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HOUSE OF REPRESENTATIVES
COMMITTEE ON
HEALTH REGULATION
ANALYSIS

BILL #: HB 243

RELATING TO: Health Care/Certificates-of-Need

SPONSOR(S): Representative(s) Rubio

TIED BILL(S): None.

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

(1) HEALTH REGULATION
(2) COUNCIL FOR HEALTHY COMMUNITIES
(3)
(4)
(5)

I. SUMMARY:

HB 243 effectively repeals the Health Facilities Development Act: the Certificate of Need (CON) review process. This bill eliminates the regulatory process that requires certain health care providers to obtain state approval from the Agency of Health Care Administration before offering new or expanded services or making major capital expenditures. The expected result of the bill is to restrain health care cost by allowing a competitive marketplace to dictate price and force the health care community to compete on price and quality of service to the consumer, as found in other previously regulated industries.

In addition, this bill removes the statutory authority for the requirement of a certificate of need for bond validation and construction projects.

This bill also repeals the statutory authority for the existence of the eleven local health councils. By eliminating the CON review process and the associated application fees and facility assessment fees, this bill eliminates current funding allocated to health councils.

HB 243 eliminates all statutory cross-references to proposed repealed statutes: the CON review process and local health councils.

The bill's effective date is July 1, 2001.

The fiscal impact of this bill is a decrease in state revenues of $3,307,685 and a corresponding decrease in expenditures by the same amount. There is an anticipated loss of over $69,833,691 in health services provided by the Local Health Councils with the statutory repeal of these entities.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes [x]	No []	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes []	No []	N/A [x]
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principle that received a "no" above, please explain:

B. PRESENT SITUATION:

Certificate of Need

The Certificate of Need program is a regulatory process that requires certain health care providers to obtain state approval from the Agency of Health Care Administration before offering new or expanded services or making major capital expenditures. For example, a certificate of need would be required if a hospital requests to increase its bed capacity or proposes to initiate certain specialized services.

Federal legislation, the National Health Planning and Resource Development Act, primarily dictated state CON laws from 1974-1986. The original intent of the Federal CON laws was to restrain skyrocketing health care costs, prevent the unnecessary duplication of health resources and achieve equal access to quality health care at a reasonable cost. With the creation of Medicare prospective payment in 1984 and the emergence of managed care, there has been a national trend toward significantly reducing CON or eliminating it altogether. Federal health planning legislation was abolished in 1986 with each state delegated the determination of whether to have a CON program. A report from the American Health Planning Association, published in 2001 shows that currently 15 states have no CON review. Florida ranks 27th in the nation as it pertains to CON regulation, with the number one state being the most restrictive.

The origin of CON in Florida parallels other states' similar laws, originating from local community efforts to allocate philanthropic and federal funding. Florida's first CON laws were part of the Health Facilities and Health Services Planning Act, passed just one year before the effective date of the Congressional mandate. In 1972, Florida was one of the first states to enact Certificate of Need requirements preceding the federal CON mandates of 1974. Florida CON laws were created to bring health care costs under control by preventing certain designated health care facilities from expanding unnecessarily, buying duplicative or unneeded costly equipment, or creating duplicative or unnecessary services. As well, CON laws intended to ensure quality of clinical care by limiting the number of providers performing certain complex medical procedures and thereby assuring clinician proficiency. Additionally, the CON process intended to evaluate impact of new providers on existing providers as well as support more cost-effective ways to provide health services. In short, CON was intended to assure citizens reasonable access to quality health care at a reasonable cost and to ensure that major expenditures and new services proposed by health care providers are needed for quality patient care within a particular region or community.

Sections 408.034 - 408.0455, F.S., designate the Agency for Health Care Administration as the single state agency to issue, revoke, or deny certificates of need. The issuance of the certificate of need predicates licensure requirements as provided under chapters 393, 395, and parts of chapter 400, F.S. It also requires that diagnostic cardiac catheterization service providers be subject to review. This section defines and establishes the application process, establishes fees, provides for conditions and monitoring once the CON is issued and related penalties for non-compliance; limits transfer; provides for special provisions for osteopathic acute care hospital, hospices, rural health networks; defines the certificate of need competitive sealed proposals; and establishes rules for pending proceedings.

The Auditor General's Report, November 2000, The *Certificate of Need and Public Medical Assistance Assessments Programs, Agency for Health Care Administration, Operational Audit* reports: that "ACHA had not diligently pursued the receipt of required reports, thereby limiting management's ability to timely evaluate: (1) whether providers adhered to the service conditions stipulated on issued Certificates of Need and related statutorily mandated fines should be imposed; and (2) whether project costs were within the budgets set forth in the applications for the Certificate of Need."

