**The Florida Senate**

# PROFESSIONAL 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 Regulation Committee

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| BILL: | CS/SB 424 |
| INTRODUCER: | Health Regulation Committee and Senator Peaden |
| SUBJECT: | Provision of Health Care Services |
| DATE: | March 22, 2007 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Garner | Wilson | HR | **Fav/CS** |
| 2. | | | HA | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## I. Summary:


The bill revises the Department of Health's (DOH) duties relating to the Area Health Education Center (AHEC) network in Florida. The bill specifies that the AHEC network include the AHECs at the medical schools in the state. The DOH must maintain an AHEC network focused on improving access to health services by persons who are medically underserved. The DOH must contract with the medical schools at these universities to assist in funding the AHEC network, which links the education of medical students, interns, and residents with the provision of primary care services to medically underserved populations.

The bill establishes requirements for the AHEC network relating to students in the health care professions and health care providers serving medically underserved populations. The bill requires the DOH to make every effort to assure that the network, rather than the participating medical schools, does not discriminate among enrollees with respect to age, race, sex, or health status. The DOH may use no more than one percent of the annual appropriation for administering and evaluating the network.

The bill amends various sections of the Florida Statutes with respect to rural hospitals and rural health care delivery systems in Florida as follows:

- Revises the purpose and functions of the Office of Rural Health (ORH or office) in the DOH 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.
- Requires the Secretary of the Agency for Health Care Administration (AHCA or agency) and the Secretary of Health to each appoint no more than five members to an advisory council to advise the office on its responsibilities as written in law.

- Requires the 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 the ORH beginning January 1, 2008.
- Revises legislative findings and intent with respect to rural health networks.
- Redefines a rural health network.
- Establishes requirements for membership in rural health networks.
- Outlines the functions, and services to be provided by members of rural health networks.
- Requires coordination between rural health networks and area health education centers, health planning councils, and regional education consortia.
- Establishes requirements for funding rural health networks and provides performance standards.
- Expands the existing Phase II funding of rural health networks to include rural health network infrastructure development grants.
- Requires the ORH to monitor rural health networks to ensure continued compliance with established certification and performance standards.
- Requires the DOH to establish rules governing the provision of grant funds under Phase I and Phase II and the establishment of performance standards for networks.
- 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.
- Specifies special conditions for rural primary care hospitals.
- Specifies the purposes of rural hospital capital improvement grants, modifies the conditions for receiving those grants, and increases the minimum amount of each grant.
- Requires the AHCA to pay certain physicians a bonus for Medicaid physician services provided within a rural county.
- Requires a study to be contracted 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 recommendations due to the Legislature by February 1, 2008.
- Provides appropriations.

The bill amends ss. 381.0402, 381.0405, 381.0406, 395.602, 395.603, 395.604, 395.6061, 408.07, 409.908, 409.9116, and 1009.65, F.S.

The bill repeals s. 395.605, F.S.

The bill creates six unnumbered sections of law.

## II. Present Situation:

**Area Health Education Center Network**

The AHECs link the resources of university health science centers with local planning, educational, and clinical resources. Through a network of health-related institutions, an AHEC provides multidisciplinary educational services to students, faculty, and local practitioners,

ultimately improving health care delivery in medically underserved areas.[1] Area Health Education Centers train health care providers in sites and programs that are responsive to state and local needs. Health career enhancement and recruitment programs for K-12 students are emphasized.[2]

The AHEC program is a long-term initiative, requiring major changes both in the traditional method of training medical and other health professions students and in the relationship between university health science centers and community health service delivery systems. The Basic AHEC Program was initiated in 1972 and the Model State Supported AHEC Program was initiated in 1993. The AHEC program is part of a series of health professions programs that are authorized under Title VII of the Public Health Service Act[3]. Title VII of the Public Health Service Act supports the training and education of health care providers through loans, loan guarantees, and scholarships to students, and grants and contracts to academic institutions and non-profit organizations. The Health Professions Education Partnerships Act of 1998 reauthorized the AHEC Program for five years.[4] Although Congress has not reauthorized Title VII of the Public Health Service Act since 2003, Congress has continued to annually fund the AHEC program.

The Florida AHEC Network is an extensive, statewide system for health professional education and support founded upon 10 regional AHECs. The organization of the network allows the AHECs to draw upon the resources of the academic health centers to address local health care issues.

