HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 701 Consumer Health Care Spending Protection
SPONSOR(S): Clarke
TIED BILLS: None. **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care		Rawlins	Collins
2) Health Access and Finance (Sub)			
3) Insurance			
4) Health Appropriations (Sub)			
5) Appropriations			

SUMMARY ANALYSIS

Currently, hospitals and ambulatory surgical centers are required to submit discharge data on a quarterly basis to the Agency for Health Care Administration. The State Center for Health Statistics collects three types of discharge information from 261 inpatient healthcare facilities and Ambulatory Patient Data is collected from 526 freestanding ambulatory surgical centers, lithotripsy centers, cardiac catheterization laboratories, and short-term acute care hospitals. The data is used for information guides and research by many that are interested in the health of Florida residents.

The bill revises the powers and duties of the Agency for Health Care Administration (agency) to include the collection and public dissemination of each licensed facility's uniform schedule of gross charges for any given service or item ("charge master"); the collection and dissemination of readmission rates, complication rates, infection rates, and the use of computerized drug order systems at each licensed facility; the collection of data necessary to risk adjust rates; and the development of an auditing program of the accuracy of health care facility patient bills and payer claims.

The bill specifies that a licensed facility shall provide to patients a written estimate of the reasonably anticipated charges prior to treatment being rendered or admission in a nonemergency situation, make available to a patient or payer records necessary for verification of the patient's bill, and shall provide a written decision to the patient, payer and agency whenever a patient appeals any charges.

According to AHCA, the fiscal impact is $1,317,104 in FY 04-05 and $2,130,400 in FY 05-06 with non-recurring expenditures of $30,652 in FY 04-05 and recurring expenditures of $1,286,452 and $2,130,400 in FY 05-06.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[x]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[x]
3. Expand individual freedom?	Yes[]	No[x]	N/A[]
4. Increase personal responsibility?	Yes[x]	No[]	N/A[]
5. Empower families?	Yes[]x	No[]	N/A[]

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

This bill requires an individual hospital to make public it's "charge master" for public review, limiting the individual freedom of a facility to set prices for goods and services without the scrutiny of the public.

B. EFFECT OF PROPOSED CHANGES:

HB 701

The bill moves forward due dates for licensed health care facilities to report data specified in 59B-9.010 through 59B-9.020, F.A.C. and 59E-7.011 through 59E-7.016, F.A.C. Facilities will need to adjust their internal procedures to meet the new schedule.

The bill requires the agency to add to its website information comparing the readmission rates, complication rates, mortality rates, infection rates, and the use of computerized drug order systems, using risk-adjusted data if applicable, at licensed facilities for not less than 100 inpatient and outpatient diagnostic and therapeutic conditions and procedures.

The agency is required to add to its website a copy of each licensed facility's uniform schedule of gross charges ("charge master") and information on any percentage increase in each facility's gross revenue due to any price increase or decrease in its charge master during the previous 12-month period.

The bill authorizes the agency to audit the accuracy of health care facility bills and payer claims for provider charges of $20, 000 or more, and will require facilities to refund the overpaid amount to any patient or payer who was overcharged within 30 days after the completion of the audit period. The agency will promulgate rules to implement the audit program and refund procedures.

The bill specifies that licensed facilities will provide patients a written estimate of the reasonably anticipated charges prior to treatment being rendered or admission in a nonemergency situation, and facilities are not permitted to charge more than the lesser of $1000 or 20 percent above the original estimate unless unanticipated complications occur.

Licensed facilities will make available to a patient or payer records necessary for verification of the patient's bill, provide notice of the right of a patient to appeal any of the charges in the patient's bill, and shall provide a written decision to the patient, payer and agency whenever a patient appeals any charges.

Licensed facilities will provide public notice of any proposed change to the facility's uniform schedule of gross charges 30 days prior to implementing on their respective Internet websites and in public reception areas.

