HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1575 Health Care
SPONSOR(S): Healthcare Council and Coley
TIED BILLS: **IDEN./SIM. BILLS:** SB 424

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	7 Y, 0 N	Ciccone	Calamas
2) Healthcare Council	13 Y, 0 N, As CS	Ciccone	Gormley
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

CS/HB 1575 provides legislative findings and intent regarding the efficient and effective delivery of health care services in rural areas and provides statutory changes regarding the state's rural health care networks and service delivery systems.

The bill expands duties and functions of the Office of Rural Health (ORH) within the Department of Health (DOH) to address the overall rural health care service delivery system. The bill directs the ORH to work with rural health care stakeholders to improve primary care access, pre-hospital emergency care, inpatient acute care and emergency medical services and coordination among these entities and services. The bill creates a ten-member advisory council within the department, with five members appointed by the department and five members appointed by the Agency for Health Care Administration (AHCA). The DOH is directed to staff the advisory council and to submit an annual report to the Governor, the Senate President and the Speaker of the House beginning July 1, 2008, summarizing the rural health office's activities including grants obtained or administered by the office, the status of rural health networks and rural hospitals, and provide recommendations to improve the rural health delivery system.

The bill requires county health department participation in a rural health network and requires each rural health network to have their principal place of business in the designated rural area and to have an independent governing board. The bill requires networks to coordinate with health education and planning entities regarding current technology, telemedicine, and long-distance learning. The bill specifies that rural health networks may qualify for certain funds, including funds to develop a strategic plan regarding joint contracting disease management under Medicaid requirements, regional quality improvement programs, specialty networks, regional broadband communications, and telemedicine and distance learning capacity.

The bill amends chapters 395, 408 and 409, F.S., regarding agency responsibilities for hospital regulation and Medicaid administration. Chapter 395, F.S., is revised to include the definition of "rural critical access hospital" to conform to federal regulation terminology, and deletes obsolete language. Rural primary care hospitals are redefined to authorize temporary inpatient care for a longer period of time from seventy-two hours to ninety-six hours. The bill further redefines rural primary care hospitals as having a minimum of six beds, rather than a maximum of six beds.

The bill provides increased annual funding for department grants to rural hospitals from $100,000 to $200,000, and establishes distribution requirements for remaining appropriated funds. The bill directs the Legislative Committee on Intergovernmental Relations (LCIR) to study without specific appropriation, rural hospital financing options or replacing or changing the use of rural hospital facilities. The bill provides $3 million in non-recurring general revenue for fiscal year 2007-2008 in the General Appropriations Act to fund the rural hospital capital improvement grant program.

The bill provides an effective date of July 1, 2007.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited government – The bill directs the Office of Rural Health (ORH) within the Department of Health (DOH) to coordinate rural health service delivery among existing and developing rural health care service providers and to make recommendations to the Governor, the Senate President and the Speaker of the House regarding the status and evolvement of rural health delivery systems. The bill also directs the Legislative Committee on Intergovernmental Regulation (LCIR) to conduct a rural health facility study.

The bill creates a new Office of Minority Health within the DOH and assigns duties and responsibilities and reporting requirements.

B. EFFECT OF PROPOSED CHANGES:

The bill expands the duties of the ORH to work with rural health networks, and creates an advisory council to assist networks in developing administrative and clinical plans to coordinate health delivery services. Networks would be required to be actively involved with service providers in rural areas and develop model quality improvement plans, including distance learning, and use of telemedicine. Rural primary care hospitals would be authorized to provide inpatient care for a longer period of time from seventy-two hours to ninety-six hours. The bill allows rural primary care hospitals to increase bed capacity by redefining rural primary care hospitals as having a minimum, rather than a maximum of six beds.

The bill revises the language governing hospital regulation to more accurately reflect categories of hospitals and align the statutory definitions with Medicare and Medicaid regulations. The bill repeals s. 395.605, F.S., relating to licensure of emergency care hospitals, which is a licensure category that is no longer used. Medicaid swing-bed reimbursement will be treated the same for rural primary care hospitals as for rural hospitals. Rural hospitals will be able to receive $200,000 annually for facility improvement, rather than the current $100,000 grant. Additional funds could be provided on the basis of hospitals providing evidence of financial stability and sustainability of proposed projects.

Background

Chapter 381, F.S., authorizes the DOH to establish the ORH and create rural health networks to help alleviate problems with the availability of health care services in rural areas.

