HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 763 CS 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	9 Y, 0 N, w/CS	Hamrick	Moore
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 763 CS 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 the US Department 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.

The bill also extends the moratorium on the authorization of hospital offsite emergency departments to July 1, 2006.

The bill takes 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 CS 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]

The bill amends the definition of "intensive residential treatment programs for children and adolescents" by removing specific reference to the Joint Commission on Accreditation of Healthcare Organizations. The definition now references the definition in s. 395.002(1), F.S., for "accrediting organizations," which includes the Joint Commission, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care.

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 the US Department of Health and Human Services.

The bill also extends the moratorium on the authorization of hospital offsite emergency departments to July 1, 2006.

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.

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

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.

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 s. 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 (AHCA); or

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

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

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 the US Department 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 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

[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.

- 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.

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.

Freestanding Emergency Departments

According to the Agency for Health Care Administration (AHCA), acute care hospitals have diversified their services in recent decades, particularly in the 1990s. The expansion of managed care in the 1990s led hospitals to eliminate unnecessary inpatient stays in favor of greater use of outpatient services. The overnight inpatient stay has become shorter and hospitals have increased their involvement with outpatient surgery, outpatient diagnostic imaging, outpatient clinical laboratories, freestanding urgent care centers, outpatient rehabilitation centers and outpatient clinic service. The development of freestanding emergency departments is part of this trend toward more hospital-based outpatient services.[5]

Emergency room patients are considered outpatients and are billed as such. The Centers for Medicare and Medicaid Services (CMS), which establishes federal payment policies for the reimbursement of hospital services, pays for emergency department patients as 'outpatients'.

[5] *Freestanding Emergency Departments*. Florida Agency for Health Care Administration. December 2004.

CMS recognizes both onsite and freestanding emergency departments. With respect to Medicare, participating hospitals' treatment of individuals with emergency medical conditions, on September 9, 2003, CMS published 42 CFR Parts 413, 482, and 489 Medicare program; Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions; Final Rule. This rule defines "dedicated emergency department" at 489.24(b) as: "any department or facility of the hospital regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

1) It is licensed by the state in which it is located under applicable state law as an emergency department;
2) It is held out to the public (by name, posted signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment…"

Section 395.003(2)(d), F.S., specifies that "the agency shall, at the request of a licensee, issue a single license to a licensee for facilities located on separate premises. Such a license shall specifically state the location of the facilities, and the licensed beds available on each separate premises…." Rule 59A-3.203(f), F.A.C., related to hospital licensure, allows for the "addition of beds or offsite facilities to a hospital's license..." According to AHCA, approximately 70 of Florida's 270 licensed hospitals list offsite outpatient facilities on their licenses. The Legislature removed the review of hospital proposals for new outpatient services from Florida's Certificate-of-Need program in 1987. AHCA does not regulate the establishment of outpatient services or the mix of outpatient services a hospital can provide.

In April 2002, AHCA approved the addition of an offsite, freestanding emergency department to the license of Munroe Regional Medical Center (MRMC) in Ocala. The freestanding emergency department is located approximately 12 miles to the southwest of the MRMC inpatient facility. The inpatient facility also includes a traditional, onsite emergency department.

In October 2003, AHCA approved the state's second freestanding emergency department for Ft. Walton Beach Medical Center. The offsite emergency department is located in Destin, approximately 12 miles to the east of the main inpatient facility.

AHCA published a proposed administrative rule in September 2003. The proposed rule was challenged and later withdrawn by the agency.

The 2004 Legislature required AHCA to submit a report to the President of the Senate and the Speaker of the House of Representatives by December 31, 2004, recommending whether it is in the public interest to allow a hospital to license or operate an emergency department located off the premises of the hospital. The Legislature imposed a moratorium on the authorization of additional emergency departments located off the premises of licensed hospitals until July 1, 2005.

The report issued in December 2004, concluded that:

- It is in the public interest to allow hospitals in certain unique communities to develop freestanding emergency departments and to have them listed separately on their license.
- As long as the hospital understands that the freestanding emergency department will be regulated identically to the onsite emergency department, there is no reason to have a concern about quality of care.
- The Legislature should add freestanding emergency departments as a project subject to Certificate-of-Need review by AHCA.

The report made two recommendations:

- Allow the development of freestanding emergency departments, adding them to projects subject to Certificate-of-Need pursuant to s. 408.036(1), Florida Statutes.
- Direct AHCA to promulgate rules designating that the regulatory criteria for onsite emergency departments also apply to offsite freestanding emergency departments.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.002, F.S., to revise the definition of "hospital" and "intensive residential treatment programs for children and adolescents."
Section 2. Amends s. 395.003, F.S., to extend the moratorium on approval of hospital freestanding emergency departments and corrects a cross reference.
Section 3. Amends s. 395.602, F.S., to revise the definition of rural hospital.
Section 4. Amends s. 408.061, F.S., to provide the definition of critical access hospital and revise the definition of a rural hospital.
Section 5. Amends s. 408.07, F.S., relating to definitions for health facilities and services to add a definition of critical access hospital and rural hospital.
Section 6. 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 7. Amends s. 459.021, F.S., relating to the registration of 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 8. Provides the bill will 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:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On April 6, 2004, the Health and Families Council adopted 2 amendments sponsored by Representative Troutman and 3 amendments sponsored by Representative Benson. The Committee Substitute differs from the original bill as filed in that the Committee Substitute:
Amendment 1-Extends the moratorium on the authorization of hospital offsite emergency departments to July 1, 2006.
Amendment 2-Amends s. 395.602 (2)(e)6., F.S., to reference the language used in s. 408.07, F.S to define a critical access hospital.
Amendment 3-Amends the definition of “intensive residential treatment programs for children and adolescents” by removing specific reference to the Joint Commission on Accreditation of Healthcare Organizations. The definition now references the definition of “accrediting organizations,” which includes the Joint Commission, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, and the Accreditation Association for Ambulatory Health Care.
Amendment 4-Amends the licensure requirement for an intensive residential treatment program by removing the Joint Commission and references the definition for “accrediting organizations.”
Amendment 5-Is a technical amendment, which substitutes a period for a comma and adds an “and”.

This analysis is drafted to the committee substitute.