CURRENT REPORTING REQUIRMENTS

Hospital Inpatient Data

The Hospital Inpatient Data Program within the Agency for Health Care Administration constitutes one component of the data collection activity for the State Center for Health Statistics. This section collects three types of discharge information from 261 inpatient healthcare facilities, as described below:

Acute Care Hospital and Short-term Psychiatric Inpatient Data Collection
Detailed data is collected on a quarterly basis from approximately 239 facilities in accordance with Florida Administrative Code 59E-7. The last revision of this rule became effective on January 1, 2000. For each inpatient discharged from a reporting hospital, 62 data elements are collected via computer diskette or CD-ROM.

Comprehensive Rehabilitation Inpatient Data Collection
Detailed data is collected on a quarterly basis from 14 facilities in accordance with Florida Administrative Code 59E-7.201. The reporting rule went into effect on March 31, 1994. For each inpatient discharged from a comprehensive rehabilitation hospital, 14 data elements are collected via computer diskette or CD-ROM.

Long-term Psychiatric Hospital Data Collection
Aggregate data is collected from 7 long-term psychiatric facilities on a quarterly basis. This information is transmitted via paper forms and entered manually into our information database.

For each facility in the three databases listed above, two additional steps are required to ensure the accuracy of the data. The data is processed through an editing program and the facilities are required to correct data errors. The Chief Executive Officer and Chief Financial Officer of each facility must personally certify the accuracy of their data. Both steps must be completed before the data is permanently added to the database.

Reporting Schedule

Quarter	Time Period Data	Due Date	Final Certification Date
1st	January 1 - March 31	June 1	September 30
2nd	April 1 - June 30	September 1	December 31
3rd	July 1 - September 30	December 1	March 31 the (following year)
4th	October 1 - December 31	March 1	

The State Center for Health Statistics (SCHS) is one of AHCA's sources for health care data and consumer information. With a staff of researchers, analysts and writers, the work includes the collection and dissemination of patient data, along with technical assistance to interested parties. Databases include hospital inpatient, ambulatory outpatient, and other health-related databases.

The State Center for Health Statistics also uses the data to create detailed reports that examine health care trends and outcomes of specific diagnoses in the Health Outcome Series. In addition, the SCHS produces a variety of publications within the Consumer Awareness Series and the Florida HMO Report to assist the public in making well-informed health care decisions.

Hospital data includes detailed patient data collected from acute care hospitals, short-term psychiatric hospitals, and comprehensive rehabilitation hospitals. It also includes aggregate data collected from long-term psychiatric hospitals. The specific data elements being reported quarterly are:

ITEM FIELD NAME	LENGTH	POSITION	DATA TYPE	
1. REPORTING YEAR	4	01 - 04	N	
2.REPORTING QUARTER	1	05	N	
3.HOSPITAL NUMBER	8	06 - 13	N	
4.TYPE OF ADMISSION	1	14	N	
5.SOURCE OF ADMISSION	2	15 - 16	N	
6.DISCHARGE STATUS	2	17 - 18	N	
7.PATIENT RACE	1	19	N	
8.PATIENT SEX	1	20	N	
9.ZIPCODE	5	21 - 25	N	
10.PRINCIPAL DIAGNOSIS CODE	5	26 - 30	A/N	
11.SECONDARY DIAGNOSIS CODES	5	31 - 75	A/N	OCCURS 09 TIMES
12.PRINCIPAL PROCEDURE CODE	4	76 - 79	A/N	
13.SECONDARY PROCEDURE CODES	4	80 - 115	A/N	OCCURS 09 TIMES
14.PRINCIPAL PAYER	1	116	A/N	
15.CHARGES BY REVENUE	7	117 - 284	N	OCCURS 24 TIMES
16.TOTAL GROSS CHARGES	8	285 - 292	N	
17.ATTENDING PHYSICIAN ID	11	293 - 303	A/N	
18.OPERATING PHYSICIAN ID	11	304 - 314	A/N	
19.DRG CODE	3	315 - 317	N	
20. R-DRG CODE * (If Available)	4	318 - 321	N	
21. A-DRG CODE * (If Available)	3	322 - 324	N	
22. SEVERITY OF ILLNESS (APR-DRG) * (If Available)	1	325	N	
23. RISK OF MORTALITY (APR-DRG) * (If Available)	1	326	N	
24. PATIENT AGE AT ADMISSION	3	327 - 329	N	
25. LENGTH OF STAY	4	330 - 333	N	
26. DAY OF WEEK ADMITTED (1 = MONDAY)	1	334	N	
27.DAYS TO PROCEDURE	4	335 - 338	N	
28.PATIENT COUNTY (Florida Only)	2	339 - 340	A/N	
29.PATIENT STATE OF RESIDENCE	2	341 - 342	A/N	
30.ATTENDING PHYSICIAN UPIN * (If Available)	6	343 - 348	A/N	
31.OPERATING PHYSICIAN UPIN * (If Available)	6	349 - 354	A/N	

