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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH CARE SERVICES
BILL RESEARCH & ECONOMIC IMPACT STATEMENT

BILL #: HB 1879

RELATING TO: Hospitals

SPONSOR(S): Rep. Fasano

STATUTE(S) AFFECTED: s. 395.003, F.S.

COMPANION BILL(S): None

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE SERVICES
(2) GOVERNMENTAL RULES & REGULATIONS
(3) HEALTH & HUMAN SERVICES APPROPRIATIONS
(4)
(5)

I. SUMMARY:

This bill revises the procedures used by the Agency for Health Care Administration (AHCA) to issue a certificate of need (CON) for skilled nursing unit beds. Current law requires that skilled nursing unit beds be awarded in a competitive process whereby the agency determines the need for such beds by district based upon a formula and then awards the beds to the best applicant based upon a list of statutory criteria, including cost, quality, efficiency, financial feasibility, the proportion of services to be provided to Medicaid recipients and medically indigent persons, and others. The bill requires the agency to file a rule which provides for the separate evaluation of CON applications for skilled nursing beds by hospitals, which awards beds to each hospital based only on facility specific criteria.

According to the Agency for Health Care Administration, this bill will increase Medicaid nursing home costs by $ 13.7 million annually.

II. SUBSTANTIVE RESEARCH:

A. PRESENT SITUATION:

Certain nursing home beds are classified as short term or skilled nursing unit beds. Patients in skilled nursing unit beds are generally reimbursed by Medicare, which will pay for such care for no more than 100 days annually. Generally, skilled nursing unit patients are in need of rehabilitation services related to a recent medical procedure such as a hip or knee replacement, or open heart surgery. In fact, Medicare will only reimburse for skilled nursing care for a patient who has been discharged from a hospital.

Medicare pays 100% of the cost for skilled nursing unit care for the first 20 days, but requires a copayment of $95 a day for days 21 through 100. Since many Medicare patients are also Medicaid eligible, Medicaid pays all or a part of this copay after day 20 for dually eligible persons.

With the advent of DRG's, or diagnostic related groups, skilled nursing unit care has become an increasingly important service for hospitals and nursing homes. A DRG payment is a fixed payment to a hospital based on the patient's diagnosis, regardless of the patient's length of stay (with some exceptions). Therefore, hospitals have an incentive to discharge Medicare patients as soon as medically advisable. Patients who are too sick to discharge to home or a nursing home bed are generally admitted to a skilled nursing unit for a period of extended recuperation/rehabilitation. And unlike hospital care, Medicare will reimburse a nursing home or hospital skilled nursing unit 100 percent of its costs for the first 3 years, 11 months of the facility's existence, after which there is a limit called the "routine cost limit".

The number of skilled nursing unit beds and facilities have increased dramatically in recent years. For example, in 1991 there were only 9 hospital based skilled nursing facilities with 399 beds. By 1996, that number had increased to 64 facilities with 1,437 beds. During that same time period, the number of community nursing facility beds increased from 66,238 to 74,935. It should be noted that a nursing home may convert a community bed into a skilled nursing unit bed at any time without a CON review by asking that the bed be Medicare-certified.

The CON process for awarding skilled nursing unit beds has been the subject of a great deal of litigation in recent years. In the past, the agency used a single bed need methodology for determining the number of community nursing home beds needed in a district or subdistrict, without regard as to whether the need was for skilled nursing unit beds. Both hospitals and nursing homes applied for these beds within the same batching cycle.

Based on an administrative law judge's order in 1994 which was affirmed by the First District Court of Appeal (*Health Care & Retirement Corporation of America v. Tarpon Springs Hospital*) that it is "unreasonable and illogical to compare the need for hospital based and Medicare-certified skilled nursing unit beds with the need for all community nursing home beds", the agency attempted to adopt a rule for establishing a separate need methodology for each type of bed. However, this rule is also being litigated and has not been adopted.

In 1995 the Legislature created the Panel for the Study of skilled Nursing Care to examine issues related to the establishment of skilled nursing home beds. Nine members were included on the panel as follows: three appointed by the nursing home industry; three appointed by the hospital industry; two legislators; and the ninth member was elected by the eight members. The panel was charged with determining the appropriate placement of skilled nursing patients. Copies of the report are available from the agency. In summary, the panel reported the following findings:

- Patients who receive treatment at freestanding nursing homes have a higher hospital length of stay prior to admission and were older than patients treated in hospital based units.

- Both DRG codes and ICD-9 codes are similar for patients treated in freestanding nursing homes and at hospital based units; however patients admitted to a freestanding nursing home were more likely to have a DRG-APR severity level of "extreme" and a risk of mortality level of "major" than patients admitted to a hospital based unit.