In 2000, the Florida Legislature established the Florida Commission on Excellence in Health Care to facilitate the development of a comprehensive statewide strategy for improving the health care delivery system through meaningful reporting standards, data collection and review, and quality measurement. As it relates to the CON process, the Commission recommended that: "the legislature should retain certificate of need regulations until after such time as systems for reporting useful clinical outcome data allowing consumers to analyze and choose between existing health care practitioners and providers are implemented".

The CON application files, which contain clinical outcome data, are open to the public and mainly utilized by health care consultants, attorneys and policy decision-making industry representatives. In addition, the office of CON within the Agency for Health Care Administration publishes a report twice a year with hospital utilization information, one of the only sources of this compilation of this data statewide.

Statutory Revisions to CON 2000

- **Increases in Licensed Bed Capacity -** As of July 2000, an exemption was created so that a proposed increase of up to 10 beds or 10 percent of a hospital's licensed capacity for acute care, mental health services, or hospital based SNU (skilled nursing unit) beds are not subject to review; and conditionally granted exemptions specify the necessity of maintaining a predetermined occupancy level and may require meeting other conditions. Previously, all projects proposing an increase in the licensed bed capacity of a hospital or nursing home were subject to CON review.
- **Establishment of a Medicare Certified Home Health Agency -** As of July 2000, there is no CON review of proposed Medicare certified home health agencies, and no exemption is required. Prior to the implementation of the "Patient Protection Act of 2000", proposed establishment of a Medicare certified home health agency was subject to CON review with exemptions possible for certain types of providers.
- **Cost Overruns -** As of July 2000, there is no CON review of cost overruns, and no exemption is required. Previously, increases in the cost of an approved project were subject to CON review if the increase exceeded specific thresholds.

Statutory Revisions in 1987 – 1997 to CON:

- **Obstetric services** – From October 1987 to present, proposals for OB services are exempt unless the total licensed bed capacity of the hospital increases. Before legislative action in 1987, proposals to initiate or expand obstetric services were reviewable.
- **Outpatient services** - From October 1987 to present, proposals for exclusively outpatient services were excluded from certificate of need review, regardless of the dollar amount involved. Before legislative action in 1987, there was not any exclusion for outpatient capital expenditures and these expenditures were subject to review.
- **Tertiary services** – From October 1987 to present, specified tertiary services are reviewable. A rule promulgated in 1988 specifies a list of tertiary services, including organ transplantation; specialty burn units; neonatal intensive care units (Level II and Level III); comprehensive medical rehabilitation; adult open heart surgery; neonatal and pediatric cardiac and vascular surgery; and pediatric oncology and hematology.
- **Capital expenditure threshold** - From July 1997 to present, no project is reviewable based solely on the amount of capital expenditure proposed. From October 1987 through June 1997, capital expenditures of $1 million or more for inpatient services were subject to CON review, unless new or expanded beds or services were proposed, and the agency adjusted the $1 million threshold annually for inflation. Prior to October 1987, the threshold for review of a proposed capital expenditure was $600,000.
- **Major medical equipment** - From July 1997 to present, acquisition of medical equipment, regardless of cost, is not reviewable. From October 1987 through June 1997, the amended definition of major medical equipment is that of equipment costing more than $1 million and which the United States Food and Drug Administration (FDA) approve for less than 3 years required review. The agency adjusted the $1 million threshold annually for inflation. Prior to October 1987, major medical equipment was defined as equipment used to provide health services and costing more than $400,000.
- **Applicable CON fees required** - From 1991 to present, the base fee for a CON application has been $5,000, plus 0.015 of each dollar of proposed capital expenditure, with the total not to exceed $22,000. In 1989, the ceiling amount to the CON application fee was increased from $9,500 to $10,000. While in the previous year, October 1987, a revision to the structure occurred to a base fee of $750, plus 0.006 of each dollar of proposed capital expenditure, with the total not to exceed $9,500. Prior to October 1987, the fee for processing a CON application was calculated with a base fee of $500, plus 0.004 of each dollar of proposed capital expenditure, with the total fee not to exceed $4,000.

