

(29) "Hospital" means a health care institution licensed by the Agency for Health Care Administration as a hospital under chapter 395.

(30) "Lithotripsy center" means a freestanding facility that employs or contracts with licensed health care professionals to provide diagnosis or treatment services using electro-hydraulic shock waves.

(31) "Local health council" means the council established ~~agency defined~~ in s. 381.4066 ~~s. 408.033~~.

(32) "Market basket index" means the Florida hospital input price index (FHIPI), which is a statewide market basket index used to measure inflation in hospital input prices weighted for the Florida-specific experience which uses multistate regional and state-specific price measures, when available. The index shall be constructed in the same manner as the index employed by the Secretary of the United States Department of Health and Human Services for determining the inflation in hospital input prices for purposes of Medicare reimbursement.

(33) "Medical equipment supplier" means an organization

that provides medical equipment and supplies used by health care providers and health care facilities in the diagnosis or treatment of disease.

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

(35) "New hospital" means a hospital in its initial year of operation as a licensed hospital and does not include any facility which has been in existence as a licensed hospital, regardless of changes in ownership, for over 1 calendar year.

(36) "Nursing home" means a facility licensed under s. 400.062 or, for resident level and financial data collection purposes only, any institution licensed under chapter 395 and which has a Medicare or Medicaid certified distinct part used for skilled nursing home care, but does not include a facility licensed under chapter 651.

(37) "Operating expenses" means total expenses excluding income taxes.

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

(39) "Physical rehabilitation center" means an organization that employs or contracts with health care professionals licensed under part I or part III of chapter 468 or chapter 486 to provide speech, occupational, or physical therapy services on an outpatient or ambulatory basis.

(40) "Prospective payment arrangement" means a financial agreement negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payor which contains, at a minimum, the elements provided for in s. 408.50.

(41) "Rate of return" means the financial indicators used to determine or demonstrate reasonableness of the financial requirements of a hospital. Such indicators shall include, but not be limited to: return on assets, return on equity, total margin, and debt service coverage.

(42) "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this

paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the Agency for Health Care Administration; or

(e) A critical access hospital.

Population densities used in this subsection must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this subsection shall be granted such designation upon application, including supporting documentation, to the Agency for Health Care Administration.

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

(44) "Teaching hospital" means any Florida hospital officially affiliated with an accredited Florida medical school which exhibits activity in the area of graduate medical

education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association and the presence of 100 or more full-time equivalent resident physicians. The Director of the Agency for Health Care Administration shall be responsible for determining which hospitals meet this definition.

Section 20. Subsection (6) of section 408.806, Florida Statutes, is amended to read:

408.806 License application process.—

(6) ~~The agency may not issue an initial license to a health care provider subject to the certificate-of-need provisions in part I of this chapter if the licensee has not been issued a certificate of need or certificate-of-need exemption, when applicable.~~ Failure to apply for the renewal of a license prior to the expiration date renders the license void.

Section 21. Subsection (3) of section 408.808, Florida Statutes, is amended to read:

408.808 License categories.—

(3) INACTIVE LICENSE.—An inactive license may be issued to a hospital, a nursing home, an intermediate care facility for the developmentally disabled, or an ambulatory surgical center ~~health care provider subject to the certificate-of-need provisions in part I of this chapter~~ when the provider is

currently licensed, does not have a provisional license, and will be temporarily unable to provide services due to construction or renovation but is reasonably expected to resume services within 12 months. Before an inactive license is issued, the licensee must have construction or renovation plans approved by the agency. Such designation may be made for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration by the licensee of the provider's progress toward reopening. ~~However, if after 20 months in an inactive license status, a statutory rural hospital, as defined in s. 395.602, has demonstrated progress toward reopening, but may not be able to reopen prior to the inactive license expiration date, the inactive designation may be renewed again by the agency for up to 12 additional months.~~ For purposes of such a second renewal, ~~if construction or renovation is required, the licensee must have had plans approved by the agency and~~ construction must have already commenced and ~~pursuant to s. 408.032(4); however, if construction or renovation is not required,~~ the licensee must provide proof of having made an enforceable capital expenditure greater than 25 percent of the total costs associated with the construction or renovation ~~hiring of staff and the purchase of equipment and supplies needed to operate the facility upon opening~~. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted

to the agency and must include a written justification for the inactive license with the beginning and ending dates of inactivity specified, a plan for the transfer of any clients to other providers, and the appropriate licensure fees. The agency may not accept a request that is submitted after initiating closure, after any suspension of service, or after notifying clients of closure or suspension of service, unless the action is a result of a disaster at the licensed premises. For the purposes of this section, the term "disaster" means a sudden emergency occurrence beyond the control of the licensee, whether natural, technological, or manmade, which renders the provider inoperable at the premises. Upon agency approval, the provider shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive license period is the date the provider ceases operations. The end of the inactive license period shall become the license expiration date. All licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the approval of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part, authorizing statutes, and applicable rules.

