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.)

Prepared By: Health Care Committee

BILL:	CS/SB 2176
INTRODUCER:	Health Care Committee and Senator Peaden
SUBJECT:	Rural Hospitals
DATE:	March 23, 2006
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Bedford	Wilson	HE	**Fav/CS**
2.			CA	**Withdrawn**
3.			HA	
4.			WM	
5.			RC	**Withdrawn**
6.				

I. Summary:

The bill amends various sections of the Florida Statutes with respect to rural hospitals and rural health care delivery systems in Florida. The bill revises the purpose and functions of the Office of Rural Health (ORH or office) in the Department of Health (DOH or department) to include fostering the development of service-delivery systems and cooperative agreements to enhance the provision of high-quality health care services in rural areas. It requires the Secretary of Health Care Administration and the Secretary of Health to each appoint not more than 5 members to an advisory council to advise the office. This bill requires ORH to annually submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives summarizing the activities of ORH.

This bill revises legislative findings and intent with respect to rural health networks. Rural health network is redefined as a nonprofit legal entity whose principal place of business is in a rural county, whose members consist of rural and urban health care providers and others, and which is established to plan, develop, and organize the delivery of health care services on a cooperative basis in a rural area. The bill establishes requirements for membership in rural health networks. The functions of rural health networks and the services to be provided by provider members are outlined. The bill requires each rural health network to design and implement a long-range development plan for an integrated system of health care. The bill requires coordination between rural health networks and area health education centers, health planning councils, and regional education consortia. The bill establishes requirements for funding rural health networks and provides performance standards. This bill creates the rural health infrastructure development grant program and defines what projects may be funded through this program. This bill requires ORH to monitor the rural health networks and authorizes DOH to establish rules governing rural health network grant programs and performance standards.

This bill amends the rural hospital licensure statutes to define the term critical access hospital, delete the terms emergency care hospital and essential access community hospital, and revise the definition of rural primary care hospital. Emergency care hospitals and essential access community hospitals are removed from the licensure requirements. This bill specifies special conditions for rural primary care hospitals.

The bill specifies the purposes of rural hospital capital improvement grants and modifies the conditions for receiving those grants. It deletes the requirement for a minimum grant for every rural hospital. This bill requires the Agency for Health Care Administration (AHCA or agency) to pay certain physicians a bonus for Medicaid physician services provided within a rural county. The bill requires a study to be conducted by the Office of Program Policy Analysis and Government Accountability on the financing options for replacing or changing the use of certain rural hospitals, with a report due to the Legislature by a specified date.

This bill substantially amends the following sections of the Florida Statutes: 381.0405, 381.0406, 395.602, 395.603, 395.604, 395.6061, 408.07, 409.908, 409.9116, and 1009.65.

The bill repeals s. 395.605, F.S

The bill creates one unnumbered section of law.

II. Present Situation:

Rural Counties in Florida

Although Florida is the fourth most populous state in the U.S., it has substantial areas that are rural both by definition and use. Florida is the ninth largest producer of farm commodities in the nation with 30 percent of its total land area in farmland. An additional 10 percent of the state is set aside for recreation and preservation in the form of state and federal parks, forests, wilderness areas, wildlife preserves, and national seashores.

As of the 2000 U.S. Census, 33 of Florida's 67 counties are considered rural based on the statutory definition of "an area with a population density of less than 100 individuals per square mile or an area defined by the most recent United States Census as rural."[1] In area, these 33 counties cover just over 42 percent of Florida's nearly 54,000 square miles of land area. Rural counties are located primarily in the Florida Panhandle, north central Florida, the south central portion of the state, and the Florida Keys.