The Agency for Health Care Administration Long Range Program Plan for FY 2001-2002 to 2005-2006 proposes that "elimination of unnecessary health facility regulation will play an important role in the Governor's and Legislature's initiatives to improve the business climate in Florida and streamline government operations. Certificates of Need, once considered mandatory for the control of both public and private health care cost in nursing facilities, hospital and home health agencies, have increasingly come to be viewed as overly restrictive deterrents to healthy competition among providers". The agency expresses two major concerns:

- The CON review has been used to give what is perceived as necessary preferences to safety net providers; and
- To control the supply of nursing home beds in order to manage the demand of services from Medicaid Recipients, thereby reducing expenditures to the Medicaid budget.

In May 1998, the Florida Community Hospitals Association published a study to review the history of the CON review process and identified current arguments for the deregulating of CON. The study suggested the consideration of the following:

- Does continued regulation create barriers to the development of managed care?
- Are market forces sufficiently in place to control excess investment, price, and utilization?
- Would market forces sufficiently ensure equitable coverage of indigent care?
- Eliminating the CON process may adversely affect quality of care.
- Would elimination of CON result in excess service capacity?

Various CON **proponents** believe that since government is the number one payer of all health services, it has a right to expect regulatory oversight to focus at a minimum on those services still paid on a fee-for-service basis, lack quality of care standards, are subject to over-utilization, or for quality purposes should be regionalized. A 1996 Dartmouth Atlas on Health Care comprehensive study of our nation's health care system reports that no other competitive industry depends so much on government for its funding and concluded that free enterprise does not exist in the health care industry. The author of the study, Veazey, believes that CON contributes to the preservation of quality services in programs such as open heart surgery, angioplasty, and neonatal intensive care by promoting a concentration of skilled staffs and preventing the proliferation of low volume programs. "Practice makes perfect: higher volumes result in higher quality and lower mortality". Additionally, according to Veazey, CON can help assure financial viability for safety net hospitals by reducing the threat from "cream-skimming" investor owned hospitals and ambulatory care centers.

Opponents of CON most often cite the movement toward a more competitive marketplace as the rationale to dismantle CON. In a recent article from T*he Journal of the James Madison Institute,* Winter 2001, argues that in the 1990s, the manner of paying for medical care is moving rapidly toward prospective market-based capitation payment methods (i.e., managed care). Increasingly, hospitals and doctors are competing for contracts to provide a full range of services in exchange for a negotiated fixed payment. This payment method makes it less likely that the creation of excess hospitals and services will occur, thereby eliminating the possibility that additional cost to the public is passed on to maintain these services. In citing this theory, proponents of deregulation often recognize that even in a more competitive environment, quality and access to health care services for all citizens is of utmost concern. Thus, even among proponents of deregulation, there is a belief there is a need to strengthen licensure oversight to assure access and quality of health care.

Many local industry proponents argue that fees associated with the CON review process are exorbitant and prohibitive in a competitive marketplace. Beginning with the letter of intent required by the Agency for Health Care Administration prior to the submission of an application, health care facilities routinely hire health planners, certified public accounts, and consultants. The CON application is reviewed in a batch cycle process, and once the Agency has made a determination, both competitive health care facilities and the actual applicant can challenge the outcome of the CON review process. Industry representatives argue that the majority of application determinations challenged in the Administrative Hearing process is too lengthy. After the submission of a formal challenge, the case is assigned a hearing officer with a scheduled hearing date, which may be months into the future. After the hearing process, each party involved in the case proposes a recommended order to the Administrative Law Judge. After careful consideration, the Administrative Law Judge then issues a recommended order to the Agency; all parties have a right to file an exception to the recommended order. Subsequently, the Agency issues a final order, and again all parties involved have the right to appeal the final order with the regional District Court of Appeals. The appellate process is lengthy, costly and time consuming to the applicant and the Agency.

The CON regulatory process has arguably been used as a tool to help control the number of nursing home beds available, thereby decreasing a demand on service and decreasing the strain on the state's Medicaid budget. According to the Agency for Health Care Administration, the percentage of Medicaid utilization of nursing home beds has steadily increased: 1990 – 57.77%, 1995 – 63.03%; and 2000 –65.74%. Medicaid mandatory services include skilled nursing facility

services, as specified in s. 409.905(8), F.S. Paragraph (b) of subsection (2) of s. 409.908, F.S., stipulates that ACHA establish and implement a Florida Title XIX (Medicaid) Long-Term Care Reimbursement Plan. Under the plan, a prospective case mix reimbursement rate is calculated for each nursing home based on the facility's cost of rendering care, with specific accounting for the costs of patient care, operating cost, and property costs. These factors combine to serve as the basis for a facility's per diem rate of reimbursement. These rates are subject to specific regional and county ceilings, and are fixed on the semi-annual semester basis by ACHA using actual audited data reported to ACHA by nursing homes. The only exception to this is an allowance for interim rate adjustments, based on outstanding factors that affect the cost of doing business. These interim rate adjustments have, up to this point, been limited to cost associated with revisions in federal or state requirements that have a direct impact on the cost of nursing home care to Medicaid recipients.

