

**Final Report
of the
2001-2002
Florida CON Workgroup**

December 2002

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Introduction

Florida's 2001-2003 Certificate of Need (CON) workgroup was established in Chapter 2000-318, *Laws of Florida*. The 2000 Legislature directed the Agency for Health Care Administration to staff a workgroup to "study issues pertaining to the Certificate of Need program, including the impact of trends in health care delivery and financing" and to "study issues relating to implementation of the CON Program."

The workgroup was directed to prepare an interim report by December 31, 2001 and a final report by December 31, 2002. This document is the required final report.

Workgroup members were appointed by the Governor, the President of the Senate and the Speaker of the House of Representatives. A complete list of the workgroup members and the category under which they were appointed is included in Appendix 1.

The group met for the first time in April 2001 in Orlando. Richard Morrison, Vice President for Government Affairs at Florida Hospital in Orlando was elected Chairman. Samira Beckwith, President of Hope Hospice and Palliative Care of Lee County (Fort Myers) was elected Vice Chair. The workgroup met again in June and every intervening month through December 2001.

Throughout the summer months, sub-committees focusing on hospitals, nursing homes and hospices met half-days and came together as a full workgroup for the remainder of the meeting.

The 2001 Legislature added to the workgroup's charge by asking them to evaluate issues related to 24-hour admissions in ambulatory surgical centers. A 24-hour admissions policy would allow physicians to admit patients to ambulatory surgical centers at any hour of the day and allow them to stay in the facility for up to 24 hours. Presently, ambulatory surgical center patients must be admitted early enough to be discharged before midnight of the same day.

In November 2001, the workgroup hosted a public meeting in Orlando to allow interested members of the public to comment on the draft report.

The workgroup submitted its *Interim Report of the Florida Certificate of Need Workgroup* in December 2001 as required. The interim report includes extensive historical and background material about the CON program and is available on the Internet at http://www.fdhc.state.fl.us/MCHQ/CON_FA/index.shtml. Bound copies of the interim report are available upon request by contacting the Agency for Health Care Administration at (850) 922-0791 or via e-mail at colvinl@fdhc.state.fl.us.

Readers of this final workgroup report who may be unfamiliar with the Florida CON program are encouraged to review the program's website and read the interim report as referenced above.

The workgroup met three times in 2002 in preparation for submission of this final report. The first meeting was held in January and focused on the issue of CON review of open heart surgery programs in Florida hospitals. At that time the workgroup voted to maintain CON review of open heart surgery programs without any change to existing statutes or rules. Workgroup Chairman Richard Morrison reported this position to House and Senate legislative committees in presentations during the 2002 session.

At the workgroup’s July 2002 meeting, Mr. Morrison suggested that the *Final Report of the Florida Certificate of Need Workgroup* should focus on a proposed bill that could be presented to the Legislature for consideration in the 2003 session. The workgroup approved the chairman’s proposal and this report includes the proposed legislation.

Mr. Morrison invited individual workgroup members, workgroup subcommittees and provider associations to prepare legislative proposals for consideration at the final workgroup meeting. By October, workgroup staff had received six proposals that were then formatted in a common style and forwarded to workgroup members for review prior to their gathering in Orlando for a final meeting on November 1, 2002. The six proposals, as submitted to workgroup members, are included in Appendix 2.

The workgroup considered the six reform proposals at its November 2002 meeting. The proposals were presented in descending order from those that proposed the greatest changes to the CON program to those that proposed the most limited change. The six proposals are briefly summarized in the following table in the order in which they were considered.

	Brief Summary
Proposal by workgroup member Andrea Eliscu	Eliminated the CON Program
Proposal by workgroup chairman Richard Morrison	Provided deadlines (not later than 2005) for AHCA to develop hospital licensure standards for tertiary services (excluding organ transplant programs) now regulated by CON; required AHCA to develop outcome-oriented licensure standards for tertiary services in hospitals and a system to delicense tertiary hospital services when hospitals failed to meet a majority of the outcome-oriented licensure standards; provided a back-up system for licensure standards for hospital tertiary services in the event of legal challenges to administrative rule processes; eliminated CON funding for local health councils and related contract management positions at the Department of Health; eliminated the role of local health councils in statewide health planning; required proposals for new hospitals to be general hospitals rather than specialty hospitals, with the exception of comprehensive inpatient medical rehab hospitals; increased flexibilities for highly utilized hospitals to add beds (including NICU and rehab) without CON review; increased fees for CON exemptions; increased CON fees; provided a phase out schedule for the CON program by 2006 or when licensure standards are implemented; required tertiary services to be provided only in general hospitals; provided limits to CON challenges.

	Brief Summary
Proposal by the Florida Hospital Association	Added open heart surgery to the statutory list of tertiary services; eliminated CON funding for local health councils and eliminated their role in statewide health planning; increased flexibilities for highly utilized hospitals to add beds (including NICU and rehab) without CON review; eliminated CON review of shared programs between hospitals; enabled hospital purchasers to acquire unimplemented CONs; enabled hospitals to convert among categories of mental health beds without CON review; created hospital licensure requirements to enable hospitals that do not have open heart surgery programs to offer emergency angioplasty; eliminated the ability of hospitals to create specialty hospitals through bed transfers; increased the flexibility for rural hospitals to build replacement facilities without CON review; increased CON fees; required AHCA to issue a final order in a CON appeal within 45 days of a DOAH recommended order or the recommended order is deemed approved; in appeals of CON cases to the district court, required the challenger in a CON appeal to pay the attorney's fees and costs of the approved CON applicant if the court finds in favor of the approved applicant.
Proposal by workgroup member Tom Panza	Enabled 24-hour admissions at ambulatory surgical centers; enabled hospitals with highly utilized comprehensive rehab services to add beds without CON review; eliminated CON review of open heart surgery programs and replaced it with regulation through the hospital licensure program, including the ability to revoke authority to operate an open heart program.
Proposal by the workgroup's nursing home subcommittee	Increased flexibilities for nursing homes to replace or transfer beds among facilities within districts without adding to the overall number of beds; created a CON advisory panel for nursing home issues; increased the occupancy standard in the current CON bed need methodology for nursing home beds; deleted the requirement for Gold Seal designation for highly utilized nursing homes to seek additional beds without CON review; changed requirements related to the submission of audited financial statements used in CON reviews.
Proposal by the workgroup's hospice subcommittee	Eliminated CON review when existing hospice programs want to add inpatient units

The workgroup heard brief summaries of the first two proposals (Eliscu and Morrison) but declined to consider either in detail. Later, a proposal to direct AHCA to develop outcome-oriented licensure standards for open heart and related interventional cardiology programs that was similar to Mr. Morrison's earlier proposal was approved by the workgroup.

The Florida Hospital Association's proposal was considered in detail with much discussion. Most of its recommendations were approved with the exception of those related to local health councils. The final position on local health councils did not recommend a change in their health planning function, but specified that funds derived from proposed CON fee increases should only be applied to the operation of the CON

program at AHCA. Funds derived from existing CON fees would continue to be partially allocated to local health councils as they are now.

The three parts of Mr. Panza's proposal were considered separately. The workgroup declined to approve the proposal to allow 24-hour admissions at ambulatory surgical centers. Mr. Panza explained that the 2002 Legislature established a pilot project to test the proposal and the workgroup concluded that it would be appropriate to wait until the report of the pilot project is completed and reviewed before making any recommendation. That report is expected in late 2003.

Mr. Panza's proposal for the limited expansion of inpatient rehab beds at highly utilized facilities without CON review was approved. It was actually discussed as an amendment to a similar proposal by the Florida Hospital Association. Earlier, the workgroup had rejected a proposal submitted in the public comment period that advocated the ability to convert hospital skilled nursing beds to inpatient rehab beds without CON review. Mr. Panza's proposal for the elimination of CON review for adult open heart surgery programs was rejected.

The workgroup approved proposals by the nursing home and hospice subcommittees largely as presented. The nursing home proposals were considered separately and amended with minor technical changes. The workgroup rejected a proposal to exempt CON proposals for nursing home projects from the proposed fee increases. The hospice proposal was approved as presented. Appendices 3 and 4 provide detailed information about all of the proposals considered by the workgroup, including information about action taken to amend the proposals.

As a result of these actions, the workgroup directed staff to create a proposed bill that includes all of the approved language. This proposed bill was circulated to workgroup members for their review prior to publication. It begins on the following page.

Proposed Legislation

A bill entitled

An Act relating to certificate-of-need; amending s. 408.032; adding open heart surgery to the list of tertiary services; amending s. 408.034; adding an occupancy standard for the nursing home bed need methodology; amending s. 408.036(1); deleting hospice inpatient facility from the projects subject to review; amending s. 408.036(2); deleting shared service projects from expedited reviews; modifying circumstances requiring transfer of a certificate of need; modifying expedited review for replacement of a nursing home; adding expedited review for relocation of nursing home beds; amending s. 408.036(3); adding exemptions for addition of comprehensive medical rehabilitation beds, conversion of mental health services beds, provision of percutaneous coronary intervention at hospitals without open heart surgery, replacement of a rural hospital, establishment of a Level II neonatal intensive care unit, addition of Level II or Level III neonatal intensive care beds, replacement of a licensed nursing home, and consolidation or combination of nursing home beds by providers that operate multiple nursing homes; amending s. 408.037; allowing a consolidated audit of a parent company; providing that the acquisition of a licensed hospital includes acquisition of any pending certificate of need application; amending s. 408.038; revising the fee schedule for certificate-of-need applications; amending section 408.039; providing that without agency action within 45 days the recommended order of the Division of Administrative Hearings becomes the final order; providing that a hospital that is the losing party in a judicial review must pay reasonable fees and costs of the prevailing hospital; amending s. 408.043(2); deleting a reference to hospice inpatient facility;

creating a Certificate of Need Nursing Home Advisory Panel; directing the Agency for Health Care Administration to develop outcome-oriented licensure standards for interventional cardiology; providing an effective date.

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

Section 1. Subsection (17) of section 408.032, Florida Statutes, is amended as follows:

408.032 Definitions relating to Health Facility and Services Development Act.-- As used in ss. 408.031-408.045, the term:

(17) "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, adult and pediatric open heart surgery, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The agency shall establish by rule a list of all tertiary health services.

Section 2. Subsection (5) of section 408.034, Florida Statutes, is amended to read:

408.034 Duties and Responsibilities of agency; rules.--

(5) The agency shall establish by rule a nursing-home-bed-need methodology that has a goal of maintaining a district average occupancy of 94 percent; and that reduces the community nursing home bed need for

the areas of the state where the agency establishes pilot community diversion programs through the Title XIX aging waiver program.

Section 3. Paragraph (e) of subsection (1) of section 408.036, Florida Statutes, is amended as follows:

408.036 Projects subject to review.--

(1) APPLICABILITY.--Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(h), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.

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

Section 4. Subsection (2) of section 408.036, Florida Statutes, is amended as follows:

408.036 Projects subject to review.--

(2) PROJECTS SUBJECT TO EXPEDITED REVIEW.-- Unless exempt pursuant to subsection (3), projects subject to an expedited review shall include, but not be limited to:

(a) Research, education, and training programs.

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

(b)(c) A transfer of a certificate of need, except that when an existing hospital is acquired by a purchaser, all certificates of need issued to the hospital which are not yet operational shall be acquired by the purchaser, without need for a transfer.

(c)(d) A 50-percent increase in nursing home beds for a facility incorporated and operating in this state for at least 60 years on or before July 1, 1988, which has a licensed nursing home facility located on a campus providing a variety of residential settings and supportive

services. The increased nursing home beds shall be for the exclusive use of the campus residents. Any application on behalf of an applicant meeting this requirement shall be subject to the base fee of \$5,000 provided in s. 408.038.

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

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

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

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

(f) Replacement of a nursing home within the same district, provided the proposed project site is located within a geographic area that contains at least 65 percent of the facility's current residents, and is within a 30-mile radius of the replaced nursing home.