As of 2000, approximately 1.1 million of Florida's 16 million residents live in rural counties.[2] Portions of other Florida counties also contain large, rural areas but are not classified as rural. Many of the counties bordering on the Atlantic Ocean and Gulf of Mexico have populations

[1] These rural counties include: Baker, Bradford, Calhoun, Columbia, DeSoto, Dixie, Franklin, Gadsden, Gilchrist, Glades, Gulf, Hamilton, Hardee, Hendry, Highlands, Holmes, Jackson, Jefferson, Lafayette, Levy, Liberty, Madison, Monroe, Nassau, Okeechobee, Putnam, Sumter, Suwannee, Taylor, Union, Wakulla, Walton, and Washington.
[2] U.S. Census Bureau, Census 2000 and 1990 Census of Population and Housing. *Florida Fun Facts*. Found at http://factfinder.census.gov/home/en/kids/funfacts/florida.html (last visited on March 20, 2006)

concentrated near the coast, but thinly populated interiors (e.g., Collier, Palm Beach, or Escambia counties).

Rural Health Care

Many of the problems of providing health services in rural areas are rooted in the way health care has developed and is provided in the United States. Health care in the U.S. is unique in that health care providers function as independent businesses in a mixed economy of public, private, for-profit, and not-for-profit government and religious entities. This market-based approach to health care creates a number of structural barriers to receiving care and results in a fragmented non-system of health care delivery.

Health and health care are aspects of rural life that are often considered secondary given the multitude of other problems encountered in rural America. But health and health care are as closely linked to the economic well-being of rural areas as they are to that of urban areas. A healthy population is necessary to provide the workforce required to build homes and to deliver the services required for everyday life. Moreover, health services are important parts of the economic life of these areas in that they employ significant numbers of rural residents and contribute to the financial stability of their communities.

In general, compared with urban Americans, rural people are not as healthy. For instance, rural communities have:

- Higher infant and maternal morbidity rates;
- Higher rates of chronic illnesses, such as hypertension and cardiovascular disease;
- Problems unique to rural occupations, such as machinery accidents, skin cancer from sun exposure, and breathing problems from exposure to agricultural chemicals;
- High rates of mental illness and stress-related diseases (especially among the rural poor);
- Lower rates of having health insurance with pharmacy coverage plans; and,
- Twenty-five percent higher prescription drug expenditures compared to urban-based counterparts.[3]

Rural adults are less likely than urban adults to engage in preventive behaviors such as regular blood pressure checks, Pap smears, or breast examinations. Higher percentages of rural adults engage in high-risk lifestyle behaviors such as smoking, not wearing seat belts and not engaging in regular exercise - all of which have implications for a person's health status. Some speculate that these pervasive behaviors among rural residents are associated with inadequate health promotion education, that often is delivered by inadequately prepared health professionals. Other experts propose that the health promoting information that is disseminated may not be culturally appropriate for rural consumers. Both of these factors can contribute to a person not modifying risky lifestyle behaviors.

[3] Gamm, L., Hutchison, L., Dabney, B., & Dorsey, A. (2003a). *Rural healthy people 2010: A companion Document to Healthy People 2010 (Vol. I).* College Station, TX: Texas A & M University.

Rural Health Infrastructure and Outcomes

There is a relative disparity between the health of Florida's urban and rural residents and their access to health care services. This disparity is an ongoing concern for policymakers and stakeholders. As evidence of these concerns, Florida has been involved in a variety of efforts to address the health care needs of rural residents over the past half-century. These efforts include the:

- Hill-Burton program that provided federal funding for the construction of community hospitals during the 1950s and 60s;
- Establishment of state and regional comprehensive health planning and health systems agencies from the 1960s through 1985;
- Regional health planning efforts by local health councils from 1985 to present;
- Establishment of the Office of Rural Health in 1991;
- Authorization of rural health networks in 1993;
- Implementation of the federal critical access hospital program in 1997;
- Provision of rural emergency medical and hospital capital improvement grants to sustain essential services in rural communities and enhance the development of coordinated health care delivery in rural communities; and
- Legislative approval in 2000, for a new medical school at Florida State University to train primary care physicians to practice in underserved and rural communities.

While Florida has made considerable progress through these efforts, much still needs to be done to ensure that rural residents continue to have reasonable access to quality health services. These investments in Florida's health care infrastructure have not provided the significant return on investment that was anticipated. Despite advances over the past decade in reducing morbidity and mortality, the health of Florida's rural population remains at greater risk for selected conditions than its urban counterpart. Rural Florida residents have a higher mortality rate than urban residents for motor vehicle accidents, infant mortality, diabetes, Alzheimer's Disease, and chronic lower respiratory disease. The infant death rate for Florida's rural counties increased for 1999 and 2000 while Florida's overall rate declined.