- Patients discharged from a hospital based unit are more likely to be discharged home or to another nursing home; and patients discharged from a freestanding nursing home are more likely to be discharged to a hospital or to die.

- Regardless of setting, patients with an "extreme" risk of mortality level are more likely to die than patients with a "minor" or "moderate" risk of mortality level.

Panel members agreed that the current data base is insufficient to determine the reasons for differences in some outcome measures reported by the study. Recommendations of the panel were as follows:

- CON review for the establishment of both hospital based and freestanding skilled beds should be continued (on a 5 to 4 vote).

- The Legislature should review existing CON review criteria to determine which should be eliminated to reduce the cost and length of time of CON review.

- If federal requirements are repealed, the Legislature should review all licensure requirements for short-term skilled nursing care.

- Hospitals and freestanding nursing homes should report the same data, preferably by electronic means.

Agency staff conducted a survey of states in 1995 with and without a CON program to determine the types of regulations governing the establishment of skilled nursing beds. According to the survey results, several states reported a moratorium on the establishment of all nursing home beds. Of the 39 states and District of Columbia which have CON programs, all but two require review for the establishment of hospital based skilled nursing units, and 25 states utilize the same review for both hospital based and freestanding beds. Some states allow hospitals to convert a small number of acute care beds to skilled nursing beds; and one state prohibits the establishment of nursing home beds in hospitals. A few states indicated that there has been little interest in the

establishment of hospital based skilled nursing beds, while several states reported increased competition between hospitals and freestanding nursing homes.

B. EFFECT OF PROPOSED CHANGES:

By October 1, 1997, the agency will file a rule methodology that provides for a separate evaluation of CON application for skilled nursing beds in hospitals. This rule will likely be litigated. If the agency prevails and the rule is upheld, an estimated 50 hospitals will convert (from acute care beds) or open 1,000 to 1,500 skilled nursing unit beds.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

The bill directs the agency to file a new rule.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, hospitals, nursing homes and the agency will all experience additional legal and administrative tasks relating to CON applications for skilled nursing unit beds.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

None.

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

No.

b. Does the bill require or authorize an increase in any fees?

No.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

No.

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Yes, through the payment of CON application fees.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

The bill modifies the options for hospitals to obtain skilled nursing unit beds.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

No.

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. SECTION-BY-SECTION RESEARCH:

Section 1. Amends s. 395.003, F.S., relating to hospital licensure, to add a new subsection (5) which directs the agency to file a rule methodology that provides for a separate evaluation of CON applications for skilled nursing beds in hospitals. Applications will not be subject to comparative review with nursing homes. Nursing homes will not have standing to challenge a CON awarded to a hospital, and hospitals will not have standing to award a CON awarded to a nursing home. The agency will be required to issue a CON for skilled nursing unit beds to any hospital which can provide at least 6 or more hours of nursing care per day and can demonstrate an occupancy rate of at least 75 percent at the end of the second year of operation.

Section 2. Provides an effective date of upon becoming a law.

III. FISCAL RESEARCH & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

None.	FY 97-98	FY 98-99

2. Recurring Effects:

Medicaid Services:

Revenues		
U.S. Grants (Title XIX)	$7,508,720	$7,508,720
Expenditures		
Nursing Home Care		
General Revenue Fund	$5,981,614	$5,981,614
Medical Care Trust Fund	$7,508,720	$7,508,720
Total Nursing Home Care	$13,390,334	$13,390,334

3. Long Run Effects Other Than Normal Growth:

   None.

4. Total Revenues and Expenditures:

   Same as 2. above.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   None.

2. Recurring Effects:

   None.

3. Long Run Effects Other Than Normal Growth:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

   Nursing homes will see a reduction in the number of skilled nursing unit patients because these patients will be admitted to a hospital skilled unit instead. Hospitals and nursing homes will experience increased litigation costs associated with the rule which the agency is directed to file under this legislation.

2. Direct Private Sector Benefits:

   Patients will have a greater choice in the selection of a skilled nursing unit facility. Hospitals will not have to compete with other hospitals or nursing homes to obtain a CON for skilled nursing unit beds.

3. Effects on Competition, Private Enterprise and Employment Markets:

   Indeterminate.

D. FISCAL COMMENTS:

The fiscal impact listed above was estimated by the agency and is based on the assumption that the bill will reduce occupancy rates in freestanding nursing homes which will in turn increase operating costs. Since 65 percent of all patient days in freestanding nursing homes are funded by Medicaid, an increase in Medicaid per diem rates is expected by the agency.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

This bill amends chapter 395, F.S., which relates to hospital and ambulatory surgical center regulation. However, the bill relates to certificate of need which is regulated in chapter 408, F.S.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

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