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

The agency shall develop rules to implement the provisions for expedited review, including time schedule, application content which

may be reduced from the full requirements of s. 408.037(1), and application processing.

Section 5. Subsection (3) of section 408.036, Florida Statutes, is amended as follows:

408.036 Projects subject to review.--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. ~~Effective until June 30, 2001, C~~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.e.~~ Certify that the prior 12-month average occupancy rate for the nursing home beds at the facility meets or exceeds 96 percent.

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

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

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

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

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

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

(r) For the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services, provided that conversion under this paragraph shall not establish a new licensed bed category at the hospital but shall apply only to categories of beds licensed at that hospital.

(s) For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital without an operational adult open heart surgery program. In addition to any other documentation otherwise required by the agency, a request for an exemption submitted under this paragraph must comply with the following:

1. The applicant must certify that it will meet and continuously maintain the licensure requirements adopted by the agency for the provision of these services. These licensure requirements are to be adopted by rule and are to be consistent with the guidelines published by the American College of Cardiology and the American Heart Association for the provision of percutaneous coronary interventions in hospitals without adult open heart services. At a minimum, the rules shall require the following:

a. Cardiologists must be experienced interventionalists who have performed a minimum of 75 interventions within the previous 12 months;

b. The hospital must provide a minimum of 36 emergency interventions annually, in order to continue to provide the service;

c. The hospital must have sufficient physician, nursing and laboratory staff to provide the services twenty four hours a day, seven days a week;

d. Nursing and technical staff must have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers;

e. Cardiac care nursing staff must be adept in hemodynamic monitoring and IABP management;

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

g. Hospitals implementing the service must first undertake a 3 to 6 month training program which includes establishing standards, testing logistics, creating quality assessment and error management practices, and formalizing patient selection criteria.

2. The applicant must certify that it will utilize at all times the patient selection criteria for the performance of primary angioplasty at hospitals without adult open heart surgery programs issued by the American College of Cardiology and the American Heart Association. At a minimum, these criteria would provide for the following:

a. Avoidance of interventions in hemodynamically stable patients presenting with identified symptoms or medical histories;

b. Transfer of patients presenting with a history of coronary disease and clinical presentation of hemodynamic instability.

3. The applicant must agree to submit a quarterly report to the agency detailing patient characteristics, treatment and outcomes for all patients receiving emergency percutaneous coronary interventions pursuant to this exemption. This report must be submitted within 15 days of the close of each calendar quarter.

The exemption provided by this paragraph shall not apply unless the agency determines that the hospital has taken all necessary steps to be in compliance with the requirements, including the training program required pursuant to sub-subparagraph 1.g.

4. Failure of the hospital to continuously comply with the rules adopted pursuant to sub-subparagraphs 1.c. through 1.f. and subparagraphs 2. and 3. will result in the immediate expiration of this exemption.

5. Failure of the hospital to meet the volume requirements of sub-subparagraph 1.a. and 1.b. within 18 months after the program begins offering the service will result in the immediate expiration of this exemption.

(t) For the replacement of a statutory rural hospital within the same district, provided the proposed project site is within 10 miles of the existing facility, and is within the current primary service area, defined as the least number of ZIP codes comprising 75 percent of the hospital's inpatient admissions.

(u) For the establishment of a Level II neonatal intensive care unit with at least 10 beds, upon documentation to the agency that the

applicant hospital had a minimum of 1500 births during the previous 12 months.

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

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

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

408.037 Application content.--

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

Section 7. Subsection (2) of section 408.037, Florida Statutes, is amended to read:

408.037 Application content.--

(2) The applicant must certify that it will license and operate the health care facility. For an existing health care facility, the applicant must be the license holder of the facility. Provided, however, that acquisition of a licensed hospital prior to final agency

action on its application for a certificate of need shall transfer the application to the new owner and license holder.

Section 8. Section 408.038, Florida Statutes, is amended to read:

408.038 Fees.--The agency shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding ~~the functions of the local health councils and~~ the activities of the agency and shall provide funds to the local health councils. Except for the increased amount of fees received pursuant to subsection (3), the fees ~~and~~ shall be allocated as provided in s. 408.033(2)(f). The fee shall be determined as follows:

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

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

(3) Any increase in fee revenue generated by increases in the minimum base fee or increases in the fee limit, as authorized by the 2003 Legislature, shall be used only to fund activities of the certificate of need program.

Section 9. Paragraph (e) of subsection (5) of section 408.039, Florida Statutes, is amended as follows:

(5) ADMINISTRATIVE HEARINGS.--

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

is specifically exempt from the time limitations provided in s. 120.60(1).

Section 10. Paragraph (c) of subsection (6) of section 408.039, Florida Statutes, is amended as follows:

(6) JUDICIAL REVIEW.--

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

Section 11. Subsection (2) of section 408.043, Florida Statutes, is amended as follows:

408.043 Special provisions.--

(2) HOSPICES.-- When an application is made for a certificate of need to establish or to expand a hospice, the need for such hospice shall be determined on the basis of the need for and availability of hospice services in the community. The formula on which the certificate of need is based shall discourage regional monopolies and promote competition. ~~The inpatient hospice care component of a hospice which is a freestanding facility, or a part of a facility, which is primarily engaged in providing inpatient care and related services and is not licensed as a health care facility shall also be required to obtain a certificate of need.~~ Provision of hospice care by any current provider of health care is a significant change in service and therefore requires a certificate of need for such services.

Section 12. Certificate of Need Nursing Home Advisory Panel

(1) There is hereby created a Certificate of Need Nursing Home Advisory Panel to serve as a body of experts to guide the agency in its development of policy related to nursing home certificate of need issues. The agency shall provide staff support to the Panel. The Panel shall be composed of the following members:

(a) The designee of the Deputy Secretary of Health Quality Assurance;

(b) The designee of the Deputy Secretary of Medicaid;

(c) The designee of the Secretary of the Department of Elder Affairs;

(d) Two representatives of the Local Health Councils;

(e) One representative of the Florida Association of Homes for the Aging;

(f) One representative of the Florida Health Care Association;

(g) One representative of nonprofit nursing homes;

(h) One representative of for-profit nursing homes; and

(i) One representative of Florida Hospices and Palliative Care, Inc.

(2) The Panel shall meet at least quarterly and advise the agency regarding:

(a) Long term care needs of Florida's elderly;

(b) Issues specific to different districts or subdistricts;

(c) Options for ensuring access to long term care for Medicaid eligible and other individuals;

(d) Reimbursement policy that will encourage development of alternative long term care initiatives;

(e) Development of a timely utilization reporting schedule for assisted living facilities and home and community based services; and

(f) Changes necessary for a more viable nursing home bed need formula which will ensure access, and take into account the alternatives to nursing home care available in each district or subdistrict using information from the reports submitted by such providers.

Section 13. The Agency for Health Care Administration is directed to develop outcome-oriented licensure standards for interventional cardiology, including open heart surgery and cardiac catheterization.

Section 14. This Act shall take effect upon becoming a law.

Proposal by the Florida Hospital Association	
Proposed Legislative Language	Notes/Explanation
<p>Definitions relating to Health Facility and Services Development: "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, <u>adult and pediatric open heart surgery</u>, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The agency shall establish by rule a list of all tertiary health services.</p>	<p>This change specifically adds open heart surgery programs to the statutory list of tertiary hospital services. While open heart surgery programs are not included in the statutory definition of tertiary services, they are defined as tertiary services in administrative rules that cover CON review of open heart surgery programs.</p>
<p>The Legislature intends that the cost of local health councils be borne by application fees for certificates of need and by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration ...</p>	<p>This change would require the Legislature to find a source of funds other than CON fees for local health councils. This would also affect two or three positions at the Department of Health where the local health council contracts are managed. Workgroup Chairman Rich Morrison makes a similar proposal.</p>
<p>The agency, in conjunction with the local health councils, is responsible for the coordinated planning of health care services in the state.</p>	<p>This change would eliminate the remaining role for local health councils in the development in statewide health planning. Presently, applicable preferences included in district health plans are considered in the CON review process.</p>

Proposed Legislative Language	DRAFT BILL	Notes/Explanation
<p>Definitions relating to Health Facility and Services Development: "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, <u>adult and pediatric open heart surgery</u>, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The agency shall establish by rule a list of all tertiary health services.</p>	<p>page 2, lines6-17</p> <p>408.032(17)</p>	<p>This change specifically adds open heart surgery programs to the statutory list of tertiary hospital services. While open heart surgery programs are not included in the statutory definition of tertiary services, they are defined as tertiary services in administrative rules that cover CON review of open heart surgery programs.</p>
<p>The Legislature intends that the cost of local health councils be borne by application fees for certificates of need and by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration ...</p> <p>The motion as written failed. The workgroup voted unanimously that any incremental increase in CON fees would not result in an incremental increase in funding support for the local health councils. Funding for the support of local health councils should continue from CON fees and should be frozen at the current level of \$150,000/year/council until such time as the Legislature identifies some other funding source within the state's budget for the continuation of local health councils..</p>	<p>page 10, line 28 through p 11 line 10</p> <p>408.038(3)</p>	<p>This change would require the Legislature to find a source of funds other than CON fees for local health councils. This would also affect two or three positions at the Department of Health where the local health council contracts are managed. A similar proposal is made by Workgroup Chairman Rich Morrison.</p>

Proposed Legislative Language	DRAFT BILL
<p>Definitions relating to Health Facility and Services Development: "Tertiary health service" means a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, organ transplantation, <u>adult and pediatric open heart surgery</u>, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. The agency shall establish by rule a list of all tertiary health services.</p>	<p>page 2 lines 6-17 408.032(17)</p>
<p>The agency shall establish by rule a nursing-home-bed-need methodology that reduces the community nursing home bed need for the areas of the state where the agency establishes pilot community diversion programs through the Title XIX aging waiver program. The bed need methodology formula shall utilize an have a goal of maintaining a statewide average occupancy threshold of 94 percent.</p> <p>AMENDED TO MAINTAIN DISTRICT AVERAGE AT 94% RATHER THAN STATEWIDE.</p>	<p>page 2 lines 21-25 408.034(5)</p>
<p>Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(h), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.</p> <p>The establishment of a hospice or hospice inpatient facility, except as provided in s. 408.043.</p>	<p>page 3 lines 4-5 and page 12 lines 6-16 408.036(1)(e) and 408.043(2)</p>
<p>PROJECTS SUBJECT TO EXPEDITED REVIEW.-- ... Shared services contracts or projects.</p>	<p>page 3 line 13 408.036(2)(b) deleted</p>
<p><u>A transfer of a certificate of need except when an existing hospital is acquired by a purchaser, all pending certificates of need filed by the existing hospital and all approved certificates of need owned by that hospital would be acquired by the purchaser.</u></p>	<p>page 3 lines 14-17 and page 10 lines 22-27 408.036(2)new(b) and 408.037(2)</p>