Insufficient Health Services

Health care providers in Florida's rural areas continue to face major challenges in establishing and maintaining services. The relative isolation, lack of community resources, and high proportion of uninsured and government funded patients make rural health care delivery for many health care providers a continual struggle to maintain financial solvency. Some of Florida's 29 rural hospitals lack sufficient patient revenue to meet operating expenses, forcing the hospitals to make decisions about reducing or eliminating essential health services. Although recent federal and state programs have eased the financial burden for rural hospitals, future attempts to curb government health spending will pose an ongoing challenge for rural providers.

Lack of Financial Access to Health Care

Financial access to health care services is an ongoing problem for those Florida citizens without employment or the means to purchase health care services. The problem is particularly acute in rural areas where educational levels are low, employment opportunities are limited, and a significant proportion of the population lives in economic poverty. Because the private market for health care services in rural areas is inadequate to support essential health services, public programs such as Medicare, Medicaid, and KidCare try to fill the gap to provide access to health care for selected population groups and those persons at or near poverty. Despite these programs, approximately 20 percent of the adult population in rural areas remains without health insurance coverage. This is primarily because during economic downturns, rural areas have higher levels of unemployment, and correspondingly, rural residents have a greater difficulty obtaining health insurance coverage than persons in urban settings.

Twenty of Florida's 33 rural counties had an average annual unemployment rate in 2001 above the state average of 4.8 percent. Continued government support and financing of health care services is required to address market deficiencies and ensure that rural residents have physical and financial access to necessary health services.

Shortages of Health Care Providers

The reliance on market forces as the primary means to distribute health care professionals continues to produce a maldistribution of health care professionals in Florida. The situation is characterized by surpluses of physicians in urban areas and widespread shortages in rural areas.

Although state and federal efforts such as the National Health Service Corps and nursing loans and scholarships have helped to alleviate shortages of health professionals in some communities, 64 of the 67 counties in the state have an area or a population designated as a Health Professional Shortage Area; 65 of Florida's counties have designated Medically Underserved Areas or Populations; 49 counties have Dental Health Professional Shortage Areas; and 36 counties have Mental Health Professional Shortage Areas.

Office of Rural Health

Florida's Office of Rural Health (ORH or office) is located within the Department of Health (DOH or department) and has been the focal point for the development and administration of Florida's rural health policy since 1991 (s. 381.0405, F.S.). Currently, the office is staffed by two full-time positions: the Director of the Office of Rural Health and a Critical Access Hospital Coordinator. The office has an administrative assistant who also works for another program.

The office's mission is to actively foster the provision of health care services in rural areas and serve as a catalyst for improved health services to citizens in rural areas of the state. The office works with other state and federal programs as Florida's rural health representative, disseminates information on Florida's rural health services, and acquires and distributes state and federal funds to assist in maintaining a coordinated and sustainable system of rural health services. Specifically, ORH is assigned the responsibility for the following:

- Coordinating with other state programs and agencies (e.g., Medical Quality Assurance, Emergency Medical Services, Planning, Evaluation and Data Analysis within the larger Department of Health; the Agency for Health Care Administration; the Department of Children and Families), area health education centers, state universities, and rural health interest groups such as the Florida Hospital Association and the Florida Rural Health Association;
- Providing technical assistance to rural providers;
- Collecting and disseminating information about rural health;
- Acquiring grant funds for rural health programs and providers; and
- Working to improve access to emergency medical services in rural areas.

Since 1997, the office has been focused on three key programs within rural health; the Medicare Rural Hospital Flexibility Program, the Rural Hospital Capital Improvement Grant Program, and the development and support of the state's statutory rural health networks.

