# SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 2132

SPONSOR: Health, Aging, and Long-Term Care Committee and Senator Saunders

SUBJECT: Certificate of Need

DATE: April 9, 2003 REVISED: _____ _____ _____ _____

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Harkey | Wilson | HC | Favorable/CS |
| 2. | | | JU | |
| 3. | | | GO | |
| 4. | | | AHS | |
| 5. | | | AP | |
| 6. | | | | |

## I. Summary:

Committee Substitute for Senate Bill 2132 makes changes to the Certificate-of-Need (CON) program that were recommended by the Certificate-of-Need Workgroup. The bill designates adult and pediatric open heart surgery as a tertiary service. The bill removes shared service contracts or projects from CON review. The expedited review of a transfer of an active CON is narrowed to exclude from CON review a purchaser acquiring an existing hospital with an active CON. The bill makes certain conversions of hospital beds from one use to another exempt, rather than subject to an expedited CON review. The bill also exempts from CON review: emergency percutaneous coronary intervention in a hospital that does not have an open-heart surgery program; establishing a Level II neonatal intensive care unit in a hospital that had at least 1,500 live births during the prior 12 months; and adding a limited number of, or converting, hospital beds for specified purposes. The bill increases fees for CON applications and changes procedures relating to administrative hearings and judicial review. The bill requires funding for local health councils to remain at the 2002-2003 appropriation in subsequent years.

The bill creates a 15-member Hospital Statutory and Regulatory Reform Council to review and propose updating of laws regulating hospitals. Nine of the members would be appointed by the Florida Hospital Association, two would be appointed by the Governor, two by the President of the Senate, and two by the Speaker of the House of Representatives.

This bill amends ss. 408.032, 408.033, 408.036, 408.038, and 408.039, F.S., and creates one unnumbered section of law.

## II. Present Situation:

The Certificate-of-Need (CON) regulatory process under chapter 408, F.S., requires that before specified health care services and facilities may be offered to the public they must be approved by the Agency for Health Care Administration (AHCA). Section 408.036, F.S., specifies which health care projects are subject to review. Subsection (1) of that section lists the projects that are subject to ***full comparative review*** in batching cycles by AHCA against specified criteria. The projects subject to full CON review are:

- The addition of beds by new construction or alteration.
- The new construction or establishment of additional health care facilities, including a replacement health care facility when the proposed project site is not located on the same site as the existing health care facility.
- The conversion from one type of health care facility to another.
- An increase in the total licensed bed capacity of a health care facility.
- The establishment of a hospice or hospice inpatient facility, except as provided in s. 408.043, F.S.
- The establishment of inpatient health services by a health care facility, or a substantial change in such services.
- An increase in the number of beds for acute care, nursing home care, 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.
- The establishment of tertiary health services[1].

Subsection (2) lists the kinds of projects that can undergo an ***expedited review***. These include: research, education, and training programs; shared services contracts or projects; a transfer of a certificate of need; certain increases in nursing home beds; 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 facility; and certain conversions of hospital mental health services beds to acute care beds.

Subsection (3) lists projects that may be ***exempt*** from full comparative review upon request. These include:

- Replacement of a licensed health care facility on the same site;

[1] The term "tertiary health services" is defined in s. 408.032(17), F.S., as those medical interventions which are concentrated in a limited number of hospitals due to the high intensity, complexity, and specialization of the care. The goal of such limitations is the assurance of quality, availability and cost-effectiveness of the service. AHCA determines need for the expansion of tertiary health services by health planning district or multi-district service planning area. Health planning districts are comprised of more than one county, with the exception of District 10, Broward County. Section 408.032(17), F.S., requires AHCA to establish by rule a list of all tertiary health services and to review the list annually to determine whether services should be added or deleted. Under s. 408.032(17), F.S., "organ transplantation, specialty burn units, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature", are tertiary services along with those listed by AHCA in rule. Under Rule 59C-1.002, F.A.C., in addition to the tertiary services named in the statute, the following services are designated as tertiary services: heart transplantation, kidney transplantation, liver transplantation, bone marrow transplantation, lung transplantation, pancreas and islet cells transplantation, heart/lung transplantations, adult open-heart surgery, neonatal and pediatric cardiac and vascular surgery, and pediatric oncology and hematology.