Proposed Legislative Language	DRAFT BILL
<p>The conversion of mental health services beds licensed under chapter 395 or hospital-based distinct part skilled nursing unit beds to general acute care beds; the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services; or the conversion of general acute care beds to beds for mental health services.</p>	<p>page 3 line 28 through page 4 line 9</p> <p>408.036(2)(e)</p>
<p>PROJECTS SUBJECT TO EXPEDITED REVIEW</p> <p>Replacement of a health care facility when the proposed project site is located within the geographic area that contains at least 65 percent of the facility's current patients/residents in the same district and within a <u>± 30-mile</u> radius of the replaced health care facility.</p> <p>AMENDED TO APPLY ONLY TO NURSING HOMES.</p>	<p>page 4 lines 10-13</p> <p>408.036(2)(f)</p>
<p><u>The moving of a portion of a provider's licensed beds to a replacement facility within the same nursing home district (not to exceed 30 mile radius) provided the total number of beds in the district does not increase.</u></p>	<p>page 4 lines 14-17</p> <p>408.036(2)(g)</p>
<p>For the addition of hospital beds licensed under chapter 395 for acute care, mental health services, or a hospital-based distinct part skilled nursing unit in a number that may not exceed 30 <u>40</u> total beds or 10 percent of the licensed capacity of the bed category being expanded whichever is greater; <u>for the addition of medical rehabilitation beds licensed under chapter 395 in a number that may not exceed 8 total beds or 10 percent of capacity whichever is greater; or for the addition of mental health services beds licensed under chapter 395 in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater.</u> Beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, or at a long-term care hospital, may not be increased under this paragraph.</p> <p>In addition to any other documentation otherwise required by the agency, a request for exemption submitted under this paragraph must:</p> <p>Certify that the prior 12-month average occupancy rate for the category of licensed beds being expanded at the facility meets or exceeds 75 80 percent or, for a hospital-based distinct part skilled nursing unit, the prior 12-month average occupancy rate meets or exceeds 96 percent.</p> <p>AMENDED TO RAISE THE OCCUPANCY RATE TO 90 PERCENT FOR INPATIENT REHAB.</p>	<p>page 4 line 26 through page 6 line 5</p> <p>408.036(3)(n)</p>

Proposed Legislative Language	DRAFT BILL
<p>For the addition of acute care beds, as authorized by rule consistent with s. 395.003(4), in a number that may not exceed 30 40 total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.</p>	<p>page 6 lines 6-11 408.036(3)(o)</p>
<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.</p> <p>In addition to any other documentation required by the agency, a request for exemption submitted under this paragraph must:</p> <p>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.</p> <p>Effective on July 1, 2001, certify that the facility has been designated as a Gold Seal nursing home under s. 400.235.</p>	<p>page 6 line 12 through page 7 line 3 408.036(3)(p)</p>
<p>For establishment of a specialty hospital offering a range of medical service restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county.</p>	<p>page 7 lines 4-9 408.036(3)(q)deleted</p>
<p>EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):</p> <p><u>For the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services.</u></p>	<p>page 7 lines 21-25 408.036(3)(r)</p>

Proposed Legislative Language	DRAFT BILL
<p><u>1. For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital without an approved adult open heart surgery program. In addition to any other documentation otherwise required by the agency, a request for an exemption submitted under this paragraph must comply with the following:</u></p> <p><u>2. The applicant must certify that it will meet and continuously maintain the requirements adopted by the agency for the provision of these services. These licensure requirements are to be adopted by rule and are to be consistent with the guidelines published by the American College of Cardiology and the American Heart Association for the provision of percutaneous coronary interventions in hospitals without adult open heart services. At a minimum, the rules shall require the following:</u></p> <ul style="list-style-type: none"> <u>a. Cardiologists must be experienced interventionalists who have performed a minimum of 75 interventions within the previous 12 months;</u> <u>b. The hospital must provide a minimum of 36 emergency interventions annually, in order to continue to provide the service;</u> <u>c. The hospital must offer sufficient physician, nursing and laboratory staff to provide the services twenty four hours daily, seven days a week;</u> <u>d. Nursing and technical staff must have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers;</u> <u>e. Cardiac care nursing staff must be adept in hemodynamic monitoring and IABP management;</u> <u>f. Formalized written transfer agreements must be developed with a hospital with an adult open heart surgery program and written transport protocols must be in place to ensure safe and efficient transfer of a patient within 60 minutes . Transfer and transport agreements must reviewed and tested, with appropriate documentation maintained at least every 3 months;</u> <u>g. Hospitals implementing the service, must first undertake a 3 to 6 month training program which includes establishing standards, testing logistics, creating quality assessment and error management practices and formalizing patient selection criteria.</u> <p><u>3..The applicant must certify that it will utilize at all times the patient selection criteria for the performance of primary angioplasty at hospitals without adult open heart surgery programs issued by the American College of Cardiology and the American Heart Association. At a minimum, these criteria would provide for the following:</u></p> <ul style="list-style-type: none"> <u>a. Avoidance of interventions in hemodynamically stable patients presenting with identified symptoms or medical histories;</u> <u>b. Transfer of patients presenting with a history of coronary disease and clinical presentation of hemodaynamic instability.</u> <p><u>4. The applicant must agree to submit a quarterly report to the agency detailing patient characteristics, treatment and outcomes for all patients receiving emergency percutaneous coronary interventions pursuant to this exemption. This report must be submitted within 15 days of the close of each calendar quarter.</u></p> <p><u>The exemption provided by the paragraph shall not apply unless the agency determines that the hospital has taken all necessary steps to be in compliance with these paragraphs, including the training program required pursuant to paragraph (1) subsection (g).</u></p> <p><u>5. Failure of the hospital to continuously comply with the rules adopted pursuant to paragraph 1.sub-paragraphs c.d.e.f. and paragraphs 2 and 3 will result in the immediate expiration of this exemption.</u></p> <p><u>6. Failure of the hospital to meet the volume requirements of paragraph1. subparagraphs a and b within 18monts after the programs begins offering the service will result in the immediate expiration of this exemption.</u></p>	<p>page 7 line 26 through page 9 line 21</p> <p>408.036(3)(s)</p>

Proposed Legislative Language	DRAFT BILL
<p><u>For the replacement of a statutory rural hospital when the proposed project site is located in the same district and within 10 miles of the existing facility and within the current primary service area, defined as the least number of zip codes comprising 75 percent of the hospital's inpatient admissions.</u></p>	<p>page 9 lines 22-26</p> <p>408.036(3)(t)</p>
<p><u>For the creation of at least a 10 bed Level II neonatal intensive care unit upon demonstrating to the agency that the applicant hospital had a minimum of 1500 births during the previous 12 months.</u></p>	<p>page 9 lines 27-29</p> <p>408.036(3)(u)</p>
<p><u>For the addition of Level II or Level III neonatal intensive care beds in a number not to exceed 6 beds or 10 percent of licensed capacity in that category whichever is greater, provided that the hospital certifies that the prior 12-month average occupancy rate for the category of licensed neonatal intensive care beds meets or exceeds 75 percent.</u></p>	<p>included in page 4 line 26 through page 6 line 5</p> <p>408.036(3)(n)</p>
<p>EXEMPTIONS.--Upon request, the following projects are subject to exemption from the provisions of subsection (1):</p> <p>For replacement of a licensed health care facility within the geographic area that contains at least 85 percent of the facility's current residents on the same site, or within 3 miles of the same site, provided that the number of beds in each licensed bed category will not increase.</p>	<p>page 10 lines 1-3</p> <p>408.036(3)(v)</p>
<p><u>Providers that operate multiple nursing home facilities within the same nursing home district should be allowed to consolidate facilities, combine facilities or transfer beds between facilities provided the aforementioned action does not increase the net bed inventory in the district and the relocation does not exceed 30 miles from the original site.</u></p>	<p>page 10 lines 4-8</p> <p>408.036(3)(w)</p>
<p>An audited financial statement of the applicant <u>or, if the applicant is part of a consolidated audit which breaks out each entity separately, an audited financial statement of the parent company.</u> In an application submitted by an existing health care facility, health maintenance organization, or hospice, financial condition documentation must include, but need not be limited to, a balance sheet and a profit-and-loss statement of the 2 previous fiscal years' operation.</p>	<p>page 10 lines 12-18</p> <p>408.037(1)(c)</p>

Proposed Legislative Language	DRAFT BILL
<p>A transfer of a certificate of need <u>except when an existing hospital is acquired by a purchaser, all pending certificates of need filed by the existing hospital and all approved certificates of need owned by that hospital would be acquired by the purchaser.</u></p>	<p>page 10 lines 22-27 and page 3 lines 14-17 408.036(2)new(b) and 408.037(2)</p>
<p>FEES.--The agency shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the functions of the local health councils and the activities of the agency and shall be allocated as provided in s. 408.033. The fee shall be determined as follows:</p> <p>A minimum base fee of <u>\$10,000</u> \$5,000. NOTE: AMENDMENT TO EXEMPT NURSING HOMES FAILED</p>	<p>page 10 line 28 through page 11 line 10</p> <p>408.038</p>
<p>In addition to the base fee of <u>\$10,000</u> \$5,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed <u>\$50,000</u> \$22,000.</p>	<p>same as above</p>
<p>The Legislature intends that the cost of local health councils be borne by application fees for certificates of need and by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration ...</p> <p>THE MOTION AS WRITTEN FAILED. THE WORKGROUP VOTED UNANIMOUSLY THAT ANY INCREMENTAL INCREASE IN CON FEES WOULD NOT RESULT IN AN INCREMENTAL INCREASE IN FUNDING SUPPORT FOR THE LOCAL HEALTH COUNCILS. FUNDING FOR THE SUPPORT OF LOCAL HEALTH COUNCILS SHOULD CONTINUE FROM CON FEES AND SHOULD BE FROZEN AT THE CURRENT LEVEL OF \$150,000/YEAR/COUNCIL UNTIL SUCH TIME AS THE LEGISLATURE IDENTIFIES SOME OTHER FUNDING SOURCE WITHIN THE STATE'S BUDGET FOR THE CONTINUATION OF LOCAL HEALTH COUNCILS.</p>	<p>same as above</p>
<p>ADMINISTRATIVE HEARINGS.—</p> <p>The agency shall issue its final order within 45 days after receipt of the recommended order. If the agency fails to take action within <u>45 days</u>, the Division of Administrative Hearing recommended order is deemed approved, such time, or as otherwise agreed to by the applicant and the agency, the applicant may take appropriate legal action to compel the agency to act. When making a determination on an application for a certificate of need, the agency is specifically exempt from the time limitations provided in s. 120.60(1).</p>	<p>page 11 line 14-21</p> <p>408.039(5)(e)</p>

Proposed Legislative Language	DRAFT BILL
<p>The court, in its discretion, may award reasonable attorney's fees and costs to the prevailing party if the court finds that there was a complete absence of a justiciable issue of law or fact raised by the losing party. <u>If the losing party is a hospital, the court shall order it to pay the reasonable attorney's fees and costs, which shall include fees and costs incurred as a result of the administrative hearing and the judicial appeal, of the prevailing hospital party.</u></p> <p>AMENDMENT TO INCLUDE ALL PROVIDER TYPES FAILED. INTENDED TO APPLY TO HOSPITALS ONLY AT THE DCA ONLY.</p>	<p>page 11 line 25 through page 12 line 2</p> <p>408.039(6)(c)</p>
<p>There is hereby created a Certificate of Need Nursing Home Advisory Panel to serve as a body of experts to guide the agency in its development of policy related to nursing home certificate of need issues. The agency shall provide staff support to the Panel.</p> <p>The Panel shall be composed of the following members:</p> <ul style="list-style-type: none"> (a) The designee of the Deputy Secretary of Managed Care and Health Quality, (b) The designee of the Deputy Secretary of Medicaid, (c) The designee of the Secretary of Department of Elder Affairs, (d) Two representatives of the Local Health Councils, (e) One representative of the Florida Association of Homes for the Aging, (f) One representative of the Florida Health Care Association, (g) One nonprofit nursing home representative, and (h) One for profit nursing home representative. <p>The Panel shall meet at least quarterly and advise the agency regarding:</p> <ul style="list-style-type: none"> (a) Long term care needs of Florida's elderly, (b) Issues specific to different Districts or subdistrict, (c) Options for ensuring access to long term care for Medicaid eligible and other individuals, (d) Reimbursement policy that will encourage development of alternative long term care initiatives, (e) Development of a timely utilization reporting schedule for assisted living facilities and home and community based services, <p>Changes for a more viable nursing home bed formula which will ensure access, and takes into account the alternatives to nursing home care available in each District or subdistrict using information from the reports submitted by such providers.</p> <p>AMENDED TO INCLUDE A REPRESENTATIVE OF FLORIDA HOSPICES AND PALLIATIVE CARE, INC.</p>	<p>page 12 line 18 through page 13 line 15</p>
<p>ENTIRE MORRISON PROPOSAL FAILED DUE TO LACK OF A SECOND. LATER PROPOSAL DIRECTS AHCA TO DEVELOP LICENSURE STANDARDS FOR INTERVENTIONAL CARDIOLOGY</p>	<p>page 13 lines 16-18</p>