Medicare Rural Hospital Flexibility Program

Beginning with the Balanced Budget Act of 1997 (Public Law 105-33), the U.S. Congress started a process designed to improve the financial viability of small, rural hospitals. The initial program was "fine-tuned" through provisions of the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000. Rural hospitals suffer not only from small, relatively poor patient populations but they have also been penalized by Medicare which provided service reimbursement rates lower than those provided to urban hospitals for the same services. Oftentimes, the reimbursement was for less than the actual cost of care, thereby actually costing the hospital money. This is especially important for rural hospitals since they have proportionally more Medicare patients than do urban hospitals. The Medicare Rural Hospital Flexibility Program was intended to rectify some of these imbalances. The program presented a new reimbursement category for rural hospitals, that of the Critical Access Hospital. This new type of hospital is an acute care facility that provides emergency, outpatient, and limited inpatient services.

Critical Access Hospitals may have no more than 15 beds with another 10 "swing beds" allowed (these are inpatient beds which may also be used for other services such as part of a Skilled Nursing Facility). Average annual length of stay for all inpatients must be 96 hours (4 days) or less. Emergency services must be available 24 hours per day, seven days per week. Certain other regulations must be followed concerning physical location, relations with larger, tertiary care hospitals, and credentialing and quality assurance procedures. In return, these hospitals will be reimbursed on a "reasonable cost" basis for inpatient, outpatient, and laboratory services delivered to Medicare patients. For small hospitals with significant numbers of Medicare patients this, at the very least, allows them to stop losing money on services delivered. The office oversees the conversion applications, financial feasibility studies; community needs assessments, and conversion of rural hospitals to Critical Access status.

The Medicare Rural Hospital Flexibility Program also contains a grant program, administered by the Federal Office of Rural Health Policy. Grants of up to $775,000 per state per year are provided to improve rural health systems with an emphasis on improving Emergency Medical Services. The office applies for, receives, and administers these grant funds.

Rural Hospital Capital Improvement Grant Program

In 1999, the Florida Legislature established the rural hospital capital improvement grant program through which statutory rural hospitals, as defined by s. 395.602, F.S., may apply for financial assistance to "acquire, repair, improve, or upgrade systems, facilities, or equipment" (s. 395.6061, F.S.). Upon fulfilling basic application conditions, each qualifying rural hospital receives a minimum of $100,000 per year for such capital improvements, if funds have been appropriated by the Legislature. The application, review, and administration procedures for this program are responsibilities of ORH.

Rural Health Networks

In 1993, the Legislature established the basis for the formation of cooperative, nonprofit health networks in rural areas of Florida in s. 381.0406, F.S. These organizations were directed to address the fundamental problems in rural health: inadequate financing, problems with recruitment and retention of health personnel, and migration of patients from rural providers to urban providers, thus undermining the abilities of rural hospitals to continue to provide timely and effective care. The networks are intended to integrate public and private health resources, to emphasize cooperation over competition, and to increase usage of statutory rural hospitals in an effort to support rural economies.

Nine rural health networks have been formed in Florida. Currently, these cover 28 of the 33 rural counties as well as parts of 13 non-rural counties. The department has the responsibility for certifying the networks and for distributing grant funds to eligible participants. Florida's rural health networks have been in operation since 1993 and serve as the regional organizations responsible for carrying out much of Florida's rural health policy. Rural health networks work closely with rural communities and providers to encourage, organize, and coordinate actions to provide increased health access and improved health care services to rural communities.

Rural Hospitals/Rural Primary Care Hospitals

There are currently 29 operating statutory rural hospitals in Florida; two rural hospitals recently closed. These hospitals serve as the nucleus for the organization and delivery of care in their respective communities. Twelve rural hospitals have converted to critical access hospitals under the Medicare Rural Hospital Flexibility Grant program. One of these recently closed. This program allows these hospitals to receive cost-based Medicare reimbursement and continue to provide essential health services to rural residents.

The mission of the rural hospitals is to provide appropriate, life-saving health care in rural/isolated areas of the state. Rural hospitals are located in rural counties having a population density of less than 100 persons per square mile. By definition, rural hospitals have 100 or fewer beds. Nineteen rural hospitals have 50 or fewer beds. The majority of rural hospitals are located in the Panhandle. Rural hospitals represent approximately two percent of hospital admissions statewide. Typically they operate at a loss and are subsidized by the state in an attempt to compensate for the cost of operation.