Local Health Planning Councils

Section 408.033, F.S., establishes eleven District Local Health Councils to develop strategies and set priorities for implementation of health care services based on each district's unique need. The members of each council are appointed in an equitable manner by the county commission having jurisdiction in the respective district. The local health councils are statutorily responsible for advising the Agency for Health Care Administration on health issues and local resources available, promote public awareness of community health needs, collect data and conduct analyses and studies related to health care needs. Local health planning councils also monitor the health care needs of the medically indigent, the on-site construction progress of certificate of need approved projects, address the health goals and policies of the State Comprehensive Plan, and advise and assist local governments within each district on the development of optional health plan elements.

Subsection (2) of section 408.033, F.S., provides that the cost of local health councils be borne by the application fees for certificate of need and by assessments on selected health facilities subject to facility licensure review. Fees and assessments deposited in the Health Care Trust Fund, added with federal funding, create a $13 million current cash balance of fiscal year 2000-2001. For the same fiscal year, approximately $1.58 million in CON application fees have been transferred to the Department of Health for operating the health councils with an additional $677,000 from assessment fees. The remaining CON application fee revenues: $1.858 million, stayed in the Agency for Health Care Administration to administer the Healthy Facilities and Services Development Act (CON review process).

The Agency for Health Care Administration assesses selected health care facilities subject to licensure by the Agency including abortion clinics, assisted living facilities, ambulatory surgical centers, birthing centers, clinical laboratories, home health agencies, hospices, hospitals, Intermediate Care Facilities for the Developmentally Disabled, nursing homes, multiphasic testing centers, including health maintenance organizations and prepaid health clinics. Licensed hospitals and nursing homes are assessed an annual fee based on number of beds, not to exceed $500; while all other facilities and organizations licensed by the Agency are assess an annual fee of $150. Exemptions from assessment fees include statutorily defined rural hospitals, facilities operated by the Department of Children and Families, Department of Health and the Department of Corrections. All health care facility assessments and proceeds from the application of Certificate of Needs are deposited in the Health Care Trust Fund by the Agency in an amount to maintain aggregate funding for local Health Councils. In addition, Local Health Councils receive grant monies and are reimbursed from federal funds provided to the state for specific activities performed by the Health Councils through the Health Care Trust Fund.

According to the staff of Health & Human Services House Appropriations Committee, both the Agency for Health Care Administration and the Department of Health generate an administrative trust fund fee, for the administration of the Health Care Trust Fund. The Agency for Health Care

Administration pays $454,884 annually and the amount paid by the Department of Health is undetermined at this time.

Subsection (3) of section 408.033, F.S. , provides that the local health planning councils in conjunction with the Agency coordinate planning of health services in the state.

C. EFFECT OF PROPOSED CHANGES:

Certificate of Need

This bill will effectively eliminate the Certificate of Need regulatory process that requires certain health care providers to obtain state approval from the Agency of Health Care Administration before offering new or expanded services or making major capital expenditures. The expected result of the bill is to restrain health care cost by allowing a competitive marketplace to dictate price and force the health care community to compete on price and quality of service to the consumer, as found in other previously regulated industries.

In addition, this bill removes the statutory authority for the requirement of a certificate of need for bond validation and construction projects. Some opponents of CON deregulation argue that the repeal of the CON review process will destabilize the current bond market.

ACHA is statutorily required to allow "any willing provider" to participate in the Medicaid program. This combined with the continually increasing age of the state's population and the comparatively low rate of nursing home beds available per 1,000 people over sixty-five, raise concerns that if CON is completely repealed, there will be a possible increase strain on the Medicaid budget.

Local Health Planning Councils

The Certificate of Need application fees and assessment on facilities provide the state funding for the eleven Health Planning Council Districts in Florida. HB 243 repeals the statutory authority for the existence of the Health Planning Councils. Each of the eleven districts receive $150,000 annually, collectively $1.65 million from the Health Care Trust Fund. The degree of each council's actual operating budget differs from district to district, greatly depending on the Council's ability to secure local, federal and private funding. Each Health Planning council is charged with providing local community support in the areas of health planning, data collection and the development of cost-effective, innovative medical programs, such as the statewide AIDS Insurance Continuation program administered by District 11: Health Council of South Florida. District 11 estimates that this program alone has saved the State of Florida an estimated $111 million over the past 5 years by providing payment of health care premiums, reducing the need of AIDS patient's need for publicly, state-funded medical assistance.