<p>PROJECTS SUBJECT TO EXPEDITED REVIEW.-- ... Shared services contracts or projects.</p>	<p>page 3, line 13 408.036(2) delete(b)</p>	<p>This change eliminates the notion of shared services programs among CON-reviewable services. It would require any hospital to get a CON in order to have the ability to operate a program that is subject to CON review. Any sharing or cooperation that they then wished to engage in would be subject only to licensure requirements — not CON review.</p>
<p>A transfer of a certificate of need <u>except when an existing hospital is acquired by a purchaser, all pending certificates of need filed by the existing hospital and all approved certificates of need owned by that hospital would be acquired by the purchaser.</u></p>	<p>page 3 lines 14-17 and page 10 lines 22-27 408.036(2)new(b) and 408.037(2)</p>	<p>This change would allow the purchaser of a hospital to acquire any CONs that had already been obtained but not yet developed or implemented by the hospital. Currently, since undeveloped CONs are issued to the license holder, and the license holder would change in the event of a sale, the new owner would have to re-apply for any undeveloped CONs. <u>The change would also transfer any pending CONs to the purchaser.</u> This does not apply to beds that have already been licensed or services that are already operational — these assets would be part of the sale.</p>

<p>The conversion of mental health services beds licensed under chapter 395 or hospital-based distinct part skilled nursing unit beds to general acute care beds; the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services; or the conversion of general acute care beds to beds for mental health services.</p>	<p>page 3 line 28 through page 4 line 9</p> <p>408.036(2)(e)</p>	<p>The 2000 Legislature slightly streamlined the process to allow hospitals to convert beds among acute care, mental health and skilled nursing services. This was done by shifting the process from full batched CON review to expedited CON review. This proposed change would revert back to full batched review for the conversion of skilled nursing beds to acute care beds and, coupled with the change below, allow hospitals to convert beds among categories of mental health with a simple exemption request. <u>Conversion of SNU to acute became exempt in 2001 (this paragraph should have been revised then); changes within mental health would be exempt rather than expedited</u></p>
<p>EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):</p>		
<p><u>For the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services.</u></p>	<p>page 7 lines 21-25</p> <p>408.036(3)(r)</p>	<p>This change would allow hospitals to convert between adult or pediatric inpatient psychiatric or substance abuse beds through a simple exemption letter. It would not change the hospital licensure requirements associated with these</p>

		different categories.
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<p><u>1. For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital without an approved adult open heart surgery program. In addition to any other documentation otherwise required by the agency, a request for an exemption submitted under this paragraph must comply with the following:</u></p> <p><u>2. The applicant must certify that it will meet and continuously maintain the requirements adopted by the agency for the provision of these services. These licensure requirements are to be adopted by rule and are to be consistent with the guidelines published by the American College of Cardiology and the American Heart Association for the provision of percutaneous coronary interventions in hospitals without adult open heart services. At a minimum, the rules shall require the following:</u></p> <p><u>a. Cardiologists must be experienced interventionalists who have performed a minimum of 75 interventions within the previous 12 months;</u></p> <p><u>b. The hospital must provide a minimum of 36 emergency interventions annually, in order to continue to provide the service;</u></p> <p><u>c. The hospital must offer sufficient physician, nursing and laboratory staff to provide the services twenty four hours daily, seven days a week;</u></p> <p><u>d. Nursing and technical staff must have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers;</u></p> <p><u>e. Cardiac care nursing staff must be adept in hemodynamic monitoring and IABP management;</u></p> <p><u>f. Formalized written transfer agreements must be developed with a hospital with an adult open heart surgery program and written transport protocols must be in place to ensure safe and efficient transfer of a patient within 60 minutes . Transfer and transport agreements must reviewed and tested, with appropriate documentation maintained at least every 3 months;</u></p> <p><u>g. Hospitals implementing the service, must first undertake a 3 to 6 month training program which includes establishing standards, testing logistics, creating quality assessment and error management practices and formalizing patient selection criteria.</u></p> <p><u>3..The applicant must certify that it will utilize at all times the patient selection criteria for the performance of primary angioplasty at hospitals without adult open heart surgery programs issued by the American College of Cardiology and the American Heart Association. At a minimum, these criteria would provide for the following:</u></p> <p><u>a. Avoidance of interventions in hemodynamically stable patients presenting with identified symptoms or medical histories;</u></p> <p><u>b. Transfer of patients presenting with a history of coronary disease and clinical presentation of hemodynamic instability.</u></p> <p><u>4. The applicant must agree to submit a quarterly report to the agency detailing patient characteristics, treatment and outcomes for all patients receiving emergency percutaneous coronary interventions pursuant to this exemption. This report must be submitted within 15 days of the close of each calendar quarter.</u></p> <p><u>The exemption provided by the paragraph shall not apply unless the agency determines that the hospital</u></p>	<p>page 7 line 26 through page 9 line 21</p> <p>408.036(3)(s)</p>	<p>This change would allow hospitals to begin offering emergency angioplasty services without obtaining a CON for a back-up open heart surgery program.</p> <p>The Agency for Health Care Administration would be required to develop hospital licensure rules for the provision of angioplasty and related procedures in emergency situations.</p> <p>Currently, hospitals cannot legally provide angioplasty and related procedures in emergency situations unless they have CON-approved open heart surgery programs.</p> <p>WORKGROUP STAFF ASKED TO VERY CLEARLY DEFINE “EMERGENCY” AND SPECIFY THE SOURCE OF ANY EMERGENCY. ISSUE IS ER INTAKE VS EMERGENCIES THAT ARISE IN OTHER DEPARTMENTS, SUCH AS RADIOLOGY OR CATH LAB.</p>
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<p><u>has taken all necessary steps to be in compliance with these paragraphs, including the training program required pursuant to paragraph (1) subsection (g).</u></p> <p><u>5. Failure of the hospital to continuously comply with the rules adopted pursuant to paragraph 1.sub-paragraphs c.d.e.f. and paragraphs 2 and 3 will result in the immediate expiration of this exemption.</u></p> <p><u>6. Failure of the hospital to meet the volume requirements of paragraph1. subparagraphs a and b within 18months after the programs begins offering the service will result in the immediate expiration of this exemption.</u></p>		
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<p>For the addition of hospital beds licensed under chapter 395 for acute care, mental health services, or a hospital-based distinct part skilled nursing unit in a number that may not exceed 30 40 total beds or 10 percent of the licensed capacity of the bed category being expanded whichever is greater; <u>for the addition of medical rehabilitation beds licensed under chapter 395 in a number that may not exceed 8 total beds or 10 percent of capacity whichever is greater; or for the addition of mental health services beds licensed under chapter 395 in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater.</u> Beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, or at a long-term care hospital, may not be increased under this paragraph.</p> <p>In addition to any other documentation otherwise required by the agency, a request for exemption submitted under this paragraph must:</p> <p>Certify that the prior 12-month average occupancy rate for the category of licensed beds being expanded at the facility meets or exceeds 75 80 percent or, for a hospital-based distinct part skilled nursing unit, the prior 12-month average occupancy rate meets or exceeds 96 percent.</p> <p>AMENDED TO RAISE THE OCCUPANCY RATE TO 90 PERCENT FOR INPATIENT REHAB.</p>	<p>page 4 line 26 through page 6 line 5</p> <p>408.036(3)(n)</p>	<p>This change would expand hospitals' ability to add beds through a CON exemption for highly utilized services. The proposal increases the number of acute care beds that could be added in smaller hospitals from 10 to 30. Larger hospitals with high utilization could add more beds if they have more than 300 licensed acute care beds.</p> <p>This change would also expand the flexibility to add comprehensive inpatient medical rehabilitation beds and mental health beds through a CON exemption when the hospital experiences very high occupancy.</p> <p>Similar proposals are presented by Mr. Morrison and Mr. Panza.</p>
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<p>For the addition of acute care beds, as authorized by rule consistent with s. 395.003(4), in a number that may not exceed 30 40 total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.</p>	<p>page 6 lines 6-11 408.036(3)(o)</p>	<p>This change would expand hospitals' ability to add beds through a CON exemption for beds that are highly utilized during a specific season (normally the winter quarter.) The proposal increases the number of acute care beds that could be added in smaller hospitals from 10 to 30. Larger hospitals with high utilization could add more beds if they have more than 300 licensed acute care beds.</p>
<p>For establishment of a specialty hospital offering a range of medical service restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county.</p>	<p>page 7 lines 4-9 408.036(3)(q)</p>	<p>This change would eliminate the CON exemption that allows a hospital to establish an age or gender-specific specialty hospital by transferring some of its beds to a new facility in the same county. The proposed change does not specify whether CON review should be full-batched or expedited. Eliminates an exemption voided by subsequent legislation.</p>
<p><u>For the replacement of a statutory rural hospital when the proposed project site is located in the same district and within 10 miles of the existing facility and within the current primary service area, defined as the least number of zip codes comprising 75 percent of the hospital's inpatient admissions.</u></p>	<p>page 9 lines 22-26 408.036(3)(t)</p>	<p>This change would allow a CON exemption for statutory rural hospitals to build replacement facilities within 10 miles of their present location when the new location is within their primary</p>

		service area.
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<p><u>For the creation of at least a 10 bed Level II neonatal intensive care unit upon demonstrating to the agency that the applicant hospital had a minimum of 1500 births during the previous 12 months.</u></p>	<p>page 9 lines 27-29 408.036(3)(u)</p>	<p>This change would allow hospitals that have a large OB program to add a NICU through a CON exemption.</p>
<p><u>For the addition of Level II or Level III neonatal intensive care beds in a number not to exceed 6 beds or 10 percent of licensed capacity in that category whichever is greater, provided that the hospital certifies that the prior 12-month average occupancy rate for the category of licensed neonatal intensive care beds meets or exceeds 75 percent.</u></p>	<p>included in page 4 line 26 through page 6 line 5</p>	<p>This change would allow hospitals with highly utilized NICU services to add 6 beds through a CON exemption.</p>
<p>FEES.--The agency shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the functions of the local health councils and the activities of the agency and shall be allocated as provided in s. 408.033. The fee shall be determined as follows:</p> <p>A minimum base fee of \$10,000 \$5,000. NOTE: AMENDMENT TO EXEMPT NURSING HOMES FAILED</p>	<p>page 10 lines 28 through page 11 line 10 408.038</p>	<p>This change would raise the minimum CON fee from \$5,000 to \$10,000.</p> <p>Compare the proposal by Mr. Morrison.</p>
<p>In addition to the base fee of \$10,000 \$5,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed \$50,000 \$22,000.</p>	<p>same</p>	<p>This change would increase the maximum CON fee from \$22,000 to \$50,000.</p>
<p>ADMINISTRATIVE HEARINGS.—</p> <p>The agency shall issue its final order within 45 days after receipt of the recommended order. If the agency fails to take action within <u>45 days, the Division of Administrative Hearing recommended order is deemed approved, such time, or as otherwise agreed to by the applicant and the agency, the applicant may take appropriate legal action to compel the agency to act.</u> When making a determination on an application for a certificate of need, the agency is specifically exempt from the time limitations provided in s. 120.60(1).</p>	<p>page 11 lines 14-21 408.039(5)(e)</p>	<p>In cases of CON appeals, this change would require the Agency for Health Care Administration to issue a final order within 45 days of a recommended order forwarded from the Division of Administrative Hearings.</p>