There is a growing need for telemedicine services between rural hospitals and specialists to provide remote consultation for treating individual patients. Many rural hospitals do not have full-time radiologists to interpret x-rays. Most rural hospital telemedicine now involves only telephone service and faxing to other physicians at hospitals that might receive patients transferred from rural hospitals to provide services not available in the rural settings. At the present time, most Florida health insurance does not provide compensation for telemedicine consultations.

Where telemedicine consults are available, it has been reported anecdotally that approximately 80 percent of patients can be successfully treated at the rural hospitals without incurring patient transfer costs. Rural clinics are often formally affiliated with larger hospitals that accept transfer patients with serious ailments.

Rural hospitals report that they need to have access to a sophisticated medical information utility. They need to download a variety of professional development programming to serve doctors, nurses, and other health professionals. They need to pilot test alternative advanced telecommunications applications that can support effective telemedicine practices.

Rural hospitals lack the technology and equipment to support the delivery and management of these health care services. They lack building wiring for networking and other resources typically employed for distance learning. To date:

- A majority of rural hospitals have implemented some form of automated billing, but very few have automated patient records.
- Many of the computer workstations in rural hospitals are not networked and billing and patient care records systems are generally not integrated.
- Most rural hospitals have no satellite or Instructional Television Fixed Service capability for receiving video signals for accessing continuing education training material.

Medicare and Medicaid Bonus Payments

In addition to the challenges facing rural hospitals, another issue limiting health care access in rural communities is the sparse number of physicians in practice in rural counties. The persistent shortage of primary care physicians in rural and underserved areas of the nation has become one of the most challenging health care policy issues facing medical educators and health care policymakers in the U.S. in the past half century. Incentives, both financial and personal, have combined to create a modern-day physician workforce overloaded with specialists who choose to practice primarily in metropolitan and suburban markets. The ultimate consequence of this skewed distribution of physician location and services has been a shortage of basic health care services for certain groups of the U.S. population, particularly in rural areas

The federal government, recognizing the need for economic incentives to facilitate this process, has established several key programs that promote the provision of primary care services to those of greatest need. Of these, two programs involve bonus payments in the Medicare program for physicians practicing in Health Professional Shortage Areas and Physician Scarcity Areas.

Health Professional Shortage Areas Bonus Payments

The federal Health Professional Shortage Area designation identifies an area or population as having a shortage of dental, mental, and primary health care providers. Those designations are used to qualify for state and federal programs aimed at increasing primary care services to underserved areas and populations.

Among these programs is a ten percent bonus Medicare payment for providers practicing medicine in a Health Professional Shortage Area. The bonus is paid for all Medicare services provided in the shortage area and may be billed along with other incentives programs.

Physician Scarcity Areas Bonus Payments

The Medicare Modernization Act of 2003, §413(a), requires that a new five percent bonus payment be established and paid for services rendered by physicians in geographic areas designated as Physician Scarcity Areas. Under the program, physician scarcity designations are based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in a particular county. Medicare will pay a five percent bonus on a quarterly basis based on where the service is performed and not on the address of the beneficiary. The bonus may be billed in conjunction with other bonus payments under Medicare.

Both of these Medicare bonus programs are authorized under the federal physician payment regulations found in 42 CFR 447.200 and 42 CFR 447.203. A similar bonus payment system in Medicaid would require a state plan amendment that clearly explains how the bonus payment is provided.

III. Effect of Proposed Changes:

Section 1. Amends s. 381.0405, F.S., which establishes the Office of Rural Health, to state that ORH shall assist rural health care providers in improving the health status and health care of rural residents and help rural providers to integrate their efforts and prepare for prepaid and at-risk reimbursement. The purpose of ORH is amended to require the office to foster the development of service-delivery systems and cooperative agreements to enhance the provision of high-quality health care services in rural areas and serve as a catalyst for improved health services to residents in rural areas of the state. The bill adds the following functions for ORH: to work with rural stakeholders in order to foster the development of strategic planning that addresses problems affecting health care delivery in rural areas; develop standards, guidelines, and performance objectives for rural health networks; foster the expansion of rural health network service areas to include rural counties that are not yet covered; and administer state grant programs for rural hospitals and rural health networks.

