HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 763 Critical Access Hospitals
SPONSOR(S): Troutman and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1472

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	8 Y, 0 N	Hamrick	Mitchell
2) Health & Families Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 763 provides that a critical access hospital is not required to have treatment facilities for surgery, obstetrical care, or similar services as long as they maintain the federal Medicare designation as a critical access hospital. It provides an exemption to critical access hospitals from the state hospital licensure requirement to offer surgical services. Obstetrical care and similar services are already optional services for hospitals licensed under Chapter 395, F.S.

The bill requires critical access hospitals to meet federal criteria provided for in the Social Security Act including certification by the Secretary of Health and Human Services. The bill updates the definition of a "rural hospital" to include a new definition for a critical access hospital and renumbers the corresponding definitions within statute.

This act shall take effect July 1, 2005.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited Government-The bill reduces state restrictions on hospitals in rural areas to enable them to continue to provide needed services. The bill may limit surgical and obstetrical services to residents in rural areas.

B. EFFECT OF PROPOSED CHANGES:

HB 763 provides that a critical access hospital is not required to have treatment facilities for surgery, obstetrical care, or similar services as long as they maintain their designation as a federal defined critical access hospital. This legislation will allow critical access hospitals to utilize the space they are required to maintain for surgery for other things such as expanding the size of emergency rooms. Under federal requirements, a critical access hospital is not required to provide surgery and obstetrical services.[1]

Currently s. 395.002, F.S., requires every hospital to regularly make available treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

The bill grants hospitals having or receiving Medicare critical access hospital designation an exemption from the state licensure requirement to offer surgical services. Obstetrical care and similar services are currently optional services for hospitals licensed under Chapter 395, F.S.

The bill updates the definition of a “rural hospital” to include a new definition for a critical access hospital.

The bill requires a critical access hospital to meet federal requirements provided in the Social Security Act, including certification by the Secretary of Health and Human Services.

BACKGROUND ON THE CURRENT SITUATION

Currently, state statute (s. 395.002, F.S.) requires a hospital to “regularly make available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.”

Under federal requirements a critical access hospital must provide the basic services necessary to their community; maintain a low average length of stay, and network with other healthcare providers to ensure that the healthcare needs of the community are met.

Balanced Budget Act of 1997

The Balanced Budget Act of 1997 (BBA) replaced the Essential Access Hospital/Rural Primary Care Hospital (EACH/RPCH) program with a new Medicare Rural Hospital Flexibility Program that is available to any interested state that meets federal and state requirements.

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[1] See 42 U.S.C., s. 1820 (c) of the Social Security Act.

The Medicare Rural Hospital Flexibility Program provides funding to State Governments to strengthen rural health by:

- Allowing small hospitals the flexibility to reconfigure operations and be licensed as critical access hospital.
- Offering cost-based reimbursement for Medicare acute inpatient and outpatient services.
- Encouraging the development of rural-centric health networks.
- Offering grants to States to help implement a critical access hospital program in the context of broader initiatives to strengthen the rural health care infrastructure.

The Medicare Rural Hospital Flexibility Program allows a critical access hospital to receive cost-based reimbursement from Medicare, which has a higher reimbursement rate and provides greater flexibility from federal rules and regulations. In order for a rural hospital to receive these benefits a rural hospital must convert to a critical access hospital.[2]

The reimbursement that a critical access hospital can receive is intended to improve their financial performance and thereby reduce hospital closures. These hospitals are certified under a different set of Medicare Conditions of Participation that are more flexible than the conditions of participation for acute care hospitals.

Federal law permits a state to establish a Medicare rural hospital flexibility program, if it develops at least

- One rural health network in the state; and
- Designates at least one facility as a critical access hospital.

Rural Hospitals

Currently section 408.07 F.S., defines “rural hospital” as an acute care hospital having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of no greater than 100 persons per square mile;

2. An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

4. A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the State Center for Health Statistics at the Agency for Health Care Administration; or

5. A hospital designated as a critical access hospital by the Department of Health in accordance with federal regulations and state requirements.

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[2] Centers for Medicare and Medicaid Services, *Fact Sheet*, December 2004.

A rural hospital licensed under chapter 395, F.S., with 25 or fewer licensed beds may apply to the Department of Health's Office of Rural Health for critical access hospital designation.

Critical Access Hospitals

The Social Security Act establishes the federal criteria for state designation of a facility as a critical access hospital.[3]

In order for a hospital to be considered a critical access hospital it must be certified by the Secretary of Health and Human Services as a critical access hospital.[4] The Secretary certifies a critical access hospital when the hospital is:

- Located in a State that has an established a designated critical access hospital within the guidelines of the Medicare Rural Hospital Flexibility Program.
- Designated as a critical access hospital by the State in which it is located; and
- Meets such other criteria as the Secretary may require.