<p>The court, in its discretion, may award reasonable attorney's fees and costs to the prevailing party if the court finds that there was a complete absence of a justiciable issue of law or fact raised by the losing party. <u>If the losing party is a hospital, the court shall order it to pay the reasonable attorney's fees and costs, which shall include fees and costs incurred as a result of the administrative hearing and the judicial appeal, of the prevailing hospital party.</u></p> <p>AMENDMENT TO INCLUDE ALL PROVIDER TYPES FAILED. INTENDED TO APPLY TO HOSPITALS ONLY AT THE DCA ONLY.</p>	<p>page 11 line 25 through page 12 line 2</p> <p>408.039(6)(c)</p>	<p>This change would require the challenger in a CON appeal to pay the attorney's fees and costs of the approved CON applicant if the court finds in favor of the approved applicant.</p>
	<p>page 13 lines 16-18</p>	<p>ENTIRE MORRISON PROPOSAL FAILED DUE TO LACK OF A SECOND. LATER PROPOSAL DIRECTS AHCA TO DEVELOP LICENSURE STANDARDS FOR INTERVENTIONAL CARDIOLOGY</p>
<p>The agency shall establish by rule a nursing-home-bed-need methodology that reduces the community nursing home bed need for the areas of the state where the agency establishes pilot community diversion programs through the Title XIX aging waiver program. The bed need methodology formula shall utilize an <u>have a goal of maintaining a statewide average occupancy threshold of 94 percent.</u></p> <p>AMENDED TO MAINTAIN DISTRICT AVERAGE AT 94% RATHER THAN STATEWIDE.</p>	<p>page 2 lines 21-25</p> <p>408.034(5)</p>	<p>This change would raise the occupancy standard in the CON bed need methodology from 91 to 94 percent. This would result in very small bed need calculations in selected planning areas.</p> <p>Statewide nursing home occupancy is 85.76 percent as of June 2002.</p> <p>There is a legislatively-mandated moratorium on CONs for new community nursing home beds scheduled to remain in effect until June 30, 2006.</p>

<p>There is hereby created a Certificate of Need Nursing Home Advisory Panel to serve as a body of experts to guide the agency in its development of policy related to nursing home certificate of need issues. The agency shall provide staff support to the Panel.</p> <p>The Panel shall be composed of the following members:</p> <ul style="list-style-type: none"> (a) The designee of the Deputy Secretary of Managed Care and Health Quality, (b) The designee of the Deputy Secretary of Medicaid, (c) The designee of the Secretary of Department of Elder Affairs, (d) Two representatives of the Local Health Councils, (e) One representative of the Florida Association of Homes for the Aging, (f) One representative of the Florida Health Care Association, (g) One nonprofit nursing home representative, and (h) One for profit nursing home representative. <p>The Panel shall meet at least quarterly and advise the agency regarding:</p> <ul style="list-style-type: none"> (a) Long term care needs of Florida's elderly, (b) Issues specific to different Districts or subdistrict, (c) Options for ensuring access to long term care for Medicaid eligible and other individuals, (d) Reimbursement policy that will encourage development of alternative long term care initiatives, (e) Development of a timely utilization reporting schedule for assisted living facilities and home and community based services, <p>Changes for a more viable nursing home bed formula which will ensure access, and takes into account the alternatives to nursing home care available in each District or subdistrict using information from the reports submitted by such providers.</p>	<p>page 12 line 18 through page 13 line 15</p>	<p>This change would establish a panel to make recommendations on the future of CON review for nursing home beds in Florida.</p> <p>The 2002 Legislature directed the Agency for Health Care Administration to create a plan to reduce Medicaid utilization of nursing homes by December 1, 2002. The Agency was also directed to revise the CON nursing home bed need methodology in follow-up to the strategies recommended in the plan. This activity, which has already begun, will draw from the recommendations of the above-mentioned plan.</p> <p>When complete, this material will be provided to the Office of Long Term Care Policy in the Department of Elder Affairs.</p>
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<p>PROJECTS SUBJECT TO EXPEDITED REVIEW</p> <p>Replacement of a health care facility when the proposed project site is located within the geographic area that contains at least 65 percent of the facility's current patients/residents in the same district and within a ± <u>30</u>-mile radius of the replaced health care facility.</p> <p>AMENDED TO APPLY ONLY TO NURSING HOMES.</p>	<p>page 4 lines 10-13</p> <p>408.036(2)(f)</p>	<p>This change would expand the geographic area in which nursing homes could develop replacement facilities and apply to do so through the expedited review process. Currently, replacement facilities are those that are rebuilt on-site (<u>exempt</u>) or within a mile of the current site (<u>expedited</u>). The proposal would expand the potential area for replacement to a 30-mile radius within the same district. This change could result in changes to the bed supply in some nursing home planning areas (subdistricts.)</p>
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<p><u>The moving of a portion of a provider’s licensed beds to a replacement facility within the same nursing home district (not to exceed 30 mile radius) provided the total number of beds in the district does not increase.</u></p>	<p>page 4 lines 14-17</p> <p>408.036(2)(g)</p>	<p>This change would expand the geographic area in which nursing homes could transfer beds to a new facility and apply to do so through the expedited review process. The proposal would expand the potential area for transferred beds to a 30-mile radius within the same district as long as the total number of beds in the district does not increase.</p> <p>Currently, the Agency only accepts CON applications to transfer nursing home beds when the proposal does not increase the number of beds in any planning area (subdistrict.)</p>
<p>EXEMPTIONS.--Upon request, the following projects are subject to exemption from the provisions of subsection (1):</p> <p><u>For replacement of a licensed health care facility within the geographic area that contains at least 85 percent of the facility’s current residents on the same site, or within 3 miles of the same site, provided that the number of beds in each licensed bed category will not increase.</u></p>	<p>page 10 lines 1-3</p> <p>408.036(3)(v)</p>	<p>This change would expand the geographic area in which nursing homes could develop replacement facilities and apply to do so through a CON exemption. Currently, exempt replacement facilities are those that are rebuilt on-site or within a mile of the current site. The proposal would expand the potential area for <u>exempt</u> replacement to a 3-mile radius within the same district. AMENDED TO APPLY ONLY TO</p>

		NURSING HOMES.
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<p><u>Providers that operate multiple nursing home facilities within the same nursing home district should be allowed to consolidate facilities, combine facilities or transfer beds between facilities provided the aforementioned action does not increase the net bed inventory in the district and the relocation does not exceed 30 miles from the original site.</u></p>	<p>page 10 lines 4-8 408.036(3)(w)</p>	<p>This change would expand the geographic area in which nursing home operators could relocate beds among their own facilities within a district through a CON exemption. The proposal would expand the potential area for relocated beds to a 30-mile radius within the same district. This change could result in changes to the bed supply in some nursing home planning areas (subdistricts.)</p>
<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.</p> <p>In addition to any other documentation required by the agency, a request for exemption submitted under this paragraph must:</p> <p>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.</p> <p>Effective on July 1, 2001, certify that the facility has been designated as a Gold Seal nursing home under s. 400.235.</p>	<p>page 6 line 12 through page 7 line 3 408.036(3)(p)</p>	<p>This change would delete the requirement for a highly utilized nursing home to be a Gold Seal facility before it could qualify for an exemption to add 10 beds or 10 percent of the existing number of beds, whichever is greater.</p> <p>The deletion of the effective date for consideration of class I or class II deficiencies makes this an ongoing requirement to add beds through CON exemption.</p> <p>After two rounds of Gold Seal designations there are 10 Gold Seal nursing homes.</p>

<p>An audited financial statement of the applicant <u>or, if the applicant is part of a consolidated audit which breaks out each entity separately, an audited financial statement of the parent company.</u> In an application submitted by an existing health care facility, health maintenance organization, or hospice, financial condition documentation must include, but need not be limited to, a balance sheet and a profit-and-loss statement of the 2 previous fiscal years' operation.</p>	<p>page 10 lines 12-18 408.037(1)(c)</p>	<p>This change relates to the financial information that is submitted in a CON application and it would not be limited to nursing homes. It would allow the submission of an audited financial statement of the parent company when the consolidated audit breaks out entities, including the CON applicant, separately.</p> <p>Currently, the program requires audited financial statements of the applicant only.</p>
<p>Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(h), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.</p> <p>The establishment of a hospice or hospice inpatient facility, except as provided in s. 408.043.</p>	<p>page 3 lines 4-5 and page 12 lines 6-16 408.036(1)(e) and 408.043(2)</p>	<p>This change would continue CON review for new hospice programs and eliminate CON review when existing hospice programs want to develop a hospice inpatient unit.</p>

Proposed Legislative Language	Notes/Explanation
<p>The agency is designated as the single state agency to issue, revoke, or deny certificates of need and to issue, revoke, or deny exemptions from certificate-of-need review in accordance with the district plans and present and future federal and state statutes. The agency is designated as the state health planning agency for purposes of federal law.</p>	<p>This change would eliminate consideration of district health plan preferences in the CON review process.</p>
<p>PROJECTS SUBJECT TO EXPEDITED REVIEW.-- ... Shared services contracts or projects.</p>	<p>This change eliminates the notion of shared services programs among CON-reviewable services. It would require any hospital to get a CON in order to have the ability to operate a program that is subject to CON review. Any sharing or cooperation that they then wished to engage in would be subject only to licensure requirements — not CON review.</p>
<p><u>A transfer of a certificate of need except when an existing hospital is acquired by a purchaser, all pending certificates of need filed by the existing hospital and all approved certificates of need owned by that hospital would be acquired by the purchaser.</u></p>	<p>This change would allow the purchaser of a hospital to acquire any CONs that had already been obtained but not yet developed or implemented by the hospital. Currently, since undeveloped CONs are issued to the license holder, and the license holder would change in the event of a sale, the new owner would have to re-apply for any undeveloped CONs. This does not apply to beds that have already been licensed or services that are already operational — these assets would be part of the sale.</p>

Proposed Legislative Language	Notes/Explanation
<p>The conversion of mental health services beds licensed under chapter 395 or hospital-based distinct part skilled nursing unit beds to general acute care beds; the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services; or the conversion of general acute care beds to beds for mental health services.</p>	<p>The 2000 Legislature slightly streamlined the process to allow hospitals to convert beds among acute care, mental health and skilled nursing services. This was done by shifting the process from full batched CON review to expedited CON review. This proposed change would revert back to full batched review for the conversion of skilled nursing beds to acute care beds and, coupled with the change below, allow hospitals to convert beds among categories of mental health with a simple exemption request.</p>
<p>EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):</p>	
<p><u>For the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services.</u></p>	<p>This change would allow hospitals to convert between adult or pediatric inpatient psychiatric or substance abuse beds through a simple exemption letter. It would not change the hospital licensure requirements associated with these different categories of mental health services.</p>