The coordination function of ORH will be accomplished through providing information; promoting cooperative agreements; promoting the coordination of primary care, prehospital emergency care, inpatient acute care, and emergency medical services; and coordinating federal rural hospital and rural health care grant programs. The bill requires ORH to assist rural health care providers in recruiting health care practitioners and promoting policies that create incentives for practitioners to serve in rural areas. Technical assistance is also required for rural health

networks in developing their long-range development plans. The bill also requires ORH to provide links to best practices and other technical-assistance resources on its website and to conduct research on best practices in the delivery of health care services in rural areas.

This bill creates an advisory council for ORH. The Secretary of Health and the Secretary of Health Care Administration shall appoint no more than 5 members each to the advisory council. Members must be appointed for 4-year staggered terms and may be reappointed to a second term of office. Members are to serve without compensation, but are entitled to reimbursement for per diem and travel expenses. The bill requires, beginning January 1, 2007, ORH to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, summarizing the activities of the office.

Section 2. Amends s. 381.0406, F.S., relating to rural health networks, to state that the Legislature finds the following is necessary for the efficient and effective delivery of health care services in rural areas:

- The integration of public and private resources.
- The introduction of innovative outreach methods.
- The adoption of quality improvement and cost-effectiveness measures.
- The organization of health care providers into joint contracting entities.
- An agreement on clinical pathways and establishing referral linkages.
- The analysis of costs and services in order to prepare health care providers for prepaid and at-risk financing.
- The coordination of health care providers.

The bill states that the Legislature finds that rural health care providers are not prepared for market changes such as the move to managed care and capitation-reimbursement methodologies. The bill provides that rural health networks will work to increase the financial stability of rural hospitals by linking hospital services to other services and to out-of-area services that are not available locally when necessary.

The bill defines rural health network as a nonprofit legal entity whose principal place of business is in a rural county, whose members consist of rural and urban health care providers and others, and which is established to plan, develop, and organize the delivery of health care services on a cooperative basis in a rural area. The bill provides that rural health networks will now include members that provide health promotion and disease-prevention services, public health services, comprehensive primary care, emergency medical care, and acute inpatient care. County health departments are required to be members of the rural health network whose service area includes the county in which the county health department is located. Federally qualified health centers and emergency medical services providers are encouraged to become members of the rural health networks in the areas in which their patients reside or receive services.

The bill outlines the following functions for the rural health networks:

- Seek to develop linkages with specialty physician care in addition to the other types of care that are not available in rural services areas.

- Encourage members through training and educational programs to adopt standards of care, promote evidence-based practice of medicine and develop patient information exchange systems in order to improve quality and access to services.
- Develop continuous quality-improvement programs and train members in the use of such programs.
- Develop disease-management systems and train network members and other health care providers in the use of such systems.
- Promote outreach to targeted areas of high service need.
- Seek to develop community care alternatives for elders who would otherwise be placed in nursing homes.
- Emphasize community care alternatives for persons with mental health and substance abuse disorders who are at risk of being admitted to an institution.
- Collect data and conduct analyses and studies to measure area residents' health status and the adequacy of the health care delivery system in the network service area.
- Design and implement a long-range development plan for an integrated system of care that provides for adequate financing and reimbursement, including strategies and priorities for implementation, and that is responsive to the unique local health needs and the area health services market. The initial plan must be submitted to ORH for review and approval no later than July 1, 2007. The plan must be updated and submitted to ORH every 3 years.

The requirement to develop risk management and quality assurance programs for network providers is deleted. The bill requires that the networks are to be not-for-profit corporations, having an independent board of directors. It also provides that boards of other community health care entities may not serve in whole as the board of a rural health network; however some overlap is encouraged. The bill requires provider agreements between the network and its health care provider members that must specify participation in the essential functions of the network, which include disease-management initiatives, systems for exchanging patient information, specialty-referral agreements, and quality-assurance and quality-improvement programs.