- Hospice services or swing beds in a rural hospital;
- Conversion of licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital;
- The addition of nursing home beds at a skilled nursing facility that is part of a retirement community that provides a variety of residential settings and supportive services and that has been incorporated and operated in this state for at least 65 years on or before July 1, 1994;
- An increase in the bed capacity of a nursing home licensed for at least 50 beds as of January 1, 1994, which is not part of a continuing care facility;
- An inmate health care facility built by or for the exclusive use of the Department of Corrections;
- The termination of an inpatient health care service, upon 30 days' written notice to the agency;
- The delicensure of beds, upon 30 days' written notice to the agency;
- The provision of adult inpatient diagnostic cardiac catheterization services in a hospital;
- Mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility;
- State veterans' nursing homes for which at least 50 percent of the construction cost is federally funded and for which the Federal Government pays a per diem rate not to exceed one-half of the cost of the veterans' care;
- Combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict;
- Division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict;
- The addition of hospital beds 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;
- The addition of acute care beds 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;
- Nursing home beds in a number not exceeding ten total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater;
- 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;
- 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; and
- 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.[2]

**Fees for CON Review**

Under s. 408.038, F.S., AHCA must assess fees for CON applications and the fees will be used to fund the activities of local health councils, created in s. 408.033, F.S., as well as the activities of AHCA relating to the CON program. There is a minimum base fee of $5,000 and in addition to the base fee, an additional 0.015 percent of each dollar of proposed expenditure up to a maximum fee of $22,000.

**Challenges to Applications**

Challenges to an application and the cost of defending against challenges are a major reason for the perception that the CON process is burdensome. Applicants competing for a CON may challenge the agency's intended issuance or denial of a certificate of need. Section 408.039(5)(c), F.S., allows existing hospitals to initiate or intervene in an administrative hearing upon a showing that an established program will be substantially affected by the issuance of any certificate of need. AHCA must issue its final order within 45 days of its receipt of the recommended order, but the applicant and AHCA may agree to a different timing for the final order.

Under s. 408.039(6), F.S., a party to an administrative hearing for a CON application may seek judicial review in the District court of Appeal, and AHCA must be a party in such proceedings. The court may award 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.

**Certificate-of-Need Workgroup**

As required by Section 15 of Chapter 2000-318, Laws of Florida, a workgroup on CON was established to study issues pertaining to the CON program including the impact of trends in health care delivery and financing. The workgroup met eight times in 2001 and produced an interim report in December 2001. In 2002, the group held three meetings and produced a final report in December 2002, which included recommended changes to the CON program in the form of a draft bill. Much of the workgroup's recommended bill is incorporated in SB 2132.

**Issues**

In the past few years, the Legislature has considered proposals related to CON that call into question whether or not CON is still an appropriate market entry and quality control mechanism for Florida hospitals. Several issues are brought to the discussion. One issue is the question of whether the CON process is a mechanism for maintaining quality or an outdated planning mechanism that thwarts competition among providers. CON programs emerged in the late 1960s and early 1970s as a way to regulate growth of facilities and costs in health care. After the passage of the National Health Planning and Resources Development Act of 1974 (PL93-641)

[2] This exemption is repealed on July 1, 2002.

most states implemented CON programs. After the act was repealed in the 1980s, a number of states abolished their CON programs. At present, 36 states have CON programs.