Proposed Legislative Language	Notes/Explanation
<p><u>1. For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital without an approved adult open heart surgery program. In addition to any other documentation otherwise required by the agency, a request for an exemption submitted under this paragraph must comply with the following:</u></p> <p><u>2. The applicant must certify that it will meet and continuously maintain the requirements adopted by the agency for the provision of these services. These licensure requirements are to be adopted by rule and are to be consistent with the guidelines published by the American College of Cardiology and the American Heart Association for the provision of percutaneous coronary interventions in hospitals without adult open heart services. At a minimum, the rules shall require the following:</u></p> <p><u>a. Cardiologists must be experienced interventionalists who have performed a minimum of 75 interventions within the previous 12 months;</u></p> <p><u>b. The hospital must provide a minimum of 36 emergency interventions annually, in order to continue to provide the service;</u></p> <p><u>c. The hospital must offer sufficient physician, nursing and laboratory staff to provide the services twenty four hours daily, seven days a week;</u></p> <p><u>d. Nursing and technical staff must have demonstrated experience in handling acutely ill patients requiring intervention based on previous experience in dedicated interventional laboratories or surgical centers;</u></p> <p><u>e. Cardiac care nursing staff must be adept in hemodynamic monitoring and IABP management;</u></p> <p><u>f. Formalized written transfer agreements must be developed with a hospital with an adult open heart surgery program and written transport protocols must be in place to ensure safe and efficient transfer of a patient within 60 minutes . Transfer and transport agreements must reviewed and tested, with appropriate documentation maintained at least every 3 months;</u></p> <p><u>g. Hospitals implementing the service, must first undertake a 3 to 6 month training program which includes establishing standards, testing logistics, creating quality assessment and error management practices and formalizing patient selection criteria.</u></p> <p><u>3. The applicant must certify that it will utilize at all times the patient selection criteria for the performance of primary angioplasty at hospitals without adult open heart surgery programs issued by the American College of Cardiology and the American Heart Association. At a minimum, these criteria would provide for the following:</u></p> <p><u>a. Avoidance of interventions in hemodynamically stable patients presenting with identified symptoms or medical histories;</u></p> <p><u>b. Transfer of patients presenting with a history of coronary disease and clinical presentation of hemodynamic instability.</u></p> <p><u>4. The applicant must agree to submit a quarterly report to the agency detailing patient characteristics, treatment and outcomes for all patients receiving emergency percutaneous coronary interventions pursuant to this exemption. This report must be submitted within 15 days of the close of each calendar quarter.</u></p> <p><u>The exemption provided by the paragraph shall not apply unless the agency determines that the hospital has taken all necessary steps to be in compliance with these paragraphs, including the training program required pursuant to paragraph (1) subsection (g).</u></p> <p><u>5. Failure of the hospital to continuously comply with the rules adopted pursuant to paragraph 1.sub-paragraphs c.d.e.f. and paragraphs 2 and 3 will result in the immediate expiration of this exemption.</u></p> <p><u>6. Failure of the hospital to meet the volume requirements of paragraph 1. subparagraphs a and b within 18 months after the programs begins offering the service will result in the immediate expiration of this exemption.</u></p>	<p>This change would allow hospitals to begin offering emergency angioplasty services without obtaining a CON for a back-up open heart surgery program.</p> <p>The Agency for Health Care Administration would be required to develop hospital licensure rules for the provision of angioplasty and related procedures in emergency situations.</p> <p>Currently, hospitals cannot legally provide angioplasty and related procedures in emergency situations unless they have CON-approved open heart surgery programs.</p> <p>Compare proposals by Mr. Morrison and Mr. Panza.</p>

Proposed Legislative Language	Notes/Explanation
<p>For the addition of hospital beds licensed under chapter 395 for acute care, mental health services, or a hospital-based distinct part skilled nursing unit in a number that may not exceed 30 40 total beds or 10 percent of the licensed capacity of the bed category being expanded whichever is greater; <u>for the addition of medical rehabilitation beds licensed under chapter 395 in a number that may not exceed 8 total beds or 10 percent of capacity whichever is greater; or for the addition of mental health services beds licensed under chapter 395 in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater.</u> Beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, or at a long-term care hospital, may not be increased under this paragraph.</p>	<p>This change would expand hospitals' ability to add beds through a CON exemption for highly utilized services. The proposal increases the number of acute care beds that could be added in smaller hospitals from 10 to 30. Larger hospitals with high utilization could add more beds if they have more than 300 licensed acute care beds.</p> <p>This change would also expand the flexibility to add comprehensive inpatient medical rehabilitation beds and mental health beds through a CON exemption when the hospital experiences very high occupancy.</p> <p>Similar proposals are presented by Mr. Morrison and Mr. Panza.</p>

FHA-5

Proposed Legislative Language	Notes/Explanation
<p>For the addition of acute care beds, as authorized by rule consistent with s. 395.003(4), in a number that may not exceed 30 40 total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.</p>	<p>This change would expand hospitals' ability to add beds through a CON exemption for beds that are highly utilized during a specific season (normally the winter quarter.) The proposal increases the number of acute care beds that could be added in smaller hospitals from 10 to 30. Larger hospitals with high utilization could add more beds if they have more than 300 licensed acute care beds.</p>
<p>For establishment of a specialty hospital offering a range of medical service restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county.</p>	<p>This change would eliminate the CON exemption that allows a hospital to establish an age or gender-specific specialty hospital by transferring some of its beds to a new facility in the same county.</p> <p>The proposed change does not specify whether CON review should be full-batched or expedited.</p>
<p><u>For the replacement of a statutory rural hospital when the proposed project site is located in the same district and within 10 miles of the existing facility and within the current primary service area, defined as the least number of zip codes comprising 75 percent of the hospital's inpatient admissions.</u></p>	<p>This change would allow a CON exemption for statutory rural hospitals to build replacement facilities within 10 miles of their present location when the new location is within their primary service area.</p>

Proposed Legislative Language	Notes/Explanation
<p><u>For the creation of at least a 10 bed Level II neonatal intensive care unit upon demonstrating to the agency that the applicant hospital had a minimum of 1500 births during the previous 12 months.</u></p>	<p>This change would allow hospitals that have a large OB program to add a NICU through a CON exemption.</p>
<p><u>For the addition of Level II or Level III neonatal intensive care beds in a number not to exceed 6 beds or 10 percent of licensed capacity in that category whichever is greater, provided that the hospital certifies that the prior 12-month average occupancy rate for the category of licensed neonatal intensive care beds meets or exceeds 75 percent.</u></p>	<p>This change would allow hospitals with highly utilized NICU services to add 6 beds through a CON exemption.</p>
<p>FEES.--The agency shall assess fees on certificate-of-need applications. Such fees shall be for the purpose of funding the functions of the local health councils and the activities of the agency and shall be allocated as provided in s. 408.033. The fee shall be determined as follows:</p> <p>A minimum base fee of <u>\$10,000</u> \$5,000.</p>	<p>This change would raise the minimum CON fee from \$5,000 to \$10,000.</p> <p>Compare the proposal by Mr. Morrison.</p>
<p>In addition to the base fee of <u>\$10,000</u> \$5,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed <u>\$50,000</u> \$22,000.</p>	<p>This change would increase the maximum CON fee from \$22,000 to \$50,000.</p>
<p>ADMINISTRATIVE HEARINGS.—</p> <p>The agency shall issue its final order within 45 days after receipt of the recommended order. If the agency fails to take action within <u>45 days, the Division of Administrative Hearing recommended order is deemed approved, such time, or as otherwise agreed to by the applicant and the agency, the applicant may take appropriate legal action to compel the agency to act.</u> When making a determination on an application for a certificate of need, the agency is specifically exempt from the time limitations provided in s. 120.60(1).</p>	<p>In cases of CON appeals, this change would require the Agency for Health Care Administration to issue a final order within 45 days of a recommended order forwarded from the Division of Administrative Hearings.</p>
<p>The court, in its discretion, may award reasonable attorney's fees and costs to the prevailing party if the court finds that there was a complete absence of a justiciable issue of law or fact raised by the losing party. <u>If the losing party is a hospital, the court shall order it to pay the reasonable attorney's fees and costs, which shall include fees and costs incurred as a result of the administrative hearing and the judicial appeal, of the prevailing hospital party.</u></p>	<p>This change would require the challenger in a CON appeal to pay the attorney's fees and costs of the approved CON applicant if the court finds in favor of the approved applicant.</p>

FHA-7

Proposal by Workgroup Member Andrea Eliscu	
Proposed Legislative Language	Notes/Explanation (Provided by Ms. Eliscu)
<p><u>Repeal sections 395.1055, 400.071, 400.602, 400.606408.031, 408.032, 408.033(3), 408.034, 408.035, 408.036, 408.037, 408.038, 408.039, 408.040, 408.041, 408.042, 408.043, 408.044, 408.045, 408.0455 and 651.118, Florida Statutes.</u></p>	<p>Current CON laws seem to only have created an oligopoly of healthcare providers. Changes to the original laws appear limited to self-serving initiatives that maintain barriers to new providers and innovative new services.</p> <p>It does not seem that the existing statutes can be modified to help meet current and future demands on healthcare services by Florida's citizens. In my opinion, repealing the current CON laws may be the only way to allow the supply and demand marketplace to begin to grow and change where necessary to meet the explosive growth expected in our state.</p> <p>As an example, among other initiatives, elimination of CON review would allow further development and expanded operation of single-specialty surgical facilities. These Single-specialty surgical facilities would provide focused care in the management of specific areas of disease. These focused facilities could maintain appropriate program volumes that maximize quality and helps ensure patient safety. Not unlike full-service hospitals, these focused facilities could also be required to provide a minimum of 2% of it services to indigent care each year.</p> <p>The only major and reasonable concerns I have heard for maintaining the CON status quo for our future healthcare system are surrounding quality and indigent care.</p> <p>I believe the quality issue should be addressed through a licensure process that would provide time-limited provisional licensure status to new providers subject to quality/volume evaluation by the Local Health Council (in a possible new role for them).</p> <p>The indigent care problem could be reduced by collecting a 2% tax on revenues from all provider facilities. The state could use those revenues to partially reimburse those entities providing unusually high levels of indigent care.</p>

ELISCU-1

Proposal by Workgroup Member Tom Panza	
Proposed Legislative Language	Notes/Explanation
<p>“Ambulatory surgical center” or “mobile surgical center” means a facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within <u>a 24 hour period the same working day and which is not permitted to stay overnight</u> and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a physician for the practice of medicine, or an office maintained for the practice of dentistry shall not be construed to be an ambulatory surgical center, provided that any facility or office which is certified or seeks certification as a Medicare ambulatory surgical center shall be licensed as an ambulatory surgical center pursuant to s. 395.003. Any structure or vehicle in which a physician maintains an office and practices surgery, and which can appear to the public to be a mobile office because the structure or vehicle operates at</p>	<p>This change would allow patients in licensed ambulatory surgical centers to stay for up to 24 hours regardless of the time of day they are admitted. It deletes the prohibition against overnight stays.</p> <p>Remember that the 2001 Legislature added to the Workgroup’s original charge and asked you to consider the subject of overnight stays in ambulatory surgical centers.</p> <p>The 2002 legislature established a pilot project for overnight stays in a licensed ambulatory surgical center in Vero Beach.</p>
<p>EXEMPTIONS.- Upon request, the following projects are subject to exemption from the provisions subsection (1):</p> <p><u>For the addition of inpatient comprehensive rehabilitation beds licensed unde Chapter 395 in a number that may not exceed 10 beds or 10 percent of the licensed capacity, whichever is greater.</u></p> <p><u>In addition to any documentation otherwise required by the Agency, a request for exemption submitted under this paragraph must:</u></p> <p><u>Certify that the prior 12-month average occupancy rate for comprehensive rehabilitation beds at the facility meets or exceeds 96 percent.</u></p> <p><u>Certify that any comprehensive rehabilitation 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.</u></p> <p><u>The time frames and monitoring processes specified in s. 408.040(2)(a)-(c) apply to any exemption issued under this paragraph.</u></p> <p><u>The Agency shall count beds authorized under this paragraph as approved beds in the published inventory of hospital beds until the beds are licensed.</u></p>	<p>This change would allow hospitals that have highly utilized comprehensive inpatient rehabilitation beds to add up to 10 beds or 10 percent of their current number of licensed rehab beds — whichever is greater — through a simple exemption letter.</p> <p>This is similar to provisions that exist now for acute care beds. It includes a relatively high 96 percent occupancy standard, which reflects the relatively slow pace of admissions and discharges in long-term care services such as inpatient rehab, when compared to acute care.</p>

Proposed Legislative Language	Notes/Explanation
<p><u>For the provision of adult open-heart services in a hospital.</u></p> <p><u>In addition to any documentation otherwise required by the Agency, a request for exemption submitted under this paragraph must:</u></p> <p><u>The applicant must certify that, prior to initiating adult open-heart services, it will meet and continuously maintain the minimum licensure requirements adopted by the Agency governing adult open-heart programs, including the most current guidelines of the American College of Cardiology and American Heart Association Guidelines for Adult Open-Heart Programs.</u></p> <p><u>The applicant must certify that it will provide a minimum of 2 percent of its services to charity and Medicaid patients.</u></p> <p><u>The applicant must certify that it will maintain sufficient appropriate equipment and health personnel to ensure quality and safety.</u></p> <p><u>The applicant must certify that it will maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.</u></p> <p><u>The applicant must certify that it will provide a minimum of 300 open-heart procedures per year by the completion of the 3rd full year of operation.</u></p> <p><u>If the exempted provider fails to meet the requirements listed in sub-subparagraph e., the Agency shall initiate revocation proceedings involving the open-heart services license within 90 days after the completion of the 3rd full year of operation.</u></p>	<p>This change would eliminate CON review for adult open heart surgery services.</p> <p>It would require the Agency for Health Care Administration to promulgate administrative rules for the regulation of open heart surgery programs through licensure requirements.</p> <p>Programs would have three years to become fully accountable for all of the licensure standards. After that, the Agency would have the authority to revoke the hospital's ability to perform open heart surgery if it failed to meet requirements.</p>