Rural health networks will coordinate with other entities in the preparation of rural infrastructure development plans, including area health education centers, health planning councils, and regional education consortia. Written memoranda can be required by DOH to evidence agreements between these entities and rural health networks. Rural health networks will initiate activities to carry out the adopted development plan. Health planning councils must support the plans through data collection and analysis in order to assess the health status of area residents and the capacity of local health services. Regional education consortia will assist rural health networks with technology when available.

Funding will be provided by DOH to support the administrative costs of the rural health networks. The rural health networks may apply for funding for network operations and for rural health infrastructure development. The bill requires DOH to develop and enforce performance standards for rural health network operations grants and rural health infrastructure development grants. Operation grants performance standards must include, but are not limited to the following:

- Have a qualified board of directors that meets at least quarterly.
- Have staff, who meet the requirements of this section as assessed by ORH or a written plan to obtain the staff.
- Comply with DOH grant-management standards in a timely and responsive manner.
- Comply with DOH standards for the administration of federal grant funding, including assistance to rural hospitals.
- Demonstrate a commitment to network activities from area health care providers and other stakeholders, as described in letters of support.

Rural health infrastructure development grant performance standards must include, but are not limited to the following:

- During the 2006-07 fiscal year develop a long-range development plan and, after July 1, 2007, have a long-range development plan that has been reviewed and approved by ORH.
- Have 2 or more successful network-development activities, such as:
  - Management of a network-development outreach grant from the federal office of Rural Health Policy.
  - Implementation of outreach programs to address chronic disease, infant mortality, or assistance with prescription medication.
  - Development of partnerships with community and faith-based organizations to address area health problems.
  - Provision of direct services, such as clinics or mobile units.
  - Operation of credentialing services for health care providers or quality-assurance and quality-improvement initiatives.
  - Support for the development of community health centers, local community health councils, federal designation as a rural critical access hospital, or comprehensive community health planning initiatives.
  - Development of the capacity to obtain federal, state, and foundation grants.

The bill provides that networks that meet performance standards shall be eligible to receive grant funds, including rural health infrastructure development grants. The bill adds to infrastructure development the enhancements of primary care services through the use of mobile clinics, quality-improvement and utilization management.

The bill creates the rural health infrastructure development grant program. Subject to legislative appropriations, DOH will make grants available to rural health networks that meet the performance standards. Each rural health network must develop a detailed plan to build administrative and clinical infrastructures in its service area which meet or exceed standards for Medicaid contracting. Clinical infrastructure means establishing the following:

- Specialty networks, such as linking rural physicians, hospitals, specialty physicians, and regional tertiary hospitals, which are supported by broadband telecommunication networks, including wireless services, to enable patient case referrals, sharing of patient health information, consultation among providers, and follow-up on patient care.
- Regional continuous quality-management systems consistent with state and federal quality initiatives.

- Comprehensive disease-management programs that address the characteristics of the local area and meet Medicaid standards.

Building administrative infrastructure means the following:

- Developing telecommunications infrastructure that provides broadband communication, including wireless service between rural and urban health care providers for the purposes of sharing health information.
- Developing telehealth and long-distance learning systems that use a telecommunications infrastructure to support links with specialists and regional hospitals and the training of medical students and other health care professionals.
- Forming entities to encourage joint contracting by rural physicians and hospitals.
- Forming or joining entities that would enable rural health care providers to take advantage of economies of scale in purchasing supplies and equipment, billing services, and personnel services.

Rural health networks will be monitored by ORH to ensure continued compliance with established certification and performance standards. Rules will be established by DOH governing the provision of grant funds and the establishment of performance standards for networks.

Section 3. Amends s. 395.602 F.S., to define critical access hospital as a hospital that meets the definition of rural hospital in paragraph (d) and meets the requirements for reimbursement by Medicare and Medicaid under 42 C.F.R. ss. 485.601-485.647. The definitions of emergency care hospital and essential access community hospital are deleted. The definition of rural primary care hospital is changed to mean a facility that has temporary inpatient care for periods of 96 hours instead of 72 hours and that has at least six licensed acute care beds, rather that no more than six such beds.

Section 4. Amends s. 395.603, F.S., to delete emergency care hospital from provisions relating to the deactivation of licensed beds.