There is research to show that CON may be ineffective as a mechanism for cost control and other research to show that it is an effective mechanism for maintaining quality of patient outcomes. In a study published in the *Journal of Health Politics, Policy and Law* in 1998, Christopher Conover and Frank Sloan looked at the effects of lifting CON through the year 1993. The authors found that mature CON programs are associated with a modest long-term reduction in acute care spending per capita, but with no significant reduction in total per capita spending. Further, they found that lifting CON requirements did not result in a surge in health care costs. In a current study of the potential impact of CON on outcomes for patients, Gary Rosenthal and Mary Sarrazin at the University of Iowa, examined the delivery of care to Medicare patients undergoing coronary artery bypass graft (CABG) surgery in all 50 states for a 6-year period. Patients fared better in CON regulated states on measures of in-hospital mortality and deaths within 30 days after surgery. The undesirable outcomes were 21 percent more likely in states that do not regulate the procedure through CON review.

**Local Health Councils**

Local health councils, established in s. 400.033, F.S., are comprised of representatives of health care providers, health care purchasers, and nongovernmental health care consumers who are appointed by the county commissions in the counties of the respective health planning district. The councils are authorized to develop a district or regional health plan that will enable the council to set priorities for implementation based on local health needs. In the CON program, local health councils provide data, hold public hearings, and perform some monitoring functions. Funding for the local health councils is provided from the fees collected for CON applications and from licensure fees collected by AHCA. Most local health councils have developed alternative sources of funding such as serving as the contract manager for Federal health-related programs. In many cases, CON-related funding has become a small portion of the local budgets of health councils.

## III. Effect of Proposed Changes:

**Section 1.** Amends the definition of "tertiary health service" found in s. 408.032(17), F.S., by adding adult and pediatric open-heart surgery to the listed examples of tertiary services. Adult and pediatric open-heart surgery are already designated as tertiary health services by rule. The practical effect of this statutory change would be to make it impossible to remove open-heart surgery from full CON review by eliminating open-heart surgery from the rule defining tertiary health service.

**Section 2.** Amends s. 408.036(2) and (3), F.S., which list, respectively, projects subject to a non-competitive expedited review, and projects subject to an exemption, as follows:

***Expedited Reviews***
Amendments to s. 408.036(2), F.S.:
(1) Delete paragraph (b), which provides for expedited review of proposed shared service contracts or projects. Elimination of shared service contracts or projects means that these would

not be reviewable under the CON program. A hospital would have to get a CON in order to operate a program that is subject to CON review. Any sharing or cooperation among hospitals would be subject only to licensure requirements, not CON review.

(2) Modify current paragraph (c), renumbered as (b), which requires an expedited review for transfer of an active CON issued for a project which has not yet been completed. Under an exception, all pending and active CONs issued to a hospital which has been acquired by a purchaser would become the property of the purchaser, without need for any CON-approved transfer.

(3) Delete current paragraph (f), thereby deleting expedited review of conversion of mental health services beds to acute care beds and conversion of acute care beds to mental health service beds; expedited review of the conversion of hospital-based skilled nursing unit (SNU) beds to acute care beds, consistent with a 2001 statutory change which exempted such conversion from CON review; and expedited review of the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services. These provisions all become exemptions under statutory changes elsewhere in Section 2 of the bill.

***Exemptions***
Amendments to s. 408.036(3), F.S.:
(1) Add a new paragraph (j), providing an exemption for the provision of emergency percutaneous coronary intervention in a hospital without an open-heart surgery program, provided specified requirements are met. This change would allow hospitals to begin offering emergency angioplasty services without obtaining a CON for a back-up open heart surgery program. AHCA is required to develop hospital licensure rules for the provision of angioplasty and related procedures in emergency situations. The rules must be consistent with guidelines published by the American College of Cardiology and the American Heart Association and must include the following:

- Cardiologists must have performed a minimum of 75 interventions within the previous 12 months;
- The hospital must provide a minimum of 36 emergency interventions annually, in order to provide the service;
- The hospital must offer sufficient professional staff to provide the services 24 hours a day, 7 days a week;
- Nursing and technical staff must have specified demonstrated experience;
- Cardiac care nursing staff must be adept in hemodynamic monitoring and Intra-Aortic Balloon Pump management;
- Formalized written transfer agreements must be developed with a hospital that has an adult open-heart surgery program and written transport protocols must be in place; and
- Hospitals that implement the program must first undertake a 3 to 6-month training program that includes specified content.

The applicant for emergency angioplasty must certify that it will use patient-selection criteria issued by the American College of Cardiology and the American Heart Association, and must agree to submit to AHCA a quarterly report on patient characteristics and treatment outcomes for

all patients who receive emergency percutaneous coronary interventions. The CON exemption expires immediately if the hospital fails to meet certain requirements and another exemption may not be granted to that hospital for 2 years.

(2) Amend paragraph (n), renumbered as (o), which provides exemptions for projects to add licensed hospital beds within certain specified limits:

- The current exemption for addition of acute care beds - 10 beds or 10 percent of the licensed capacity of acute care beds, whichever is greater - is increased to 30 beds or 10 percent of the licensed capacity of acute care beds, whichever is greater, and the required prior 12-month average occupancy rate is decreased from 80 percent or more to 75 percent or more.

- A new provision would allow an exemption for addition of comprehensive medical rehabilitation beds - limited to 8 beds or 10 percent of the licensed capacity of comprehensive medical rehabilitation beds, whichever is greater - with a required prior 12-month average occupancy rate of 80 percent or more.

- A new provision would allow an exemption for addition of mental health services beds - limited to 10 beds or 10 percent of the licensed capacity of the applicable mental health service beds category, whichever is greater - with a required prior 12-month average occupancy rate of 75 percent or more.

- The bill deletes current language that prohibits exemptions for addition of comprehensive medical rehabilitation services.

(3) Amend paragraph (o), renumbered as (p), which provides an exemption for the temporary addition of acute care beds, increasing the current limitation - 10 beds or 10 percent of licensed acute care capacity, whichever is greater - to 30 beds or 10 percent of licensed capacity, whichever is greater.

(4) Delete paragraph (q), an exemption for establishment of a specialty hospital, which was voided by subsequent legislative action (see statutory footnote to s. 408.036(3)(q), F.S.).

(5) Revise paragraph (s), providing an exemption for replacement of a statutory rural hospital, within the same district and within 10 miles of the existing facility, and within the hospital's current primary service area (defined by ZIP codes). A current exemption for replacement hospitals is limited to on-site replacement. Deletes language regarding a different exemption which was effective only for FY 2002.

(6) Create a new paragraph (t), providing an exemption for conversion of mental health services beds licensed under chapter 395, F.S., or hospital-based distinct part skilled nursing unit beds to general acute care beds; conversion between or among the licensed categories of mental health

services beds; and conversion of general acute care beds to beds for mental health services. This exemption replaces the current requirement for an expedited review of such conversions.[3]

(7) Create a new paragraph (u), providing an exemption for establishment of a Level II neonatal intensive care unit with at least 10 beds, at a hospital that had at least 1,500 live births during the prior 12 months.

(8) Create a new paragraph (v), providing an exemption for the addition of Level II or Level III neonatal intensive care beds - limited to 6 beds or 10 percent of the licensed capacity of the applicable category of beds, whichever is greater - with a required prior 12-month occupancy rate of 75 percent or more.

**Section 3.** Amends s. 408.033, F.S., to require that, beginning with the 2003-2004 fiscal year, funding for the 11 local health councils remain at the July 1, 2002.

**Section 4.** Amends s. 408.038, F.S., which pertains to fees on CON applications. The current minimum base fee of $5,000 is increased to $10,000; and the cap on the fees which are based on proposed expenditures is increased from $22,000 to $50,000.

**Section 5.** Amends s. 408.039(5)(e), F.S., concerning final agency action on a recommended order proposed by an administrative law judge. Current law allows the applicant and agency to agree on an extended deadline for final agency action following an administrative hearing. The bill compels the agency to act within 45 days after receipt of a recommended order, and failure to do so would mean that the judge's recommended order becomes the agency's final order.

Amends s. 408.039(6)(c), F.S., concerning judicial review of the agency's final order. Current law provides that the District Court of Appeal, if it finds there was no justiciable issue of law or fact raised by the losing party, may award reasonable attorney's fees and costs to the prevailing party. The bill adds that, if the losing party in an administrative hearing is a hospital, the court must order it to pay the reasonable attorney's fees and costs of the prevailing party, including fees and costs incurred as a result of the administrative hearing and the judicial appeal.

**Section 6.** Creates the Hospital Statutory and Regulatory Reform Council. The bill provides that:

- The Hospital Statutory and Regulatory Reform Council is created to provide a mechanism for the ongoing review and updating of laws regulating hospitals.
- For administrative purposes only, the Council is located within the Agency for Health Care Administration.
- The Council has 15 members:
    - 9 members appointed by the Florida Hospital Association, representing the various types of hospitals and hospital ownership;
    - 2 members appointed by the Governor, representing patients;

[3] It should be noted that current paragraph (r), added in 2001, already provides an exemption for conversion of hospital-based distinct part skilled nursing unit beds to general acute care beds.

  - 2 members appointed by the President of the Senate, representing private business, excluding insurers and HMOs; and
  - 2 members appointed by the Speaker of the House of Representatives, representing physicians.
- The Council must meet at least twice a year.
- As its first priority, the Council must review chapters 395 and 408, F.S., and make recommendations to the Legislature for the repeal of regulatory provisions no longer necessary, or that fail to promote cost-efficient, high-quality medicine.
- As its second priority, the Council must recommend to the Secretary of the Department of Health and the Secretary of the Agency for Health Care Administration regulatory changes relating to hospital licensure and regulation.
- In determining whether a statute or rule is appropriate or necessary, the Council shall consider whether:
  - The statute is necessary to prevent substantial harm to the public health, safety, or welfare;
  - The statute or rule restricts the use of new medical technologies;
  - The statute or rule has an unreasonable effect on job creation or job retention in the state;
  - The public is or can be effectively protected by other means;
  - The overall cost-effectiveness and economic effect of a proposed statute or rule will be favorable; and
  - A lower-cost regulatory alternative to the statute or rule could be adopted.

**Section 7.** Provides that the bill takes effect July 1, 2003.

## IV. Constitutional Issues:

### A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

### B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

### C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

### D. Other Constitutional Issues:

The amendment to s. 408.039, F.S., requiring a court to order a losing party to pay attorney's fees and costs if the losing party is a hospital raises the issue of equal protection. In the bill analysis from AHCA, the issue is described as follows:

Section 4 amends s. 408.039(6)(c), F.S., requiring a court to order a losing hospital to pay the attorneys' fees and costs for the administrative hearing and the judicial appeal. The first concern is a constitutional equal protection issue: the mandatory penalty is assessed only if the losing party is a hospital. Second, the amendment is ambiguous because the sentence does not specifically limit the assessment of fines and costs to parties that have not raised a justiciable issue of law or fact. As written, the amendment could be construed to require the court to order a hospital to pay the attorney's fees and costs, even if its appeal had a justiciable issue of law or fact. Third, the Amendment duplicates sanctions available under the Florida Rules of Appellate Procedure. For example, the Commentary to Fla. R. App. P. 9.300 states: "Courts have the inherent power to quash frivolous appeals, and subdivision (a) guarantees to any party the right to file a motion." In addition, under the current Fla. R. App. P. 9.400 (a) Costs shall be taxed in favor of the prevailing party unless the court orders otherwise. Taxable costs shall include (1) fees for filing and service of process; (2) charges for preparation of the record; (3) bond premiums; and (4) other costs permitted by law. See also Fla. R. App. P. 9.410. Finally, to the extent that the amendment dictates judicial rules of procedure, it raises a state constitutional issue of separation of powers of the legislature and the judiciary. "The supreme court shall adopt rules for the practice and procedure in all courts including the time for seeking appellate review . . . [r]ules of court may be repealed by general law enacted by two-thirds vote of the membership of each house of the legislature." Art. V, § 2(a), Fla. Const.