According to the 2005 Florida AHEC Network annual report, the network received $11,808,910 in FY 2005-06 in General Revenue, tobacco settlement funds, and funds to implement health literacy, obesity, and tobacco control projects.[5] The Florida AHEC Network addresses the primary health care needs of Florida's underserved populations by:

- Extending academic resources and health professions education to medically underserved communities;
- Coordinating community-based clinical rotations and serving as a point of contact for academic health centers within the communities where students train;
- Offering programs and activities designed to influence the future health professional workforce by stimulating and promoting youth interest in health careers;
- Providing information and support to community health professionals to reduce isolation of providers in medically deprived areas, improving access and use of educational and informational resources, and enhancing the quality of care;
- Engaging in special projects to reduce health disparities and improve access to quality health care, such as statewide programs to train community health workers to reach medically underserved populations, working with communities to address the issue of

[1] U.S. Department of Health and Human Services. Health Resources and Services Administration. http://bhpr.hrsa.gov/ahec/ (last visited on March 22, 2007)
[2] *Ibid*.
[3] Codified at 42 U.S.C. s. 292 *et seq*.
[4] See Public Law 105-392.
[5] Florida AHEC Network 2006 Annual Report. Found at: http://www.flahec.org/report2006.pdf (last visited on March 22, 2007)

tobacco use, and developing programs targeting health literacy and cultural sensitivity; and
- Conducting a variety of activities to evaluate the impact of its programs and administering the extensive network of affiliation agreements with academic and community partners necessary to accomplish its work.

Under s. 381.0402, F.S., the DOH, in cooperation with the state-approved medical schools in Florida must organize an AHEC network based on earlier medically indigent demonstration projects and must evaluate the impact of each network on improving access to services by persons who are medically underserved. The network must be a catalyst for the primary care training of health professionals through increased opportunities for training in medically underserved areas. The DOH must contract to assist in funding an AHEC network, which links the education of medical students, interns, and residents with the provision of primary care services to low-income persons.

The AHEC network must:

- Be coordinated with and under contract with the state-approved medical schools, which must be responsible for the clinical training and supervision.
- Divide the state into service areas with each medical school coordinating the recruiting, training, and retention of medical students within its assigned area.
- Use a multidisciplinary approach with appropriate medical supervision.
- Use current community resources, such as county health departments, federally funded primary care centers, or other primary health care providers, as community-based sites for training medical students, interns, and residents.

The DOH must establish criteria and procedures for quality assurance, performance evaluations, periodic audits, and other appropriate safeguards for the network. The department must make every effort to assure that participating medical schools do not discriminate among enrollees with respect to age, race, sex, or health status. Participating medical schools may target high-risk medically needy population groups.

**Office of Rural Health**

Florida's ORH is located within the DOH and has been the focal point for the development and administration of Florida's rural health policy since 1991 (s. 381.0405, F.S.).

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.

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**

The Medicare Rural Hospital Flexibility Program, developed under the Balanced Budget Act of 1997 (Public Law 105-33), and "fine-tuned" through provisions of the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000, was created to rectify imbalances of Medicare reimbursement rates between urban and rural providers. The program developed the Critical Access Hospital reimbursement category for rural hospitals. This new type of hospital is an acute care facility that provides emergency, outpatient, and limited inpatient services and is required to have no more than 15 beds and 10 "swing beds" (inpatient beds which may also be used for other services such as part of a Skilled Nursing Facility). The average annual length of stay for all inpatients must be 96 hours (4 days) or less and emergency services must be available 24-hours per day, 7-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 are reimbursed on a "reasonable cost" basis for inpatient, outpatient, and laboratory services delivered to Medicare patients. The ORH currently 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 ORH 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 (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 the 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, they 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 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. The ORH is responsible for contracts for rural health networks. Each network currently receives approximately $55,555 per year.

**Rural Hospitals/Rural Primary Care Hospitals**

There are currently 29 operating statutory rural hospitals in Florida. These hospitals serve as the nucleus for the organization and delivery of care in their respective communities. Eleven rural hospitals have converted to critical access hospitals under the Medicare Rural Hospital Flexibility Grant program. 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, with the majority located in the Florida Panhandle. By definition, rural hospitals have 100 or fewer beds. Nineteen rural hospitals have 50 or fewer beds.

**Medicare Bonus Payments**

The federal government, recognizing the need for economic incentives to facilitate the development of basic health care services for individuals in rural areas, has established several key programs that promote the provision of primary care services to those in greatest need. Of these, two programs involve Medicare bonus payments 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 10 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 5 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 5 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.

Each of the Medicare bonus programs are authorized under the federal physician payment regulations found in 42 CFR 447.200 and 42 CFR 447.203.