Section 5. Amends s. 395.604, F.S., to specify that, for the purposes of Medicaid swing-bed reimbursement, participation in the medical education reimbursement and loan repayment program, or coordinating primary care services, the agency shall treat rural primary care hospitals the same as rural hospitals. Rural hospitals applying for a Certificate-of-Need (CON) to be licensed as a rural primary care hospital shall receive expedited review. Rural primary care hospitals seeking relicensure as acute care general hospitals shall also receive expedited review. Rural primary care hospitals are exempt from CON requirements for home health and hospice services and for swing beds in a number that does not exceed one half of the facility's licensed beds. Rural primary care hospitals will have agreements with other hospitals, skilled nursing facilities, home health agencies, and with providers of diagnostic-imaging and laboratory services not provided on site but needed by patients. The provision authorizing the Department to seek recognition of emergency care hospitals is deleted.

Section 6. Amends s. 395.6061, F.S., to define the purpose of the rural hospital capital improvement grant program to include the acquisition, repair, improvement, or upgrade of systems, facilities, or equipment. As part of the information required for the capital improvement

grant application, the hospital must provide evidence that after July 1, 2007, the application is consistent with the rural health network long-range development plan. The provision that each rural hospital will receive $100,000 annually is deleted. The provision that any remaining funds will be disbursed annually to the hospitals is deleted.

Section 7. Amends s. 409.908, F.S., to delete the provision that the Medicaid physician fee schedule based on a resource-based relative value scale will be phased in over a 2 year period beginning on July 1, 1994, as the provision is obsolete. Physicians that have a provider agreement with a rural health care network will be paid a 10 percent bonus over the Medicaid physician fee schedule for any physician service provided within the geographic boundary of a rural county as defined by the most recent United States Census as rural.

Section 8. Amends s. 408.07, F.S., to correct a cross-reference in the definition of rural hospital.

Section 9. Amends s. 409.9116, F.S., relating to the disproportionate share/financial assistance program for rural hospitals, to correct a cross-reference.

Section 10. Amends s. 1009.65, F.S., relating to the Medical Education Reimbursement and Loan Repayment Program, to correct a cross-reference.

Section 11. Requires the Office of Program Policy Analysis and Government Accountability to contract with an entity having expertise in the financing of rural hospital capital improvement projects to study the financing options for replacing or changing the use of rural hospital facilities having 55 or fewer beds which were built before 1985 and which have not had major renovations since 1985. The contractor will assess the need to replace or convert the facility, identify all available sources of financing, and assess each community's capacity to exercise these options, propose a model for replacement, and propose alternative uses of the facility if continued operation of the facility is not financially feasible. The Office of Program Policy Analysis and Government Accountability will use the study to make recommendations to the Legislature by February 1, 2007.

Section 12. Repeals s. 395.605, F.S., which provides for the licensure of emergency care hospitals. This licensure category is not used.

Section 13. Provides that the bill takes effect July 1, 2006.

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.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Medicaid physicians who are members of rural health networks will receive a 10 percent bonus payment for physician services provided in rural counties.

Rural hospitals, to the extent the capital improvement grant program is funded and they qualify, may receive capital improvement grants.

C. Government Sector Impact:

The bill assigns additional functions to the Office of Rural Health to strengthen the department's ability to encourage development of rural health care delivery systems and to establish performance standards for rural health networks and rural hospitals that receive state funding. The bill creates a small advisory council to assist the office. The Office of Rural Health will need additional staff and funding to carry out its additional functions under the bill.

The bill adds functions and membership requirements for rural health networks that will improve the quality of health care in rural areas and will enable rural health care providers to prepare for risk-based reimbursement and managed care. The bill establishes two categories of funding for rural health networks: administrative costs for operating a rural health network (the state already provides some funding for network operations); and rural health infrastructure development (some networks currently receive grants from other sources for this purpose). The rural health infrastructure development funding would be through a new competitive grant program administered by ORH and would need to be funded.

The Office of Program Policy Analysis and Government Accountability is required to contract for a study to look at the financing options for replacing or changing the use of rural hospital facilities. Since the bill requires the Office of Program Policy Analysis and Government Accountability to contract out for the study there will need to be an appropriation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.