Ambulatory Patient Data

Ambulatory Patient Data is collected from 526 freestanding ambulatory surgical centers, lithotripsy centers, cardiac catheterization laboratories, and short-term acute care hospitals. The data is used for information guides and research by many that are interested in the health of Florida residents.

Ambulatory patient data is submitted in accordance with section 408.062, Florida Statutes, and Chapter 59B-9, Florida Administrative Code. Data is collected on ambulatory surgeries, radiological services, *lithotripsy, and cardiac catheterization from facilities that have 200 or more patient visits as defined in the administrative code. A patient visit is a face to face encounter between a provider and patient who is not formally admitted as an inpatient in an acute care hospital setting and who is not treated in the emergency room. These events must have a procedure that involves a valid Current Procedural Terminology (CPT) code occurring within the following ranges: 10000 through 69999, 93500 through 93599, and 77000 through 77999. Data is collected on ninety-eight data fields, including patient demographic information, hospital identifying information, payer information, charges, procedures, and diagnosis information. Once the data is edited, it is certified by the reporting facilities' Chief Executive Officer and Chief Financial Officer as accurate and permanently added to our database.

DATA ELEMENT	DESCRIPTION
1. Record Identification Number	A unique twelve-digit code for each record.
2. Report Year	The four-digit year.
3. Report Quarter	Single-digit representing the quarter. 1 - January through March 2 - April through June 3 - July through September 4 - October through December

4. AHCA Facility Identification Number	The eight-digit identification number assigned by the agency for reporting purposes.
5. Patient's Race	A single-digit code for identification of the patient's racial/ethnic background. 1 - American Indian/Eskimo/Aleut 2 - Asian/Pacific Islander 3 - Black 4 - White 5 - White Hispanic 6 - Black Hispanic 7 - Other 8 - No Response
6. Patient's Sex	A single-digit code. 1 - Male 2 - Female 3 - Unknown (Starting with 1/02 data)
7. Patient's Zip Code	A five-digit code of the patient's permanent address Zip code. These codes are included unless the patient's residence is outside of Florida or resides in an area within the state where the population is less than 500 people. 00000 - Unknown Zip Codes 00008 - Other States and Territories 00009 - Not a U.S. resident 00011 Masked Zip Code 32000 to 32499 00012 Masked Zip Code 32500 to 32999 00013 Masked Zip Code 33000 to 33499 00014 Masked Zip Code 33500 to 33999 00015 Masked Zip Code 34000 to 34499 00016 Masked Zip Code 34500 to 34999 00007 - Homeless (Start 1/02, formerly 22222)
8. Principal Payer Code	A single-character, alpha code. A - Medicare B - Medicare HMO C - Medicaid D - Medicaid HMO E - Commercial Insurance F - Commercial HMO G - Commercial PPO H - Workers' Compensation I - CHAMPUS J - VA K - Other State/Local Govt. L - Self pay (no third party coverage) M - Other N - Charity O - Kidcare (Starting 1/03)
9. Principal Diagnosis Code	ICD-9-CM code. Principal diagnosis is the condition established after study, this code is the chief indicator to be used for occasioning the admission of the patient to the facility. Decimal is not included. The decimal in diagnosis codes is implied between the third and fourth digit.