## III. Effect of Proposed Changes:

**Section 1.** Amends s. 381.0402, F.S., to revise DOH's duties relating to the AHEC network in Florida. The bill specifies that the AHEC network includes the AHECs at the medical schools in the state. The department must maintain and evaluate, rather than organize, an AHEC network focused on improving access to health services by persons who are medically underserved. The network must serve as a catalyst for the primary care training of health professionals by increasing opportunities for training in medically underserved areas, increasing access to primary care services, providing health workforce recruitment, enhancing the quality of health care, and addressing current and emerging public health issues.

The DOH must contract with the medical schools to assist in funding the AHEC network, which links the provision of primary care services to medically underserved populations with the education of medical students, interns, and residents. The requirements for the AHEC network to be coordinated with and under contract with the state-approved medical schools is deleted.

The bill requires the AHEC network to:

- Facilitate the recruitment, training, and retention of students in the health care professions within each AHEC service area.
- Use community resources as sites for training students in the health care professions.
- Use a multidisciplinary approach with appropriate supervision.

The AHEC network must also:

- Assist providers in medically underserved areas and other safety net providers in remaining current in their fields through a variety of community resource initiatives;
- Strengthen the health care safety net in Florida by enhancing services and increasing access to care in medically underserved areas; and
- Provide other services, such as library and information resources, continuing professional education, technical assistance, and other support services, for providers who serve in medically underserved areas.

The DOH must make every effort to assure that the network, rather than participating medical schools, does not discriminate among enrollees with respect to age, race, sex, or health status.

**Section 2.** Amends s. 381.0405, F.S., relating to the ORH, as follows:

- Requires the ORH to assist rural health care providers in improving the health of rural residents, integrating their efforts, and preparing for prepaid risk-based reimbursement.

- Requires the ORH to also coordinate its activities with rural health networks and local health councils.
- Revises the purpose of the ORH to foster the development of service-delivery systems to enhance health care services in rural areas.
- Revises the functions of the ORH to: foster the development of strategic planning; develop standards, guidelines, and performance objectives for rural health networks; foster the expansion of rural health networks to include more rural counties; and administer state grant programs for rural hospitals and rural health networks.
- Requires the ORH to design initiatives and promote cooperative agreements to improve access to primary care, prehospital emergency care, inpatient acute care, and emergency medical services.
- Requires the ORH to provide technical assistance to rural health networks to: create incentives for health care practitioners to serve in rural areas; develop their long-range development plans; and provide links to best practices and other technical-assistance resources on its website.
- Creates an advisory council for the ORH and establishes member selection criteria.
- Requires, the ORH to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives summarizing the activities of the office, the status of rural health networks and rural hospitals in the state, and providing recommendations for establishing provider networks in rural counties, beginning January 1, 2008.

**Section 3.** Amends s. 381.0406, relating to rural health networks, F.S., as follows:

- Revises legislative findings and intent for the efficient and effective delivery of health care services in rural areas.
- Redefines a rural health network.
- Modifies requirements for membership of rural health networks to require county health departments to become members and to encourage federally qualified health centers and emergency medical service providers to become members of the networks.
- Provides additional functions for rural health networks and the services to be provided by members, to the extent that resources permit, including: seeking linkages with tertiary inpatient care, specialty physician care, and other services that are not available in rural service areas; encouraging members to adopt standards of care and promote the evidence-based practice of medicine; assist members to develop initiatives that improve the quality of health care services and delivery, and obtain training to carry out such initiatives; assisting members with the implementation of disease management systems and identify available resources for training network members and other health care providers in the use of such systems; promoting outreach to areas that have a high need for services; developing community care alternatives for elders who would otherwise be placed in nursing homes; and emphasizing community care alternatives for persons with mental health and substance abuse disorders who are at risk of being admitted to an institution. Networks are also required to develop and implement a long-range development plan for an integrated system of care that is responsive to local needs and implement this plan as resources permit. The plan must be submitted to the ORH for review and comment by July 1, 2008, and every three years after.

- Deletes the requirement to develop risk management and quality assurance programs for network providers.
- Requires networks to be not-for-profit corporations, with an independent board of directors.
- Requires provider agreements between the network and its health care provider members to specify that members must participate in the essential functions of the network and support network development plan goals and objectives.
- Provides additional requirements for rural health networks to coordinate with other entities, such as area health education centers, health planning councils, and regional education consortia for the preparation of their long-term development plan.
- Requires the DOH to support the administrative costs of developing and operating the rural health networks through grants.
- Requires the DOH to develop and enforce specific performance standards for rural health network operations grants and rural health infrastructure development grants.
- Expands the existing Phase II funding of rural health networks to include rural health network infrastructure development grants and specifies additional activities that qualify as infrastructure development.
- Requires the ORH to monitor rural health networks to ensure continued compliance with established certification and performance standards.
- Requires the DOH to establish rules governing the provision of grant funds under Phase I and Phase II and the establishment of performance standards for networks.