Section 22. Subsection (10) of section 408.810, Florida Statutes, is amended to read:

408.810 Minimum licensure requirements.—In addition to the

licensure requirements specified in this part, authorizing statutes, and applicable rules, each applicant and licensee must comply with the requirements of this section in order to obtain and maintain a license.

~~(10) The agency may not issue a license to a health care provider subject to the certificate-of-need provisions in part I of this chapter if the health care provider has not been issued a certificate of need or an exemption. Upon initial licensure of any such provider, the authorization contained in the certificate of need shall be considered fully implemented and merged into the license and shall have no force and effect upon termination of the license for any reason.~~

Section 23. Section 408.820, Florida Statutes, is amended to read:

408.820 Exemptions.—Except as prescribed in authorizing statutes, the following exemptions shall apply to specified requirements of this part:

(1) Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102, are exempt from s. 408.810(5)-(9) ~~s. 408.810(5)-(10)~~.

(2) Birth centers, as provided under chapter 383, are exempt from s. 408.810(7)-(9) ~~s. 408.810(7)-(10)~~.

(3) Abortion clinics, as provided under chapter 390, are exempt from s. 408.810(7)-(9) ~~s. 408.810(7)-(10)~~.

(4) Crisis stabilization units, as provided under parts I

and IV of chapter 394, are exempt from s. 408.810(8) and (9) ~~s. 408.810(8)-(10)~~.

(5) Short-term residential treatment facilities, as provided under parts I and IV of chapter 394, are exempt from s. 408.810(8) and (9) ~~s. 408.810(8)-(10)~~.

(6) Residential treatment facilities, as provided under part IV of chapter 394, are exempt from s. 408.810(8) and (9) ~~s. 408.810(8)-(10)~~.

(7) Residential treatment centers for children and adolescents, as provided under part IV of chapter 394, are exempt from s. 408.810(8) and (9) ~~s. 408.810(8)-(10)~~.

(8) Hospitals, as provided under part I of chapter 395, are exempt from s. 408.810(7)-(9).

(9) Ambulatory surgical centers, as provided under part I of chapter 395, are exempt from s. 408.810(7)-(9) ~~s. 408.810(7)-(10)~~.

(10) Nursing homes, as provided under part II of chapter 400, are exempt from ss. 408.810(7) and 408.813(2).

~~(11) Assisted living facilities, as provided under part I of chapter 429, are exempt from s. 408.810(10).~~

~~(12) Home health agencies, as provided under part III of chapter 400, are exempt from s. 408.810(10).~~

(11)~~(13)~~ Nurse registries, as provided under part III of chapter 400, are exempt from s. 408.810(6) ~~and (10)~~.

(12)~~(14)~~ Companion services or homemaker services

providers, as provided under part III of chapter 400, are exempt from s. 408.810(6)-(9) ~~s. 408.810(6)-(10)~~.

~~(15) Adult day care centers, as provided under part III of chapter 429, are exempt from s. 408.810(10).~~

(13)~~(16)~~ Adult family-care homes, as provided under part II of chapter 429, are exempt from s. 408.810(7)-(9) ~~s. 408.810(7)-(10)~~.

(14)~~(17)~~ Homes for special services, as provided under part V of chapter 400, are exempt from s. 408.810(7)-(9) ~~s. 408.810(7)-(10)~~.

~~(18) Transitional living facilities, as provided under part XI of chapter 400, are exempt from s. 408.810(10).~~

~~(19) Prescribed pediatric extended care centers, as provided under part VI of chapter 400, are exempt from s. 408.810(10).~~

~~(20) Home medical equipment providers, as provided under part VII of chapter 400, are exempt from s. 408.810(10).~~

(15)~~(21)~~ Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of chapter 400, are exempt from s. 408.810(7).

(16)~~(22)~~ Health care services pools, as provided under part IX of chapter 400, are exempt from s. 408.810(6)-(9) ~~s. 408.810(6)-(10)~~.

(17)~~(23)~~ Health care clinics, as provided under part X of chapter 400, are exempt from s. 408.810(6) and (7) ~~s.~~

~~408.810(6), (7), and (10)~~.

(18)~~(24)~~ Multiphasic health testing centers, as provided under part II of chapter 483, are exempt from s. 408.810(5)-(9) ~~s. 408.810(5)-(10)~~.

(19)~~(25)~~ Organ, tissue, and eye procurement organizations, as provided under part V of chapter 765, are exempt from s. 408.810(5)-(9) ~~s. 408.810(5)-(10)~~.

Section 24. Section 651.118, Florida Statutes, is repealed.

Section 25. This act shall take effect July 1, 2019.