A state may designate a facility as a critical access hospital if the facility:

- Is a hospital that is located in a county in a rural area and that is located more than a 35-mile drive from a hospital, or a health clinic or health center, or is certified by the state as being a necessary provider of health care services to residents in the area;

- Makes available 24-hour emergency care services that the state determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

- Provides not more than 15 (or, in the case of a facility with extended care swing beds, 25) acute care inpatient beds for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;

- Meets rural hospital staffing requirements, except that:

    - The facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

    - The facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis;

    - The inpatient care described may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

- Meets the federal requirements for a quality assessment and performance improvement program, and appropriate procedures for review of utilization of services, that are required for rural health clinics and federally qualified health centers.

[3] See 42 U.S.C., s. 1395i-4 (c) of the Social Security Act.
[4] See 42 U.S.C., s. 1395x (mm) (1) of the Social Security Act.

Critical Access Hospitals in Florida

As of February 15, 2005, 11 out of 275 licensed Florida hospitals are designated as critical access hospitals. These 11 critical access hospitals are:

1) Calhoun-Liberty Hospital (Blountstown)
2) Campbellton-Graceville Hospital (Graceville)
3) Doctor's Memorial Hospital, Bonifay (Bonifay)
4) Florida Hospital Wauchula (Wauchula)
5) Gadsden Community Hospital (Quincy)
6) George E. Weems Memorial Hospital (Apalachicola)
7) Hendry Regional Medical Center (Clewiston)
8) Northwest Florida Community Hospital (Chipley)
9) Lake Butler Hospital (Lake Butler)
10) Shands at Live Oak (Live Oak)
11) Shands at Starke (Starke)

Only two additional hospitals are potentially eligible and have indicated some interest in the program. The majority of critical access hospitals are located in the Panhandle or north Florida, with one facility in south Florida.

All of Florida's critical access hospitals are qualified for this designation as a critical access hospital via a federal provision waiving the distance requirements (a critical access hospital must be more than 35 miles away from the nearest hospital) by certifying the facility as a "necessary provider" of health services to residents in the area. The 35-mile limit waiver and designation as a "necessary provider" provision will sunset effective January 1, 2006, per Medicare Prescription Drug, Improvement and Modernization Act of 2003, §405(h). Florida hospitals designated as critical access hospitals prior to January 1, 2006, will be grandfathered, but no other currently licensed Florida hospital will qualify after that date.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.002 F.S., relating to definitions of hospital licensing and regulation to allow an exception for critical access hospitals.
Section 2. Amends s. 408.07 F.S., relating to definitions for health facilities and services to add a definition of critical access hospital.
Section 3. Amends s. 395.003 F.S., relating to licensure a hospital, ambulatory surgical center, or mobile surgical facility to change a cross reference.
Section 4. Amends s. 408.061 F.S., relating to data collection by health care facilities, health care providers, and health insurers to change a cross reference.
Section 5. Amends s. 458.345 F.S., relating to the registration of a resident physician, assistant resident physician, intern, and fellow to practice in a teaching hospital to change a cross reference.
Section 6. Amends s. 459.021 F.S., relating to the registration of as a resident physician of osteopath, assistant resident physician of osteopath, intern, and fellow to practice in a teaching hospital to change a cross reference.
Section 7. Provides that the bill shall take effect July 1, 2005.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate. See D. Fiscal Comments.

D. FISCAL COMMENTS:

Some hospitals may reduce surgical care services in rural areas. Critical access hospitals that decide to drop surgical care would not incur the costs associated with maintaining and providing a surgical unit. Patients in these areas would have to receive these services elsewhere.

A review of the data reported to ACHA indicates that 9 critical access hospitals performed inpatient surgical procedures for the period July 2003-June 2004, for a total of 371 procedures, or an average of 30 per month.

The facility performing the least number of surgical procedures performed 6 surgeries during the 12-month period while the facility performing the most reported 131 surgical procedures. Four critical access hospitals reported performing outpatient surgeries for an average of 151 per month.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or 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 revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Section 395.602(2)(e)(6), F.S., provides a definition of a rural hospital to include a hospital designated by the Department of Health as a critical access hospital. Section 408.07, F.S., provides an identical definition which is amended in this bill to state that a hospital is a critical access hospital if it meets the

definition provided in the Social Security Act and is certified by the Secretary of Health and Human Services. The Department of Health would like to amend s. 395.602 (2)(e)(6), F.S., to reference the language used in s. 408.07, F.S.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 23, 2005, the Health Care Regulation Committee favorably passed HB 763.