Section 395.602, F.S., defines rural hospitals and includes an obsolete definition based on prior federal regulations for rural primary care hospitals that authorize such facilities to have a maximum of six licensed acute care inpatient beds, to provide twenty-four hour emergency care and temporary inpatient care for up to seventy-two hours. The existing statutory section authorizes the agency to adopt rules to license a facility as a rural primary care hospital or emergency care hospital and rules to specify requirements for making 24-hour emergency care available in the event a licensed hospital has discontinued inpatient care.

Section 395.6061, F.S., establishes a capital improvement grant program for rural hospitals and requires that a grant application include a rural health network plan and the hospital's financial status. Current law provides for a minimum $100,000 annual grant to each rural hospital that applies to the department.

C. SECTION DIRECTORY:

Section 1. Amends s. 381.0405, F.S., relating to the Office of Rural Health within the Department of Health, and creates new subsections (7), relating to the advisory council and (8), relating to the reporting requirements of the Office of Rural Health; renumbers subsequent subsection.

Section 2. Amends s. 381.0406, F.S.; relating to rural health networks.

Section 3. Creates s. 381.7366, F.S.; relating to the Office of Minority Health; legislative intent and duties.

Section 4. Amends s. 395.602, F.S.; relating to rural hospital definitions.

Section 5. Amends s. 395.603, F.S.; relating to general hospital bed deactivation.

Section 6. Amends s. 395.604, F.S.; relating to rural primary care hospitals; creates new subsections (3) through (8), relating to rural primary care hospital bed reimbursement, primary care services and licensure.

Section 7. Amends s. 395.6061, F.S.; relating to rural hospital capital improvement.

Section 8. Amends s. 409.908, F.S.; relating to Medicaid provider reimbursement.

Section 9. Amends s. 408.07, F.S.; relating to rural hospital definitions.

Section 10. Amends s. 409.9116, F.S.; relating to rural hospital disproportionate share/financial assistance program.

Section 11. Amends s. 1009.65, F.S.; relating to medical education reimbursement and loan repayment program.

Section 12. Creates an unnumbered section of statute relating the Legislative Committee on Intergovernmental Relations (LCIR); relating to a report to be submitted to the Legislature.

Section 13. Repeals s. 395.605, F.S.

Section 14. Provides an effective date of July 1, 2007 contingent upon a specific appropriation in the General Appropriations Act for Fiscal Year 2007-2008.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill provides $3 million in non-recurring general revenue for fiscal year 2007-2008 in the General Appropriations Act to the Department of Health to fund the rural hospital capital improvement grant program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Under the bill, rural hospitals will be able to receive a grant of $200,000 annually for facility improvement, rather than the current $100,000 grant.

D. FISCAL COMMENTS:

The Department of Health reports that "[t]he General Counsel's Office expects increased litigation as a result of the changes in the rural health network statute that add Level I and II performance standards and the addition of infrastructure development grant funding." To handle this anticipated increased legal workload, the department recommends authorizing a .5 FTE senior attorney position and a .5 FTE staff assistant position. According to the analysis provided by the department, authorization of these positions would require $75,458 in recurring revenue and $8,959 in nonrecurring revenue.

The Legislative Committee on Intergovernmental Relations staff concludes that some money may be necessary to contract with architectural consultants to compensate for review areas related to the rural health study that are beyond the expertise of existing staff.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

D. STATEMENT OF THE SPONSOR

No statement provided.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On **March 20, 2007**, the Health Innovation Committee adopted two amendments to the bill. These amendments:

- Created the Office of Minority Health within the Department of Health.
- Revised the effective date contingent upon a specific appropriation.

The bill was reported favorable with two amendments.

On **April 17, 2007**, the Healthcare Council adopted four amendments to the bill. These amendments:

- Removes certain terms of condition for rural hospitals to receive any remaining rural hospital capital improvement grant funds.
- Removes the Medicaid physician services incentive.
- Replaces the OPPAGA rural health study with the Legislative Committee on Intergovernmental Relations study.
- Conforms language relating to the rural hospital capital improvement grant program with $3 million appropriation in the General Appropriations Act.
- Conforms appropriation language relative to Healthcare Council amendments and provides for the effective date subject to an appropriation.

The bill was reported favorable as a Council Substitute. The analysis is written to the Council Substitute.