10. Primary Procedure Code	CPT codes between **10000-69999, 77000-77999** and **93500-93599**. Primary procedure is the procedure for which the patient was primarily admitted to the facility. **(Note: 77000-77999, not collected after 1/03)**
11. Primary Procedure Modifier Code (1)	The CPT two-digit modifier code for the primary procedure (optional field). *Available in 1999+*
12. Primary Procedure Modifier Code (2)	The CPT two-digit modifier code (optional field). *Available in 1999+*
13. Attending/Referring Physician ID	The physician having primary responsibility referring or ordering the procedure. Out of State Physicians - Physician's home state two letters Abbreviation and 9's (e.g. NY9999999) Non US Physicians - XX999999999 Unavailable/Unknown - ZZ999999999 Military physicians not licensed in FL - US999999999
14. Attending/Referring Physician UPIN	The attending/referring physician's *Unique Physician Identification Number* (blank as of 1/02).
15. Operating Physician ID	The physician having primary responsibility in performing the procedure. Must be a Florida Licensed Physician.
16. Operating Physician UPIN	The performing physician's Unique Physician Identification Number (blank as of 1/02).
17. Total Charges	Sum of individual charges rounded to the nearest dollar. Up to eight digits.
18. Radiology Professional Fee Indicator	One-digit field indicating whether or not professional fees for radiology services are in included. 1 - Yes 2 - No
19. Radiation therapy visits	This field indicates the total number of visits involved with this event if the primary procedure code is **between 77000-77999**. If the primary procedure code *is not* between 77000-77999, this field will default to 01. **(Note: 77000-77999, not collected after 1/03, field blank)**
20. Principal Procedure Code	ICD-9-CM (Volume III) procedure code. Decimal is not included. The decimal is implied between the third and fourth digit. (Available 1999+, optional field)
21. Patient Status	A two-digit code representing the patient's discharge status from the facility (Optional field, available 1999+, required field starting 1/03, only 01, 02, 03, and 04 valid choices, 05, 06, 07, 08, 20 deleted) 01 - Home 02 - To a short term general hospital 03 - To a skilled nursing facility 04 - To an intermediate care facility

	05 - To another type of institution 06 - Home under care of home health care 07 - Left facility against medical advice (AMA) 08 - Home on IV medications 20 – Expired
22. Patient's Age	Patient's age on date of procedure.
23. Procedure Day of Week	One-digit field indicating day of week procedure was performed. 1 - Monday 2 - Tuesday 3 - Wednesday 4 - Thursday 5 - Friday 6 - Saturday 7 - Sunday
24. Patient's County	County of residence. Florida patients only. The patient's ZIP code is used to reference the U.S. Postal Service database. When a ZIP code crosses county lines, the county code will contain the code of the county in which the greatest portion of that ZIP code lays. 99 - Unknown or non-Florida patient.
25. Patient's State	The patient's state of residence. The patient's ZIP code is used to reference the U.S. Postal Service Standard state or territory. XX - Unknown state of residence.
26. Pharmacy Charges	Total amount associated with pharmacy charges rounded to the nearest dollar.
27. Med/Surgical Supply Charges	Total amount associated with medical and surgical supplies rounded to the nearest dollar.
28. Radiation Oncology Charges	Total amount associated with oncology charges rounded to the nearest dollar.
29. Laboratory Charges	Total amount associated with laboratory charges rounded to the nearest dollar.
30. CT Scan Charges	Total amount associated with CAT rounded to the nearest dollar.
31. Operating Room Charges	Total amount associated with operating room charges rounded to the nearest dollar.
32. Anesthesia Charges	Total amount associated with anesthesia charges rounded to the nearest dollar.
33. MRI Charges	Total amount associated with MRI charges rounded to the nearest dollar.
34. Recovery Room Charges	Total amount associated with recovery room charges rounded to the nearest dollar.

35. Treatment/Observation Room Charges	Total amount associated with treatment and observation charges rounded to the nearest dollar. *Available 1999+*
36. Other Charges	Total amount associated with other charges that do not fit into the other categories rounded to the nearest dollar.
37 - 40 Other Diagnosis Code	Up to four secondary diagnosis codes (ICD-9-CM). Decimal is not included. Decimal implied between the third and fourth digit.