The Department of Health reports that three department full time equivalent positions associated with administration of local health councils will be impacted.

D. SECTION-BY-SECTION ANALYSIS:

Section 1. Repeals sections 154.245, 408.031, 408.032, 408.033, 408.034, 408.035, 408.036, 408.0361, 408.037, 408.038, 408.039, 408.040, 408.041, 408.042, 408.043, 408.044, 408.045, 408.0455, and 651.118, F.S., to remove the requirements of a certificate of need as a condition to bond validation and construction projects; to eliminate the Health Facility and Services Development Act, and the local and state health planning councils; and repeals the duties &

responsibilities of the Agency of Health Care Administration as it relates to the certificate of need process. It also repeals the application criteria and review process, relating to the requirements for certificate of need review and approval for health care facilities and services.

Section 2. Amends subsection (3) of s. 20.42, F.S., to remove the responsibility from the Agency for Health Care Administration for implementing the certificate of need program, as it relates to statutory organizational structure of the Agency.

Section 3. Amends subsection (4) of s. 154.205, F.S., to remove the definition of "certificate of need" from statute.

Section 4. Amends s. 154.213, F.S., to remove the requirement to have a valid certificate of need for projects defined under the health facilities authorities law as a condition for agreements of lease with public health facilities.

Section 5. Amends subsection (1) of s. 154.219, F.S., to remove language referencing the CON in the issuance of bonds.

Section 6. Amends subsection (16) of s. 159.27, F.S., to alter the definition of "health care facility" removing statutory reference to the issuance of a CON.

Section 7. Amends subsection (2) of s. 164.1031, F.S., to remove "local health councils" from definition of "regional governmental entities", as it relates to applicable laws for governmental disputes.

Section 8. Amends subsection (7) of s. 186.503, F.S., to remove the definition of "local health council" as it relates to state and regional planning laws.

Section 9. Amends subsection (10) of s. 186.507, F.S., to delete the requirement of regional planning councils to enter into agreement by memorandum with local health councils to ensure coordination of health planning as it relates to strategic regional policy plans.

Section 10. Amends s. 186.511, F.S., to delete the language requiring that local health councils shall help evaluate the strategic regional policy plan and changes in plan.

Section 11. Amends subsection (3) of s. 189.415, F.S., to delete all the language that requires a special district proposing to build, improve, or expand health facility the necessity to notify the appropriate local general–purpose government of its plans either in the 5 year plan or letter of intent to Agency as it pertains to general provisions of special district public facilities report.

Section 12. Amends subsection (1) of s. 383.216, F.S., to remove the language requiring community-based prenatal and infant care coalitions to cooperate in a non-duplicative manner with the local health planning councils.

Sections 13. Amends subsection (10) of s. 395.0192, F.S. to remove the language that allows the agency to require/establish proof of discrimination in the granting or denial of hospital staff membership on application of CON.

Section 14. Amends paragraph (h) of subsection (1) of s. 395.1055, F.S., to remove all statutory authority which allows the Agency for Health Care Administration the ability to adopt rules as it relates to hospitals submitting data which is used in the CON review process.

Section 15. Amends subsection (1) of s. 395.603, F.S., to remove the language that requires the Agency for Health Care Administration maintain inactive general hospital beds be included in the

acute care bed inventory, maintained by the Agency for certificate of need purpose as it relates to rural hospitals.

Section 16. Amends subsection (1) of s. 395.604, F.S., to remove the language that refers to sections of the Florida Statutes repealed by the Act as it relates to rural primary care hospitals.

Section 17. Amends subsection (5) & (7), 395.605, F.S., to remove statutory authority which allows for expedited review of the CON application for rural hospital that want to provide emergency care services. Deletes the exemptions for Emergency Care Hospitals form CON requirements for home health, hospice services, and swing beds in a number that does not exceed one-half of the facilities licensed beds.

Section 18. Amends portion of subsection (9) of s. 400.071, F.S., as it relates the Agency issuing a license predicated on the approval of the certificate of need to a nursing home; to revise the intent of the legislature: reflecting the repeal of s.408.035 by this Act.