**Section 4.** Amends s. 395.602, F.S., relating to rural hospitals, as follows:

- Defines 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.
- Deletes the definitions of emergency care hospital and essential access community hospital.
- Changes the definition of rural primary care hospital to 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 than no more than six such beds.

**Section 5.** Amends s. 395.603, F.S., deleting emergency care hospital from provisions relating to the deactivation of licensed beds.

**Section 6.** Amends s. 395.604, F.S., relating to rural hospital programs, as follows:

- Requires the agency to treat rural primary care hospitals in the same manner as rural hospitals when reimbursing for Medicaid swing-beds, participating in the Medical Education Reimbursement and Loan Repayment Program, and coordinating primary care services.
- Requires expedited reviews of Certificate-of-Need (CON) applications for rural hospitals applying to be licensed as a rural primary care hospital and for rural primary care hospitals seeking relicensure as acute care general hospitals.

- Exempts rural primary care hospitals from the CON requirements for home health, hospice services and for swing beds in a number that does not exceed one-half of the facility's licensed beds.
- Requires rural primary care hospitals to have agreements with other hospitals, skilled nursing facilities, home health agencies, and with providers of diagnostic imaging and laboratory services that are not provided on site but needed by patients.
- Deletes the provision authorizing the department to seek recognition of emergency care hospitals.

**Section 7.** Amends s. 395.6061, F.S., relating to the rural hospital capital improvement grant program, as follows:

- Allows a rural hospital to apply for a capital improvement grant for the acquisition, repair, improvement, or upgrade of systems, facilities, or equipment and requires the grant application to include evidence that after July 1, 2008, the application is consistent with the rural health network long-range development plan.
- Increases the minimum grant from $100,000 to $200,000 for each rural hospital, subject to legislative appropriation.
- Establishes an agreement mechanism between the DOH and rural hospitals to allow any funds from the capital improvement grant program remaining after the distribution of the minimum grant to each rural hospital to be distributed and suggests terms that the DOH may include in that agreement.

**Section 8.** Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers, to delete obsolete language requiring the Medicaid physician fee schedule based on a resource-based relative value scale to be phased in over a 2-year period beginning on July 1, 1994, and to provide physicians who have a provider agreement with a rural health care network 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 9.** Amends s. 408.07, F.S., correcting a cross-reference to the definition of rural hospital.

**Section 10.** Amends s. 409.9116, F.S., correcting a cross-reference relating to the disproportionate share/financial assistance program for rural hospitals.

**Section 11.** Amends s. 1009.65, F.S., correcting a cross-reference relating to the Medical Education Reimbursement and Loan Repayment Program.

**Section 12.** Requires a study to be contracted 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 recommendations due to the Legislature by February 1, 2008.

**Section 13.** Repeals s. 395.605, F.S., which provides for the licensure of emergency care hospitals. This licensure category is not used.

**Section 14.** Appropriates $440,000 in non-recurring general revenue to the Office of Program Policy Analysis and Governmental Accountability to contract for a study on the financing options for replacing or changing the use of certain rural hospitals.

**Section 15.** Appropriates $3,638,709 in recurring general revenue and $5,067,392 in recurring funds from the Medical Care Trust Fund to the AHCA to implement the Medicaid 10 percent physician bonus payment program.

**Section 16.** Appropriates $3 million in recurring general revenue to the DOH to implement rural health network infrastructure development.

**Section 17.** Appropriates $7.5 million in non-recurring general revenue to the DOH to implement the rural hospital capital improvement grant program.

**Section 18.** Appropriates $214,374 in general revenue and authorizes three full-time equivalent positions to the DOH for the purpose of supporting the advisory council and administering the grant programs.

**Section 19.** Provides that the bill take effect July 1, 2007.

## 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 Article 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 qualifying under the bills provisions may receive capital improvement grants.

C. Government Sector Impact:

Section 14 of the bill appropriates $440,000 in nonrecurring general revenue funds to the Office of Program Policy Analysis and Government Accountability to contract for a study of financing options for replacing or changing the use of certain rural hospitals.