41 - 82 Other Procedure Codes, Modifier 1, Modifier 2 (Repeats 14 times)

Other Procedure Codes — Up to fourteen secondary procedures (CPT or HCPCS).
Other Procedure Modifier Code (1) — The CPT or HCPCS two-digit modifier code (optional field *available 1999+).*
Other Procedure Modifier Code (2) — The CPT or HCPCS two-digit modifier code (optional field *available 1999+).*

Fines

Pursuant to 59E-7.013, Florida Administrative Code, a hospital which refuses to file, fails to timely file, or files false or incomplete reports or other information required to be filed under the provisions of s. 408.08(13), F.S., other Florida Law, or rules adopted thereunder, is subject to administrative penalties. Failure to comply with reporting requirements will also result in the referral of a hospital to the Agency's Bureau of Health Facility Regulation. In addition, any hospital which is delinquent for a reporting deficiency shall be subject to a fine of $100 per day of violation for the first violation, $350 per day of violation for the second violation, and $1000 per day of violation for the third and all subsequent violations. Violations will be considered those activities which necessitate the issuance of an administrative complaint by the agency unless the administrative complaint is withdrawn or final order dismissing the administrative complaint is entered.

Limitations of Current Systems

Although the agency publishes consumer friendly information from the required data submission, the agency does not publish readmission rates, complication rates, mortality rates, infection rates, and use of computerized drug order systems.

Data collected pursuant to 408.061, F.S. does not include information about computerized drug order systems or hospital acquired infections. The data specifications in 59B-9.010 through 59B-9.020, F.A.C. and 59E-7.011 through 59E-7.016, F.A.C. do not require that facilities report complications. However, some complications are reported as a secondary diagnosis if space is available on the discharge record. According to AHCA, it is not known whether readmissions are reported separately or combined into one discharge record.

Deaths occurring during the hospital stay are included in the data collected and published with the following disclaimer, "Discharge status does not measure the quality of care in a hospital." Data collected pursuant to 408.061.061, F.S. does not contain all the information necessary to determine risk of mortality. The data does not include all diagnoses if space is unavailable on the discharge record. The data does not include laboratory and radiology test results, other clinical information contained in the medical record, medical history, do not resuscitate orders, and physician notes that are necessary to fully evaluate risk.

Section 395.301, F.S., specifies that a licensed facility not operated by the state shall submit to the patient an itemized bill upon request within 7 days following release from the licensed facility, and the itemized bill may not include charges of hospital-based physicians if billed separately.

According to AHCA, it is current procedure that when the agency receives a request for assistance from a patient regarding a bill received from a licensed facility, the agency acts to facilitate communication between the facility and patient by requesting a written explanation from the facility.

Comprehensive Health Information System (CHIS) Advisory Council

The State Comprehensive Health Information System (CHIS) Advisory Council advises Agency staff regarding health information and statistics, pursuant to s. 408.05(8) F.S.

The CHIS has assisted in the development of the consumer publications *Choosing A Quality Health Plan: Florida HMO Report* and *Understanding Prescription Drug Costs*. The CHIS has participated in a project to increase awareness and disseminate information on local and state programs combating health disparities. The CHIS has also encouraged the continued expansion of the Agency's consumer-oriented web site, www.FloridaHealthStat.com .

The Florida Health Stat website provides consumers with a wide array of information from the online "Florida Hospital Service Guide" to the Rx Saver. In the Florida Hospital Services Guide 2003 provides consumers with information on hospitalizations for selected conditions and also information on specialized services available at Florida hospitals. The Rx Saver hotlink provides consumer with a link to an online comparison shopping web site which focuses on prescription drugs, health, wellness, and beauty products. The site provides consumers with the necessary information and services to help save money on prescription and drug store item purchases.

The CHIS meets four or more times each year at the AHCA offices in Tallahassee or various locations in the state. Meetings are noticed in the Florida Administrative Weekly and open to the public.

C. SECTION DIRECTORY:

Section 1. Provides a popular name.

Section 2. Provides the purpose of the act.

Section 3. Amends s. 408.061, F.S., revises a requirement for submission of health care data.

Section 4. Amends s. 395.10973,F.S., revises powers and duties of the Agency for Health Care Administration to include patient charge and performance outcome reporting and reporting changes in each facility's charge master; requires the agency to provide such information to the public and implement effective methods for making public disclosure; requires the agency to annually report findings to the Governor and Legislature; requires the development of an auditing program for patient bills and payor claims over a certain dollar amount; provides for fines for billing errors exceeding a specified threshold; and requires the agency to adopt certain rules.