Section 19. Amends portion of subsection (5) of s. 400.23, F.S., to remove the statutory requirements that the Agency must adopt rules to include a methodology for reviewing a nursing home facility under the proposed repealed s., 408.031-408.045, F.S., by this Act.

Section 20. Amends subsection (6) of s. 400.602, F.S., to eliminate the necessity of hospice's to have a certificate of need as a provision of licensure.

Section 21. Amends subsections (5) and (6) of s. 400.606, F.S., to change the chapter title by deleting "certificate of need"; and to remove language requiring hospices to have certificate of need in the application process for licensure.

Section 22. Amends paragraph (b) of subsection (2) of s. 400.6085, F.S., to remove clarifying language that states: "licensed beds designated for inpatient care is not required to have or a certificate of need when contacting for another entity to provide hospice service."

Section 23. Amends paragraph (d) of subsection (3) and paragraph (a) of subsection (8) of s. 408.05, F.S., to remove local health councils from the responsibility of developing written arguments with other federal, state and local agencies as it relates to producing comparable and uniformed health information and statistics. In addition, to remove the statutorily required representative of local health councils from the State Comprehensive Health Information System Advisory Council established by the Agency for Health Care Administration.

Section 24. Amends subsection (12) of s. 408.061, F.S., to remove local health council's responsibility from data collection and dissemination in establishing an integrated health care database with the Agency and other local health care entities.

Section 25. Amends subsection (1) of s. 408.063, F.S., to eliminate local health councils from the responsibility of disseminating health care information and the education of the public regarding the data collected.

Section 26. Amends the introductory paragraph and subsection (31) of s. 408.07, F.S., to remove statutory reference of sections repealed by this act and to eliminate the definition of "local health council" from this chapter.

Section 27. Amends subsection (4) of s. 408.09, F.S., to eliminate the responsibility of the Agency for Health Care Administration to assist local health councils in carrying out their respective goals.

Section 28. Amends subsection (8) of s. 408.18, F.S., to eliminate the statutory responsibility for the Agency to coordinate existing data with local health councils as it relates to the Health Care Community Antitrust Guidance Act.

Section 29. Amends paragraph (j) of subsection (2) of s. 409.9117, F.S., to eliminate the statutory responsibility of hospitals to work with local health councils in developing a plan for promoting access to affordable health care as a precursor to receiving funding from the state disproportionate share funding program.

Section 30. Amends paragraph (b) of subsection (5) of s. 430.705, F.S., to eliminate the statutory responsibility for the Agency to consider the number of certificates of need awarded for nursing home beds in the decision making process in selecting pilot project areas for long-term care community diversion programs.

Section 31. Amends introductory paragraph and subsections (1) and (4) of s. 430.708, F.S., to eliminate the statutory responsibility of the Agency for Health Care Administration to reduce the projected nursing home bed need in each certificate of need batching cycle in the community diversion pilot project areas. Subsection (4) is removed to eliminate the statutory responsibility of the Agency for Health Care Administration for determining the feasibility of increasing the nursing home occupancy threshold used in formulating nursing home bed needs under the certificate of need process.

Section 32. Amends subsection (1) of s. 458.345, F.S., to conform statutory references reflecting changes in proposed repealed section as it relates to physician practice.

Section 33. Amends subsection (1) of s. 459.021, F.S., to conform statutory reference reflecting changes of proposed repealed sections as it relates to osteopathic physician practice.

Section 34. Amends paragraph (c) of subsection (1) of s. 641.60, F.S., to remove statutory reference of district: Statewide Managed Care Ombudsman Committee districts parallel with that of repealed local health council districts.

Section 35. Certificates of Authority are required by the Department of Insurance for entities proposing to provide continuing care, or issuing continuing care agreements or construct a facility for providing continuing care in this state. Section 35 amends paragraph (a) of subsection (2) of s. 657.021, F.S., to remove the statutory reference that sets apart the necessity of a certificate of authority from the certificate of need in this provision.

Section 36. Provides for an effective date of July 1, 2001.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Health Councils:
HB 243 eliminates the State's network of local health councils. In fiscal year '01, the 11-local health councils leveraged the State's $2 million investment to bring **almost $70 million** in health care services and programs to Florida's neediest residents. According to information provided, the elimination of the local health councils will jeopardize receipt of the following program revenues at the local and regional level:

- **HIV/AIDS -** A yield of **$41 million** in private pay health insurance benefits used to support the needs of People Living with HIV/AIDS; **$13 million** in federal funds used to support community-based efforts to identify and prioritize HIV/AIDS service needs; facilitate the design and implementation of a comprehensive and integrated system of care; enhance the delivery of HIV/AIDS screening and treatment services in rural communities; increase the independence and economic self-sufficiency of HIV/AIDS clients; and identify and implement effective strategies to prevent the spread of HIV infection in targeted at-risk populations, including the African-American community where HIV is present at disproportionate rates. **$570,000** in provider support used to reduce the prenatal transmission of HIV/AIDS, improve the health status and quality of life for HIV/AIDS patients, and reduce the use of hospital-based care.

- **CHRONIC DISEASE/DISEASE MANAGEMENT - $1,266,667** in General Revenue funds used to expand access to primary and preventive health care services for the chronically ill, promote access to care in the less costly out-patient environment, and design and develop intervention strategies that resolve health care issues that disproportionately impact minority populations. **$2,000,000** in provider support used for the surgical and/or therapeutic treatment of chronic disease. **$922,000** in federal funds used to establish an electronic medium for the management and referral of indigent clients with chronic health conditions, such as Diabetes and Asthma. **$100,000** in foundation funds used to expand access to specialty screening and diagnostic services for indigent and medically underserved residents. **$75,000** in local government and foundation funds used to support the delivery of health care and pharmaceuticals to indigent and medically underserved residents, including Medicare recipients who lack access to prescription drug benefits. **$45,000** in private donations used to establish client-based networks through which to evolve the design and delivery of health care services to meet evolving needs.

- **INDIGENT CARE - $1,510,000** in local government, foundation and corporate funds used to assess the health care needs of area residents, and the design and development of a system of care that meets the needs of the indigent and medically-underserved.

- **HEALTH PROMOTION - $150,000** in General Revenue and corporate funds used to provide education to providers and the community on the need for immunizations, and to provide free flu and pneumonia vaccinations to minority residents. **$45,000** in foundation funds, corporate support, and community contributions used to design and conduct disease-specific educational programs (e.g., for juvenile diabetics, etc.) that support the adoption of risk reduction behaviors.

- **CHILDREN'S HEALTH - $2,242,839** in local government, foundation, and corporate funds used to support the payment of health insurance premiums for children enrolled in the Healthy Kids program. **$3,604,212** in federal and state funds used to improve birth outcomes and promote positive child development. **$1,407,973** in state funds used to improve access to health care services for children with complex medical needs.

- **PROGRAM PLANNING/EVALUATION - $1,895,000** in state and local government funds used to identify system deficiencies, develop appropriate strategies to effect systemic change, and increase the technical capacity of service providers.

Estimated TOTAL IMPACT: $69,833,691 with the statutory repeal of local health councils.

Agency for Health Care Administration

	Amount Year 1 (FY 01-02)	Amount Year 2 (FY 02-03)
Non-Recurring Impact		
Licenses	$0	$0
Fees	$(1,174,619)	$(1,174,619)
Grants	$0	$0
Transfers in / Another Agency	$0	$0
Subtotal Non-Recurring Revenues	**$(1,174,619)**	**$(1,174,619)**
Recurring Impact		
Licenses	$0	$0
Fees (loss of CON fee revenue)	$(1,401,995)	$(1,401,995)
Fees (loss of health Facility Assessment Fee)	$ (731,071)	$ (731,071)
Grants	$0	$0
Transfer In / Another Agency	$0	$0
Subtotal Recurring Revenues	**$(2,133,066)**	**$(2,133,066)**
Total Revenues	**$(3,307,685)**	**$(3,307,685)**

2. Expenditures:

Agency for Health Care Administration

	FTE	Amount Year 1 (FY 01-02)	Amount Year 2 (FY02-03)
Salaries and Benefits			
Health Svcs & Facil. Consult. Supv.	(2.0)	$(121,981)	$(121,981)
Health Svcs & Facil. Consultant	(10)	$(521,333)	$(521,333)
Records Specialist	(1.0)	$(30,059)	$(30,059)
Administrative Secretary	(2.0)	$(63,123)	$(63,123)
Expenses			
13 Professional Staff @ @11,057 per FTE		$(143,741)	$(143,741)
2 Support Staff @ $6,752 per FTE		$(13,504)	$(13,504)
Service Charge to General Revenue		$(155,714)	$(155,714)
Transfer to the Department of Health		$(677,703)	$(677,703)
Transfer to DOH CON fess		$(1,580,527)	$(1580,527)
TOTAL EXPEDITURES FOR AHCA:		**$(3,307,685)**	**$(3,307,685)**
Department of Health			
Salaries /Benefits		$(184,121)	$(184,121)
Expenses (transfer to DOH)		$(1,665,505)	$(1,665,505)
TOTAL EXPENDITURES FOR DOH:		**$(1,849,626)**	**$(1,849,626)**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health Care Facilities

HB 243 eliminates up to $22,000 per health care facility for CON application fee and other facility assessment fees. The bill will significantly reduce the cost of consulting fees and any attorney fees associated with the approval of an application for Certificate of Need. The actual dollar amount that will potential be saved by health care facilities cannot be determined at this time.

D. FISCAL COMMENTS:

The Agency's recommendations within their long range program plan, cites an estimated reduction in staff associated with the CON review to be as much as 18 position with a total reduction in expenditures of approximately $836,525 by FY 2005-06.

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

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not require a city or county to expend funds or to take any action requiring the expenditures of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

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

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:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

The bill does not provide any new specific rule making authority. However, it does require the Agency for Health Care Administration to amend existing rules.

C. OTHER COMMENTS:

The bill does not propose any alternative method for stricter licensure procedures in the absence of CON regulation ensuring equal access to quality health care to Medicaid and indigent patient. Nor does the bill address an alternative method for local health planning needs and regulatory functions in the absence of local health councils. The Agency for Health Care Administration suggests that if the CON review process is repealed, the agency be given authority to implement procurement of nursing home and long term care services based on performance measures. Types of performance measures including compliance history, deficiencies cited with consideration to scope and severity, and which facilities rated "best" in Florida would be established.

The current Florida legislative climate is toward minimizing unnecessary regulations and supporting market forces designed to gain operating efficiencies achieved in other previously regulated industries.

Bill

Section 34: In the proposed repeal of a statutory definition of "district" (Statewide Managed Care Ombudsman Committee districts parallel with that of repealed local health council district), a definition for "Statewide managed care ombudsman committee district" should be created.

Industry

Florida Hospital Industry is concerned that the repeal of the state CON process will have a negative impact on indigent care, citing that if the CON review process is eliminated, health facilities will no longer provide services to the medically indigent. However, there is a federal program for funding indigent care through the Hospital Disproportionate Share Program (DSH). This program applies a formula for allocating supplemental funding to hospitals that serve a large share of the indigent population. Moreover, some counties within the state have additional adopted optional taxes for funding indigent care. Removal of the CON review process will not eliminate current funding sources.

According to information provided by the Florida Hospital Association, repeal of the CON process could possibly destabilize the current Bond market. Examples cited from other states that have repealed the CON review process are as follows:

Impact of CON Deregulation on Bond Financing[1]

There has been a proliferation of new providers of services in Ohio, which eliminated CON in the late 1990s. For example:

- 130 new/proposed ambulatory surgery centers
- Two new specialty heart hospitals under construction, several more "on the drawing board"
- Four new/two planned rehab hospitals
- 11 new cancer treatment centers (4 U.S. Oncology; all in urban areas)

[1] Source: Virginia Hospital and Healthcare Association

- CT scanners up 42 percent (66 new ones)
- Eight new hospitals
- 45 New MRIs

Partially as a result of this proliferation of providers in Ohio, a number of Ohio non-profit health systems have had their bond ratings downgraded. An August 2000 report from Moody has identified eight of the 31 nonprofit hospitals or systems it rated in Ohio as having a negative outlook. Several others are already downgraded. Nearly half (14 of 31) of the Ohio nonprofit hospitals and health systems that Moody's (national investment firm) tracks in Ohio have bond ratings in the B or C range.

Pennsylvania

The results are even worse in Pennsylvania, which also deregulated CON in the late 1990s. According to a recent state report, 40 percent of Pennsylvania hospitals lost money in 1999. The mean operating margin for all hospitals in the state was less than one percent (.17 percent to be exact). Moody's identified 13 of the 51 nonprofit hospitals and health systems that it tracks in Pennsylvania as having a negative outlook. As was the case in Ohio, several more had already been downgraded. Twenty-nine of the 51 nonprofit hospitals and health systems that Moody's tracks in Pennsylvania have bond ratings in the B or even C range.

Florida Hospices and Palliative Care, Inc., provided the following statement: "…supports use of the Certificate of Need Workgroup created by the 2000 Legislature to conduct a review as comprehensive and genuine as was done by the state of Maryland before there is any deregulation or alteration of Florida's current laws and administrative rules relating to CON and licensure."

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

None.

VII. SIGNATURES:

COMMITTEE ON HEALTH REGULATION:

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