Proposal by Workgroup Chairman Rich Morrison

Proposed Legislative Language	Notes/Explanation
<p>Rules and enforcement –</p> <p>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:</p> <p><u>Minimum standards adopted for the regulation of adult open heart surgery programs, adult therapeutic cardiac catheterization and angioplasty programs, pediatric open heart surgery programs, and pediatric cardiac catheterization programs include standards for quality outcomes, staffing, necessary specialized equipment, and annual utilization. Such rules shall be adopted no later than June 30, 2003.</u></p>	<p>This change would require the Agency for Health Care Administration to develop licensure standards for adult and pediatric interventional cardiology programs by June 30, 2003.</p> <p>Compare proposals by the Florida Hospital Association and Mr. Panza.</p>
<p><u>Minimum standards adopted for the regulation of neonatal intensive care services, bone marrow transplant programs, and specialty burn units include standards for quality outcomes, staffing, necessary specialized equipment, and annual utilization. Such rules shall be adopted no later than June 30, 2004.</u></p>	<p>This change would require the Agency for Health Care Administration to develop licensure standards for NICU, bone marrow transplant and burn intensive care programs by June 30, 2004.</p> <p>Compare proposals by the Florida Hospital Association and Mr. Panza.</p>
<p><u>Minimum standards adopted for the regulation of comprehensive medical rehabilitation services, hospital-based skilled nursing services and long term acute care services include standards for quality outcomes, staffing, necessary specialized equipment and annual utilization. Such rules shall be adopted no later than June 30, 2005.</u></p>	<p>This change would require the Agency for Health Care Administration to develop licensure standards for comprehensive medical inpatient rehabilitation, hospital-based skilled nursing and long term acute care services by June 30, 2005.</p> <p>Compare proposals by the Florida Hospital Association and Mr. Panza.</p>

MORRISON-1

Proposed Legislative Language	Notes/Explanation
<p><u>In developing rules pursuant to this section for the minimum standards for quality outcomes for those services which are deemed to be tertiary services, the agency shall use at least 7 commercially or publicly available quality measurement standards that incorporate data from outside the State of Florida. Any standard adopted by the Center for Medicare and Medicaid Services shall be included among the 7 standards.</u></p> <p><u>Any hospital whose service or services fails to achieve an average rating on at least 4 of the 7 standards, when adjusted for age, sex and severity of patients, shall be directed by the agency, within 30 days of its receipt of the hospital's quality outcome scores to submit a plan for quality improvement within 60 days. If after one year from the date of the submission of the quality improvement plan the hospital has not achieved an average score on at least 4 of the 7 standards, the agency shall issue an order directing the hospital to show cause within 60 days why the service or services which are of below average quality should not be de-licensed. Should the agency determine that any service or services should be de-licensed, it shall issue an order from which the hospital may request an administrative hearing pursuant to chapter 120.</u></p>	<p>This change would require the Agency for Health Care Administration to develop certain outcome-oriented licensure standards for tertiary services in hospitals, including most of the services listed in the previous sections with the exception of hospital-based skilled nursing.</p> <p>This proposal would also require the Agency for Health Care Administration to develop a system to delicense tertiary hospital services when hospitals failed to meet a majority of the outcome-oriented licensure standards.</p> <p>Taken together, this proposal and those just above provide an alternative to market entry regulation through CON and replace it with a system of outcome-oriented licensure standards</p>

MORRISON-2

Proposed Legislative Language	Notes/Explanation
<p><u>If the above referenced standards are not adopted by the Agency by the deadlines stated then the following interim measure shall apply :</u></p> <p><u>An open heart surgery program must demonstrate that it is performing at least 350 procedure per year at the third year of operations other wise it must document that its outcomes meet the state average in terms of mortality and morbidity</u></p> <p><u>A hospital that wishes to perform angioplasty on patients with type one lesions must demonstrate that the cardiologists who would be performing the procedure have done at least 120 therapeutic angioplasties in the most recent year, that the staff have received documented training in angioplasty techniques and that the hospital is within 30 minutes travel time of an established open heart program</u></p> <p><u>A hospital that documents more than 1500 births per year may provide level II neonatal services provided it can document the commitment of sufficient qualified neonatologists and appropriate support staff to operated the unit and it agrees to provide data on the operation and outcomes of the unit. The unit shall not be less 8 beds</u></p> <p><u>A hospital that documents more than 3000 births per year may provided Level III neonatal services provided it can document the commitment of the appropriate physicians and staff to operate the unit appropriately and it agrees to provided data as referenced in(c)above. The unit shall not be less than 15 beds.</u></p> <p><u>A new pediatric open heart program must document that the pediatric surgeon has performed at least 75 such surgeries in the past year and it must demonstrate the ability to provide ongoing post operative care including the ability to do emergency open heart procedures</u></p>	<p>This change would provide a basic back-up system for outcome-oriented licensure standards for hospital tertiary services in the event that the processes proposed in the prior sections become delayed due to, for example, legal challenges to administrative rule processes needed to regulate the standards.</p> <p>This proposal provides an alternative to market entry regulation through CON and replaces it with a basic system of outcome-oriented licensure standards</p>
<p>The Legislature intends that the cost of <u>administering the certificate-of-need program local health councils</u> be borne by application fees for certificates of need as specified in s. 408.038, and by assessments on selected health care facilities subject to facility licensure by the Agency for Health Care Administration</p>	<p>This change would require the Legislature to find a source of funds other than CON fees for local health councils. This would also affect two or three positions at the Department of Health where the local health council contracts are managed.</p> <p>Compare proposals by the Florida Hospital Association.</p>

Proposed Legislative Language	Notes/Explanation
<p>The agency shall deposit in the Health Care Trust Fund all health care facility assessments that are assessed under this subsection and proceeds from the certificate-of-need application fees. The agency shall transfer to the Department of Health an amount sufficient to maintain the aggregate funding level for the local health councils as specified in the General Appropriations Act. The remaining certificate-of-need Certificate-of-need application fees shall be used only for the purpose of administering the Health Facility and Services Development Act.</p>	<p>This change would require the Legislature to find a source of funds other than CON fees for local health councils. This would also affect two or three positions at the Department of Health where the local health council contracts are managed.</p> <p>Compare proposals by the Florida Hospital Association.</p>
<p>The agency, in conjunction with the local health councils, is responsible for the coordinated planning of health care services in the state.</p>	<p>This change would eliminate the remaining role for local health councils in the development in statewide health planning. Presently, applicable preferences included in district health plans are considered in the CON review process.</p> <p>Compare the proposal by the Florida Hospital Association.</p>
<p>The agency shall assist personnel of the local health councils in providing an annual orientation to council members about council member responsibilities.</p> <p>The agency 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 agency that provides for a minimum and equal funding base for each local health council. Any remaining funds shall be distributed based on adjustments for workload. The agency may also make grants to or reimburse local health councils from federal funds provided to the state for activities related to those functions set forth in this section. The agency may withhold funds from a local health council or cancel its contract with a local health council which does not meet performance standards agreed upon by the agency and local health councils.</p>	<p>This change would eliminate the remaining role for local health councils in the development in statewide health planning. Presently, applicable preferences included in district health plans are considered in the CON review process.</p> <p>Compare the proposal by the Florida Hospital Association.</p>

MORRISON-4

Proposed Legislative Language	Notes/Explanation
<p>Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (1)-(h), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a healthcare-related project is subject to review under ss. 408.031-408.045. <u>Provided, however, that any new hospital, except a comprehensive rehabilitation hospital, whether created by newly licensed beds or by the transfer of existing beds, shall be a full service general medical service hospital and shall have a full service emergency room. A freestanding children's specialty hospital shall provide age-appropriate emergency room services; specialty psychiatric hospitals shall provide psychiatric emergency room services; and long-term care hospitals need not provide emergency room services.</u> This section shall not apply to a new comprehensive rehabilitation hospital.</p>	<p>This change would require proposals for new hospitals to be general hospitals rather than specialty hospitals, with the exception of comprehensive inpatient medical rehab hospitals.</p> <p>Existing specialty hospitals for children and inpatient mental health services would be required to provide emergency services that matched their inpatient services. Long term acute care hospitals would not be required to provide emergency services.</p>
<p>An increase in the number of beds for acute care, nursing home care beds, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, mental health services, or hospital based distinct part skilled nursing units, or at a long-term care hospital.</p>	<p>This change would eliminate full CON review for all hospital bed additions except long term acute care beds. It would preserve CON review for nursing home bed additions.</p>
<p>EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):</p> <p>For the addition of hospital beds licensed under chapter 395 for acute care, mental health services, or a hospital based distinct part skilled nursing unit in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater. Beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, or at a long term care hospital, may not be increased under this paragraph. <u>For the addition of beds at an existing hospital at its current location subject to applicable design, construction and licensure standards.</u></p>	<p>This change would expand hospitals' ability to add beds through a CON exemption for highly utilized services.</p>
<p>For the addition of acute care beds, as authorized by rule consistent with s. 395.003(4), in a number that may not exceed 10 total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital that has experienced high seasonal occupancy within the prior 12 month period or in a hospital that must respond to emergency circumstances. <u>For the addition of beds at a hospital for any existing regulated service subject to applicable design, construction and licensure standards.</u></p>	<p>This change would expand hospitals' ability to add beds through a CON exemption for highly utilized services.</p>

Proposed Legislative Language	Notes/Explanation
<p><u>For the construction of a new hospital through the transfer of up to 50 percent of its existing licensed beds to a new location within the same district provided that such new hospital shall be a full service general medical hospital and provide full service emergency room care. A new freestanding children's specialty hospital shall provide age-appropriate emergency room services; specialty psychiatric hospitals shall provide psychiatric emergency room services; and long-term care hospitals need not provide emergency room services. This section does not apply to the construction of a new comprehensive rehabilitation hospital.</u></p>	<p>This change would allow a hospital to transfer up to 50 percent of existing beds within its planning district for the construction of a new general hospital through a CON exemption.</p> <p>New specialty hospitals for children and inpatient mental health services would be required to provide emergency services that matched their inpatient services. Long term acute care and comprehensive inpatient medical rehab hospitals would not be required to provide emergency services.</p>
<p>A request for exemption under subsection (3) may be made at any time and is not subject to the batching requirements of this section. The request shall be supported by such documentation as the agency requires by rule. The agency shall assess a fee of <u>\$1,000</u> \$250 for each request for exemption submitted under subsection (3).</p>	<p>This change would increase the fee for a CON exemption from \$250 to \$1,000.</p>
<p>The agency shall assess fees on certificate-of-need applications. Such fees shall be <u>used only for the purpose of administering the Health Facility and Services Development Act and shall not be used for funding the functions of the local councils and the activities of the agency and shall be allocated as provided in s. 408.033.</u> The fee shall be determined as follows:</p> <p>A minimum base fee of <u>\$15,000</u> \$5,000.</p>	<p>This change would raise the minimum CON fee from \$5,000 to \$15,000.</p> <p>Compare the proposal by the Florida Hospital Association.</p>
<p>In addition to the base fee of <u>\$15,000</u> \$5,000, 0.015 of each dollar of proposed expenditure, except that a fee may not exceed <u>\$75,000</u> \$22,000.</p>	<p>This change would increase the maximum CON fee from \$22,000 to \$75,000.</p> <p>Compare the proposal by the Florida Hospital Association.</p>
<p><u>Proposals to initiate or modify adult open heart surgery programs, therapeutic cardiac catheterization and angioplasty programs, pediatric open heart surgery programs, pediatric cardiac catheterization programs and neonatal intensive care units, as described in agency rules, are eliminated from certificate-of-need review requirements on July 1, 2003 or on the date the licensure rules required by s. 395.1055(1)(k) have been adopted by the agency, whichever is sooner, provided that such services may only be delivered in general acute care hospitals or specialty children's hospitals licensed under chapter 395.</u></p>	<p>Coupled with the earlier proposals on page 11, this change would eliminate CON review for adult and pediatric interventional cardiology programs, and NICU services, by June 30, 2003.</p> <p>Compare proposals by the Florida Hospital Association and Mr. Panza.</p>

MORRISON-6

Proposed Legislative Language	Notes/Explanation
<p><u>Proposals to initiate or modify , bone marrow transplant programs, and specialty burn units, as described in agency rules, are eliminated from certificate-of-need review requirements on July 1, 2004 or on the date the licensure rules required by s. 395.1055(1)(j) have been adopted by the agency, whichever is sooner, provided that such services may only be delivered in general acute care hospitals or specialty children’s hospitals licensed under chapter 395.</u></p>	<p>Coupled with the earlier proposal on page 11, this change would eliminate CON review for bone marrow transplant and burn intensive care programs by June 30, 2004.</p>
<p><u>Proposals to initiate or modify comprehensive medical rehabilitation services, hospital-based skilled nursing services, and long term acute care services, as described in agency rules, are eliminated from certificate-of-need review requirements on July 1, 2005 or on the date the licensure rules required by s. 395.1055(1)(l) have been adopted by the agency, whichever is sooner; provided that such services may only be provided in general acute care hospitals licensed under chapter 395.</u></p>	<p>Coupled with the earlier proposal on page 11, this change would eliminate CON review comprehensive medical inpatient rehabilitation, hospital-based skilled nursing and long term acute care services by June 30, 2005.</p> <p>Compare proposals by the Florida Hospital Association and Mr. Panza.</p>
<p><u>The Health Facility and Services Development Act is repealed effective July 1, 2006 or effective July 1 of the year in which the regular session of the Legislature receives a report from the Secretary of the Agency for Health Care Administration certifying that all hospital licensure rules required by ss. 395.105(1)(j), (k) and (l) have been adopted by the agency, whichever is sooner; provided that all tertiary services previously covered by the Health Facility and Services Development Act may only be delivered in a general acute care hospital licensed under chapter 395.</u></p>	<p>This change would eliminate the Florida CON Program by July 1, 2006; or on July 1 of the year when the Agency for Health Care Administration reports to the Legislature that the outcome-oriented licensure standards proposed earlier in this section are fully implemented.</p> <p>In this post-CON system, tertiary services would be limited to general rather than specialty hospitals.</p>

MORRISON-7

Proposed Legislative Language	Notes/Explanation
<p>In administrative proceedings challenging the issuance or denial of a certificate of need, only applicants considered by the agency in the same batching cycle are entitled to a comparative hearing on their applications. Existing health care facilities <u>in the same district who do not file an application in the same batching cycle</u> may initiate or intervene in an administrative hearing <u>only</u> upon a showing that an established program will be substantially affected by the issuance of any certificate of need, whether reviewed under s. 408.036(1) or (2), to a competing proposed facility, service or program within the same district <u>and such challenge may be based only upon the issue of whether there is a need for the competing proposed facility, service or program.</u></p> <p><u>For purposes of this subsection, the term "substantially affected" shall mean that the existing facility must demonstrate that its earnings before taxes, depreciation and interest will be reduced by 5 percent or more annually for more than 3 consecutive years by the issuance of a certificate of need to a competing proposed facility, service or program and that the issuance of a certificate of need to a competing proposed facility, service or program would reduce the volume of admissions for a particular service by at least 10 percent annually over a 3-year period at the existing facility.</u></p>	<p>This change would limit the scope of challenges to the Agency's CON decisions when the affected party did not file a competing application in the same batch.</p> <p>The challenge would be limited to the issue of "need," which can be contrasted with the current situation in which challenges can be based on any of the diverse statutory and rule criteria associated with the CON program.</p> <p>The affected party would have to show that the approved CON would result in a 5 percent drop in earnings and a 10 percent drop in admissions for a 3-year period before gaining standing to challenge the approved CON.</p>

MORRISON-8

Proposal by the Workgroup's Nursing Home Subcommittee

Proposed Legislative Language	Notes/Explanation
<p>The agency shall establish by rule a nursing-home-bed-need methodology that reduces the community nursing home bed need for the areas of the state where the agency establishes pilot community diversion programs through the Title XIX aging waiver program. The bed need methodology formula shall utilize an <u>have a goal of maintaining a statewide average occupancy threshold of 94 percent.</u></p>	<p>This change would raise the occupancy standard in the CON bed need methodology from 91 to 94 percent. This would result in very small bed need calculations in selected planning areas.</p> <p>Statewide nursing home occupancy is 85.76 percent as of June 2002.</p> <p>There is a legislatively-mandated moratorium on CONs for new community nursing home beds scheduled to remain in effect until June 30, 2006.</p>
<p>There is hereby created a Certificate of Need Nursing Home Advisory Panel to serve as a body of experts to guide the agency in its development of policy related to nursing home certificate of need issues. The agency shall provide staff support to the Panel.</p> <p>The Panel shall be composed of the following members:</p> <ul style="list-style-type: none"> (a) The designee of the Deputy Secretary of Managed Care and Health Quality, (b) The designee of the Deputy Secretary of Medicaid, (c) The designee of the Secretary of Department of Elder Affairs, (d) Two representatives of the Local Health Councils, (e) One representative of the Florida Association of Homes for the Aging, (f) One representative of the Florida Health Care Association, (g) One nonprofit nursing home representative, and (h) One for profit nursing home representative. <p>The Panel shall meet at least quarterly and advise the agency regarding:</p> <ul style="list-style-type: none"> (a) Long term care needs of Florida's elderly, (b) Issues specific to different Districts or subdistrict, (c) Options for ensuring access to long term care for Medicaid eligible and other individuals, (d) Reimbursement policy that will encourage development of alternative long term care initiatives, (e) Development of a timely utilization reporting schedule for assisted living facilities and home and community based services, <p>Changes for a more viable nursing home bed formula which will ensure access, and takes into account the alternatives to nursing home care available in each District or subdistrict using information from the reports submitted by such providers.</p>	<p>This change would establish a panel to make recommendations on the future of CON review for nursing home beds in Florida.</p> <p>The 2002 Legislature directed the Agency for Health Care Administration to create a plan to reduce Medicaid utilization of nursing homes by December 1, 2002. The Agency was also directed to revise the CON nursing home bed need methodology in follow-up to the strategies recommended in the plan. This activity, which has already begun, will draw from the recommendations of the above-mentioned plan.</p> <p>When complete, this material will be provided to the Office of Long Term Care Policy in the Department of Elder Affairs.</p>

NURSING HOME-1

Proposed Legislative Language	Notes/Explanation
<p>PROJECTS SUBJECT TO EXPEDITED REVIEW</p> <p>Replacement of a health care facility when the proposed project site is located within the geographic area that contains at least 65 percent of the facility’s current patients/residents in the same district and within a <u>± 30-mile</u> radius of the replaced health care facility.</p>	<p>This change would expand the geographic area in which nursing homes could develop replacement facilities and apply to do so through the expedited review process. Currently, replacement facilities are those that are rebuilt on-site or within a mile of the current site. The proposal would expand the potential area for replacement to a 30-mile radius within the same district. This change could result in changes to the bed supply in some nursing home planning areas (subdistricts.)</p>
<p><u>The moving of a portion of a provider’s licensed beds to a replacement facility within the same nursing home district (not to exceed 30 mile radius) provided the total number of beds in the district does not increase.</u></p>	<p>This change would expand the geographic area in which nursing homes could transfer beds to a new facility and apply to do so through the expedited review process. The proposal would expand the potential area for transferred beds to a 30-mile radius within the same district as long as the total number of beds in the district does not increase.</p> <p>Currently, the Agency only accepts CON applications to transfer nursing home beds when the proposal does not increase the number of beds in any planning area (subdistrict.)</p>
<p>EXEMPTIONS.--Upon request, the following projects are subject to exemption from the provisions of subsection (1):</p> <p>For replacement of a licensed health care facility within the geographic area that contains at least 85 percent of the facility’s current residents on the same site, or within 3 miles of the same site, provided that the number of beds in each licensed bed category will not increase.</p>	<p>This change would expand the geographic area in which nursing homes could develop replacement facilities and apply to do so through a CON exemption. Currently, replacement facilities are those that are rebuilt on-site or within a mile of the current site. The proposal would expand the potential area for replacement to a 3-mile radius within the same district.</p>
<p><u>Providers that operate multiple nursing home facilities within the same nursing home district should be allowed to consolidate facilities, combine facilities or transfer beds between facilities provided the aforementioned action does not increase the net bed inventory in the district and the relocation does not exceed 30 miles from the original site.</u></p>	<p>This change would expand the geographic area in which nursing home operators could relocate beds among their own facilities within a district through a CON exemption. The proposal would expand the potential area for relocated beds to a 30-mile radius within the same district. This change could result in changes to the bed supply in some nursing home planning areas (subdistricts.)</p>

NURSING HOME-2

Proposed Legislative Language	Notes/Explanation
<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.</p> <p>In addition to any other documentation required by the agency, a request for exemption submitted under this paragraph must:</p> <p>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.</p> <p>Effective on July 1, 2001, certify that the facility has been designated as a Gold Seal nursing home under s. 400.235.</p>	<p>This change would delete the requirement for a highly utilized nursing home to be a Gold Seal facility before it could qualify for an exemption to add 10 beds or 10 percent of the existing number of beds, whichever is greater.</p> <p>The deletion of the effective date for consideration of class I or class II deficiencies makes this an ongoing requirement to add beds through CON exemption.</p> <p>After two rounds of Gold Seal designations there are 10 Gold Seal nursing homes.</p>
<p><u>Each facility that is affiliated with a parent company must submit audited GAAP prepared financial statements regarding the individual recommended facility and audited consolidated GAAP prepared financial statements regarding the facility's parent company.</u></p>	<p>This change relates to the financial information that is submitted in a CON application and it would not be limited to nursing homes. It would require the submission of audited financial statements for both the applicant and its parent company.</p> <p>Currently, the program requires audited financial statements of the applicant only.</p>
<p>An audited financial statement of the applicant <u>or, if the applicant is part of a consolidated audit which breaks out each entity separately, an audited financial statement of the parent company.</u> In an application submitted by an existing health care facility, health maintenance organization, or hospice, financial condition documentation must include, but need not be limited to, a balance sheet and a profit-and-loss statement of the 2 previous fiscal years' operation.</p>	<p>This change relates to the financial information that is submitted in a CON application and it would not be limited to nursing homes. It would allow the submission of an audited financial statement of the parent company when the consolidated audit breaks out entities, including the CON applicant, separately.</p> <p>Currently, the program requires audited financial statements of the applicant only.</p>

NURSING HOME-3

Proposal by the Workgroup's Hospice Subcommittee

Proposed Legislative Language	Notes/Explanation
<p>Unless exempt under subsection (3), all health-care-related projects, as described in paragraphs (a)-(h), are subject to review and must file an application for a certificate of need with the agency. The agency is exclusively responsible for determining whether a health-care-related project is subject to review under ss. 408.031-408.045.</p> <p>The establishment of a hospice or hospice inpatient facility, except as provided in s. 408.043.</p>	<p>This change would continue CON review for new hospice programs and eliminate CON review when existing hospice programs want to develop a hospice inpatient unit.</p>

HOSPICE-1