## V. Economic Impact and Fiscal Note:

### A. Tax/Fee Issues:

The bill increases fees for CON applications. The base fee is increased from $5,000 to $10,000, and the maximum fee is increased from $22,000 to $50,000.

### B. Private Sector Impact:

Applicants for a CON would pay an increased fee. Some health care services and activities that previously would have required a CON review would no longer do so.

### C. Government Sector Impact:

Certificate of Need Revenue

The proposed bill increases CON fees in order to ensure the projected future funding of the CON program. The estimate of $2,970,104 in CON fee revenue for FY 2003 is based on fees for projects reviewed or exempted in 2002, modified by provisions in this bill. The proposed revisions to the type of projects subject to review will change the number of CON applications reviewed by the program, but there is no way to estimate how the proposed reforms will affect the number of applications. No trend data for years before 2002 have been incorporated in the estimate, because 2002 was the first full year of the moratorium on approval of additional nursing home beds.

**DATA FOR 2002:**

| | |
|---|---|
| Projects reviewed | 95 |
| Base fee | $475,000 |
| Capital expenditure fee | $1,276,013 |
| Total CON application fees | $1,751,013 |
| | |
| Exemptions reviewed | 51 |
| Exemption fees | $12,750 |
| 2002 TOTAL CON Fee Revenue | $1,763,763 |

**ESTIMATES FOR FY 2003:**

| | | |
|---|---|---|
| Projects reviewed | 79 | (2002 total, less 16 more exemptions) |
| Base fee | $790,000 | ($10,000 x 79) |
| Capital expenditure fee | $2,163,354 | (0.015 x expenditure, limit $50,000) |
| Total CON application fees | $2,953,354 | |
| | | |
| Exemptions reviewed | 67 | (2002 total, plus 16 more exemptions) |
| Exemption fees | $16,750 | ($250 x 67) |
| 2003 TOTAL CON Fee Revenue | $2,970,104 | |
| Annual estimated revenue from Health Care Facility Fee Assessments: | $683,112 | |

CON application fee revenue increase:

| | | |
|---|---|---|
| Increase in the base fee | $395,000 | |
| Capital expenditure fees for projects with fees over $22,000 | $1,035,918 | (44 projects)* |
| Total increase | $1,430,918 | |

*These 44 projects, with fees capped at $22,000, would generate $968,000. The same projects, capped at $50,000, would generate $2,003,918. The difference is the amount shown: $1,035,918.

Certificate of Need Expense

Estimates for CON program expenses include $1,879,146 in annual transfers to the Department of Health for local health council contracts and contract management positions. Annual expenses of $224,914 for CON and Financial Analysis program staff are based on 17 professional staff and 4 support staff, per the following:

| # FTEs | Pay Band (PG) | Position Title | Annual Salary and Benefits* |
|---|---|---|---|
| 1 | 010 (426) | Reg Analyst Sup | $72,731.30 |
| 1 | 020 (426) | HS & FC Sup | $67,710.19 |
| 1 | 008 (25) | Econ Analyst | $57,171.53 |

| # FTEs | Pay Band (PG) | Position Title | Annual Salary and Benefits* |
|---|---|---|---|
| 6 | 010 (24) | HS & FC | $328,535.32 |
| 2 | 008 (24) | Audit Eval Analyst | $108,750.35 |
| 3 | 008 (23) | Reg Analyst IV | $146,288.93 |
| 1 | 003 | Records Spclst | $32,455.61 |
| 1 | 008 (21) | Reg Analyst II | $37,073.48 |
| 1 | 004 (14) | Accountant I | $34,490.37 |
| 1 | 003 (413) | Staff Assistant | $27,223.20 |
| 3 | 003 (412) | Admin Sec | $107,776.04 |
| 21 | | | $1,020,206.32 |

*Based on actual salaries. No new positions requested. Due to the proposed increase in CON fees, projected expenditures for the program will be covered.

State funding for local health councils would remain at the level provided by the Legislature in 2002-2003.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Amendments:

None.