Section 15 of the bill appropriates $3,638,709 in recurring general revenue and $5,067,392 in recurring funds from the Medical Care Trust Fund to the AHCA to implement the Medicaid 10-percent physician bonus payment program. Recent Medicaid Impact Conference estimates find that a 10 percent bonus for these physicians would cost $12,524,439 ($5,369,229 in General Revenue).

Section 16 of the bill appropriates $3 million in recurring general revenue funds to the DOH to implement rural health network infrastructure development. Section 17 of the bill appropriates $7.5 million in nonrecurring general revenue funds to the DOH to implement the rural hospital capital improvement grant program.

Section 18 of the bill appropriates 3 full-time equivalent (FTE) positions at an associated salary rate of $121,619 to the DOH. The DOH reports that this estimate was included in the appropriation from CS/CS/CS SB 2176 (2006) and does not account for the cost of living adjustments that occurred after the 2006 Regular Session. The following fiscal estimate includes the cost of living adjustment for the 3 FTEs, as well as an additional two .50 FTEs for the increased legal caseload expected by the DOH. More specifically, the ORH estimates that implementing the bill will require 3 FTEs: a pay grade 26 position, a pay grade 25 position, and a pay grade 12 position.

Pay grade 26 - This is a high-level position that will be primarily responsible for implementation of the rural health network (RHN) activities specified under s. 381.0406, F.S. The complexity of these tasks will require an individual capable of working independently with knowledge and experience in health care delivery, managed care, contract management, and performance measurement. Specific responsibilities include: providing technical assistance to rural health networks to develop long-range development plans; developing rural health network performance standards and guidelines; administering the rural health network grant process; developing and adopting rules; and monitoring rural health network activities and compliance. Pay grade 25 – This position will be primarily responsible for activities related to the newly created Advisory Council, administering the Rural Hospital Capital Improvement Program, preparing the newly required annual report which includes reports on the status of rural network networks and the status of rural hospitals, and performing data collection and analysis. Pay grade 12 – This is a high-level staff support position that will provide administrative support for all functions of the ORH.
Advisory Council costs were estimated based on seven advisory council members needing reimbursement for travel and expenses for two meetings at $500 per meeting.

The DOH's 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 the legal

workload increase, one half FTE senior attorney and one half FTE staff assistant are included in the fiscal note.

| Estimated Expenditures | 1st Year | 2nd Year |
|---|---|---|
| **Salaries** | (no lapse) | (Annualized/Recur) |
| 1 FTE (pay grade 26, min plus 10% | $ 51,019 | $ 51,019 |
| 1 FTE (pay grade 25; min plus 10%) | 47,858 | 47,858 |
| 1 FTE (pay grade 12; min plus 10%) | 24,699 | 24,699 |
| .50 FTE (pay grade 230; min plus 10%) | 28,395 | 28,395 |
| .50 FTE (pay grade 13; min plus 10%) | 12,916 | 12,916 |
| Subtotal Salaries | $164,887 | $164,887 |
| **Benefits** (29%) | $ 47,817 | $ 47,817 |
| **Expenses** | | |
| Non-recurring Expense Standard for 2 FTE non-professionals @ $2,933 | $ 5,866 | $0 |
| Non-recurring Expense Standard for 3 professionals @ $3,426 | 10,278 | $0 |
| Non-recurring OCO standard (computer work stations) 5 FTE @ $1,300 | 6,500 | $0 |
| Subtotal Non-recurring | $22,644 | |
| Recurring Expense Standard for 2 non-professionals (no travel) @ $5,270 | $ 10,540 | $ 10,540 |
| Recurring Expense Standard for 3 professionals @ $6,489 | 19,467 | 19,467 |
| Recurring Expenses 3 FTE medium travel @ $9,606 | 28,818 | 28,818 |
| Advisory Council travel and per diem | 7,000 | 7,000 |
| Advisory Council meeting expenses | 1,000 | 1,000 |
| Annual Report printing | 500 | 500 |
| Subtotal Recurring Expenses | $ 67,325 | $ 67,325 |
| HR Outsourcing 5 positions (3 FTE and 2 ½ time FTE) @ $401 | 2,005 | 2,005 |
| **Total Estimated Expenditures** | $304,678 | $282,034 |

| Estimated Revenue | 1st Year | 2nd Year |
|---|---|---|
| | | (Annualized/Recur) |
| | $0 | $0 |
| **Total Estimated Revenue** | $0 | $0 |

## VI. Technical Deficiencies:

On page 11, line 5, the word "Establishing" should be replaced with the words "The establishment of" in order to be consistent with the rest of the paragraph.

## VII. Related Issues:

None.

# VIII. Summary of Amendments:

None.