Section 5. Amends s. 395.301, F.S., requires disclosure to nonemergency patients of a good faith estimate of anticipated charges; prohibits a facility from requiring that a patient sign certain forms as a condition of admission or provision of service; provides conditions under which a patient shall not be required to pay amounts exceeding the original estimate; requires patient notification of right to appeal charges in an itemized bill and of any interest applied to such charges; requires the facility to disclose information necessary to verify the accuracy of the bill; requires a method for appealing charges on the bill; requiring the facility to maintain a log of all such appeals; and requires the facility to file annually with the agency a copy of its charge master and to disclose to the agency and the public any changes to the charge master.

Section 6. Provides that the act shall take effect on July 1, 2004.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   According to AHCA, the fiscal impact is $1,317,104 in FY 04-05 and $2,130,400 in FY 05-06 with non-recurring expenditures of $30,652 in FY 04-05 and recurring expenditures of $1,286,452 and $2,130,400 in FY 05-06.

   Recurring expenditures include salaries and expenses for 10 FTEs. These include 5 FTEs to perform audits of the accuracy of health care facility patient bills and payer claims and administer refunds, 1 FTE to manage contracts to produce performance outcomes for each licensed facility, and 1 FTE to perform analyses related to facility charges, charge master updates and provide technical oversight. Three (3) FTE will perform the legal duties associated with this bill. Recurring salary and benefits are $440,702 in FY 04-05 and $530,400 in FY 05-06.

   The legislation affects approximately 870 facilities (270 hospitals and 600 ambulatory surgical centers). The hospital audits will require 100 man-hours which includes 24 hours of preparation, 24 hours on-site auditing and 52 hours to finalize the audit including determination of facility error rate, preparing documentation related to fines, if any, and determination of patient or payers who will receive a refund. Annually 80 to 90 audits will be conducted so that each licensed hospital will be audited at least once every 3 years as required by the bill. Total man-hours are 100 hours per hospital X 85 hospitals or 8500 man-hours per year. Given that one (1) FTE equals approximately 1,854 hours annually this is equivalent to 8500 / 1854 hours = 4.6 FTEs therefore four Regulatory Analysts (class code 1644 and PG 023) and one Regulatory Analyst Supervisor (class code 1645 and PG 426) are required. Additional auditors will be required if the number of licensed hospitals increase or the number of ambulatory surgical centers subject to audits increase if their charges exceed $20,000 as specified in the proposed bill.

   AHCA estimates 10% of the ambulatory surgical center audits (60) will result in a filing of an administrative case by the Agency. Approximately 60% of the cases filed (36) may result in an administrative hearing. Assuming an average of 2.5 days hearing for each case (20 hours), 8 days working time (64 hours) for preparation of pleadings, depositions, travel, and correspondence on each case, this equates to 84 X 36= 3024 hours. Other sources of legal tasks and litigation come from rule development, rule challenges, waivers, declaratory statements, public records requests, and subpoenas from cases in which the Agency is not a party. Annually, at least one administrative case is anticipated from these activities (84 hours) and at least 60 hours are required for these duties. Two Senior Attorneys (class code 7738, PG 230) are required. Experience has shown that we cannot hire attorneys for less than 10 percent above the minimum, and expect to retain them long enough to justify the training that they receive from the Agency. Six lap top computers will be needed at the Agency standard allowance of $1,468 (OCO funds) due to travel and additional litigation workload as well as a docking station for the computer when the attorney is working from headquarters in Tallahassee, the cost is $182 for per Docking Station and Components. One (1) Administrative Assistant I (class code 709, PG 15) is added to handle the additional administrative tasks associated with the legal work.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Licensed hospitals and ambulatory surgical centers will incur additional costs to report their charge master and other data to the agency and provide a written estimate of anticipated charges to each patient prior to treatment in an elective situation and for other notification requirements.

Employers and the general population may benefit from additional information about licensed hospital and ambulatory surgical center prices

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides the Agency for Health Care Administration with specific rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES