The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 644
INTRODUCER:	Senator Simon
SUBJECT:	Rural Hospitals
DATE:	January 22, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AHS	
3.			FP	

I. Summary:

SB 644 creates a new hospital license type for rural emergency hospitals (REH). To be licensed as a REH, a hospital is required by the bill to meet federal requirements for REHs and be certified as such by the Secretary of the federal Department of Health and Human Services (HHS). The bill authorizes REHs to enter into any contracts necessary to be eligible for federal reimbursement and allows the Agency for Health Care Administration (AHCA) to seek federal approval to provide Medicaid reimbursement to licensed REHs.

Additionally, the bill requires health insurance policies and health maintenance organization (HMO) contracts issued or renewed on or after July 1, 2024, to cover services provided by REHs to the extent not preempted by federal law if the service would be covered when performed in a general hospital.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Rural Hospitals

A rural hospital is an acute care hospital that has 100 or fewer beds, an emergency room, and is one of the following:

- The sole provider within a county with a population density of up to 100 persons per square mile;
- An acute care hospital, in a county with a population density of up to 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;
- A hospital supported by a tax district or sub-district whose boundaries encompass a population of up to 100 persons per square mile;

- A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92, regardless of the number of licensed beds;
- A hospital with a service area[1] that has a population of up to 100 persons per square mile; or
- A hospital designated as a critical access hospital, as defined in s. 408.07, F.S.[2]

As of January 17, 2024, there are 22 licensed rural hospitals in Florida.[3]

Closure of Rural Hospitals

Around the country between 2010 and 2021 a total of 136 rural hospitals have closed. In 2020 alone, a record 19 rural hospitals shuttered.[4] Rural hospitals naturally face challenges due to low patient volumes, which can make it challenging to maintain fixed-operating costs and meet performance measures, and the fact that many of the patients treated in rural hospitals are older, sicker, and poorer when compared with the national average.[5] In addition to the patient-side issues, rural hospitals also suffer from above average staffing shortages with only 10 percent of physicians in the U.S. practicing in rural areas despite 20 percent of the population residing in those areas.[6] These issues were compounded and exacerbated by the COVID-19 pandemic which increased the severity of staffing shortages, increased costs, and worsened health outcomes.

In Florida, between 2010 and present, three rural hospitals closed: Healthmark Regional Medical Center in Defuniak Springs, Regional General Hospital in Williston, and Shands Lake Shore Regional Medical Center in Lake City.[7]

Rural Emergency Hospitals

To respond to the number of rural hospital closures, the federal Consolidated Appropriations Act of 2021 created a new Medicare provider type designated as a Rural Emergency Hospital.[8] Federal rule defines a this newly-created type of hospital as an entity that operates for the purpose of providing emergency department services, observational care, and other outpatient medical and health services specified by the Secretary in which the annual per-patient average length of stay does not exceed 24 hours.[9] Only rural hospitals with 50 or fewer beds and critical

[1] "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Transparency at the agency.
[2] S. 395.602(2)(b), F.S.
[3] Florida Health Finder search, Class 1 Hospital Rural. Search tool available at https://quality.healthfinder.fl.gov/, (last visited Jan. 17, 2024).
[4] Rural Hospital Closures Threaten Access – Solutions to Preserve Care in Local Communities, The American hospital, September 2022, available at https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf, (last visited Jan. 17, 2024).
[5] *Id.*
[6] *Id.*
[7] Supra n. 3
[8] 42 USC s. 1395x(kkk).
[9] 42 CFR s. 485.502

access hospitals that were enrolled and certified to participate in Medicare on or before December 7, 2020, qualify for certification as a REH.[10]

REHs are required to be licensed by the state in which they are located, maintain a Medicare provider agreement with the federal Centers for Medicare & Medicaid Services (CMS), and meet the other conditions of participation established in 42 CFR s. 485.5 through 42 CFR s. 485.546. These conditions of participation establish requirements related to governance, services offered, staffing, physical environment, and emergency preparedness, among others.[11] Some of the requirements provide that the REH must:

- Have an organized medical staff that operates under bylaws approved by the governing body of the REH and which is responsible for the quality of medical care provided to patients in the REH. The medical staff must be composed of medical or osteopathic doctors and may include other categories of physicians. Additionally, an REH may supplement the care provided through the use telemedicine services provided by a distant-site hospital as long as the distant-site hospital meets specified requirements.[12]
- Have an organized nursing service that is available to provide 24-hour care to patients of the REH.[13]
- Provide emergency, laboratory, radiological, pharmaceutical, and outpatient medical and health services as detailed in the rule.[14]
- Have an infection control program and a quality assessment and performance improvement program.

An REH is eligible for payment through the Medicare program for services at an amount that is equal to the amount that would be paid to a hospital for providing the equivalent outpatient service increased by five percent.[15] Additionally, an REH will receive a monthly facility payment of $272,866 from the Medicare program until October 1, 2024, after which the amount will be $267.408.68. In future years, the payment will increase by the hospital market basket percentage.[16]

Currently, 15 states authorize REHs including Arkansas, Illinois, Indiana, Iowa, Kansas, Michigan, Montana, Nebraska, Nevada, New Mexico, New York, Oklahoma, South Dakota, Texas, and West Virginia.[17]

[10] Rural Emergency Hospitals, Centers for Medicare and Medicaid Services, available at https://www.cms.gov/medicare/health-safety-standards/guidance-for-laws-regulations/hospitals/rural-emergency-hospitals, (last visited Jan. 18, 2024).
[11] Supra n. 10
[12] 42 CFR s. 485.512
[13] 42 CFR s. 485.530
[14] 42 CFR ss. 485.516-485.524
[15] 42 CFR s. 419.92
[16] MLN Fact Sheet, rural Emergency Hospitals, available at https://www.cms.gov/files/document/mln2259384-rural-emergency-hospitals.pdf, (last visited Jan. 18, 2024).
[17] National Conference of State Legislatures, Rural Emergency Hospitals, available at https://www.ncsl.org/health/rural-emergency-hospitals, (last visited Jan. 18, 2024).

Mandated Health Insurance Coverages

Section 624.215, F.S., requires every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, to submit to the AHCA and the legislative committees having jurisdiction, a report that assesses the social and financial impacts of the proposed coverage. As of January 22, 2024, Senate Committee on Health Policy staff has not received this report.

Under the federal Patient Protection and Affordable Care Act (ACA), individuals and small businesses can shop for health insurance coverage on the federal marketplace. All non-grandfathered plans[18] must include minimum essential coverage (MEC),[19] including an array of services that includes the 10 essential health benefits (EHBs). These 10 EHBs are further clarified or modified each year through the federal rulemaking process and are open for public comment before taking effect. The 10 general categories for the EHBs are:

- Ambulatory services (outpatient care);
- Emergency services;
- Hospitalization (inpatient care);
- Maternity and newborn care.
- Mental health and substance abuse disorder services;
- Prescription drugs.
- Rehabilitative services and rehabilitative services and devices;
- Laboratory services;
- Preventive care and chronic disease management; and
- Pediatric services, including oral and vision care.[20]

States are free to modify the EHBs offered in their states by adding coverage; however, because of concerns that federal funds would be used on costly mandated coverages that were not part of the required EHBs, the ACA contains a provision requiring that, starting in 2016, the states would have to pay for the cost of the coverage. As a result, the State of Florida may be required to defray the costs of any additional benefits beyond the required EHBs put in place after 2011.[21]

Examples of health insurance benefits mandated under Florida law include:

- Coverage for certain diagnostic and surgical procedures involving bones or joints of the jaw and facial region (s. 627.419(7), F.S.);
- Coverage for bone marrow transplants (s. 627.4236, F.S.);
- Coverage for certain cancer drugs (s. 627.4239, F.S.);
- Coverage for any service performed in an ambulatory surgical center (s. 627.6616, F.S.);

[18] A "grandfathered health plan" are those health plans, both individual and employer plans, that maintain coverage that were in place prior to the passage of the PPACA or in which the enrollee was enrolled on March 23, 2010 while complying with the consumer protection components of the PPACA. If a group health plan enters a new policy, certificate, or contract of insurance, the group must provide the new issuer the documentation from the prior plan so it can be determined whether there has been a change sufficient to lose grandfather status. *See* 26 U.S.C. 7805 and 26 C.F.R. s. 2590.715-1251(a).

[19] To meet the individual responsibility provision of the PPACA statute, a benefit plan or coverage plan must be recognized as providing minimum essential coverage (MEC). Employer based coverage, Medicaid, Medicare, CHIP (i.e.: Florida KidCare), and TriCare would meet this requirement.

[20] 42 U.S.C. s. 18022(b)(1)(A)-(J).

[21] *See* 42 U.S.C. s. 18031(d)(3)(B)(ii).

- Diabetes treatment services (s. 627.6408, F.S.);
- Osteoporosis (s. 627.6409, F.S.);
- Certain coverage for newborn children (s. 627.641, F.S.);
- Child health supervision services (s. 627.6416, F.S.);
- Certain coverages related to mastectomies (s. 627.6417, F.S.);
- Mammograms (s. 627.6418, F.S.); and
- Treatment of cleft lip and cleft palate in children (s. 627.64193, F.S.).

III. Effect of Proposed Changes:

SB 644 amends s. 395.602, F.S., to create a new definition of REH to mean "a hospital that meets the criteria specified in 42 U.S.C. s. 1395x(kkk)(2) and is certified as a rural emergency hospital by the United States Secretary of Health and Human Services" and to provide that a facility is eligible for licensure as an REH if it meets the definition. The bill allows an REH to enter into any contracts necessary to be eligible for federal reimbursement as an REH. Additionally, the bill amends the definition of "rural hospital" in s. 395.602, F.S., and the definition of "hospital" in s. 395.002, F.S., to add REHs and adds REHs to the requirement in s. 395.0163(1)(b), F.S., that the AHCA review construction plans and specifications prior to initiating such construction.

The bill creates a non-statutory section of law to authorize the AHCA to seek federal approval to provide Medicaid reimbursements to licensed REHs and amends ss. 627.6051, 627.6614, and 641.31078, F.S., to require individual and group health insurance policies, as well as health maintenance organization contracts, respectively, issued or renewed on or after July 1, 2024,to provide coverage for services performed in an REH if such service would be covered by the policy or contract when provided in a general hospital, to the extent such coverage is not preempted by federal or state law.

Additionally, the bill repeals one obsolete provision and amends several statutory sections to conform cross references to the changes made by the bill.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may have an indeterminate positive fiscal impact on rural hospitals that convert to REHs and on rural communities that do not lose access to health services due to such conversion, rather than the closure of their rural hospital.

C. Government Sector Impact:

The bill may have an indeterminate negative fiscal impact on the AHCA due to requiring the agency to regulate a new facility type. As of this writing, the AHCA has not submitted an estimate for such fiscal impact, if there is one.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Sections 5-7 of the bill require a health insurance policy or HMO contract to provide coverage for any service performed in a rural hospital if such service were performed in a general hospital and were covered by a policy or contract in a general hospital. Since the bill does not limit the application of this mandate only to policies or contracts that provide major medical coverage, the bill appears to apply this mandate to supplemental and limited benefit coverage offered by health insurers or HMOs. As a result, if an insured or subscriber had such coverage and obtained services at a general hospital and the general hospital was reimbursed by an insurer or HMO, the insurer or HMO would be required to reimburse for such coverage at a rural hospital, although the policy or contract of the patient was not the same. In this way, the bill may create a coverage mandate on insurers and HMOs for unspecified benefits and reimbursement rates at rural hospitals since insurers and HMOs establish networks and may have different participating or non-participating providers, as well as covered benefits.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.002, 395.602, 395.0163, 627.6051, 627.6614, 641.31078, 409.9116, and 1009.65.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.