HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 31A Certificates of Need for Hospitals
SPONSOR(S): Health Innovation Subcommittee; Brodeur
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	9 Y, 3 N, As CS	Guzzo	Poche
2) Health & Human Services Committee			

SUMMARY ANALYSIS

The certificate of need (CON) program, administered by the Agency for Health Care Administration (AHCA), requires certain health care facilities to obtain authorization from the state before offering certain new or expanded services. Health care facilities subject to CON review include hospitals, nursing homes, hospices, and intermediate care facilities for the developmentally disabled.

Florida's CON program was established in 1973, and has undergone several changes over the years. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act, which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria. Each state was required to have a CON program in compliance with those standards as a condition for obtaining federal funds for health programs. The federal health planning legislation was repealed in 1986, but Florida retained its CON program.

Currently, there are 22 states that do not require CON review for the addition of hospital beds. Of those states, 14 do not have CON requirements for any type of health care facility or service, and 8 states do not have CON requirements relating specifically to the addition of hospital beds.

The Florida CON program has three levels of review: full, expedited and exempt. Expedited review is primarily targeted towards nursing home projects. Projects required to undergo full comparative review, include:

- Construction of a new hospital;
- Replacement of a hospital if the proposed project site is more than one mile from the hospital being replaced;
- Conversion from one type of hospital to another, including the conversion between a general hospital, specialty hospital, or a long-term care hospital; and
- Establishment of tertiary health services and comprehensive rehabilitation services.

The CON program provides exemptions from full CON review for the addition of beds to certain existing services provided in health care facilities, including, comprehensive rehabilitation, neonatal intensive care, and psychiatric and substance abuse services.

An applicant for CON review must submit a fee with the application. The minimum CON application filing fee is $10,000. In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however the total fee may not exceed $50,000. The fee for a CON exemption is $250.

The bill eliminates CON review requirements for hospitals and hospital services and makes necessary conforming changes throughout part I of chapter 408, F.S. The bill also removes the CON review requirement for increasing the number of comprehensive rehabilitation beds in a facility that offers comprehensive rehabilitation services.

The bill is expected to have a significant negative fiscal impact on AHCA resulting from the loss of CON application and exemption fees for hospital services.

The bill provides an effective date of July 1, 2015.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Hospital Licensure

Hospitals are licensed by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[1] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.[2]

A specialty hospital, in addition to providing the same services as general hospitals, provides other services, including:

- A range of medical services restricted to a defined age or gender group;
- A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or
- Intensive residential treatment programs for children and adolescents.[3]

Section 395.1041(2), F.S., requires AHCA to maintain an inventory of hospitals with an emergency department. The inventory must list all services within the service capability of each hospital, and such services must appear on the face of the hospital's license. As of May 28, 2015, 219 out of the 305 licensed hospitals in the state have an emergency department.[4]

Facilities must meet initial licensing requirements by submitting a completed application and required documentation, and the satisfactory completion of a facility survey. The license fee is $1,565.13 or $31.46 per bed, whichever is greater.[5] The survey fee is $400.00 or $12.00 per bed, whichever is greater.[6]

Section 395.1055, F.S., authorizes AHCA to adopt rules for hospitals. Separate standards may be provided for general and specialty hospitals.[7] The rules for general and specialty hospitals must include minimum standards to ensure:

- A sufficient number of qualified types of personnel and occupational disciplines are on duty and available at all times to provide necessary and adequate patient care;
- Infection control, housekeeping, sanitary conditions, and medical record procedures are established and implemented to adequately protect patients;
- A comprehensive emergency management plan is prepared and updated annually;
- Licensed facilities are established, organized, and operated consistent with established standards and rules; and
- Licensed facility beds conform to minimum space, equipment, and furnishing standards.[8]

The minimum standards for hospital licensure are provided under rule 59A-3, F.A.C.

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[1] S.395.002(12), F.S.
[2] Id.
[3] S. 395.002(28), F.S.
[4] Agency for Health Care Administration, Facility/Provider Search Results, *Hospitals,* available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (report generated on May 28, 2015).
[5] Rule 59A-3.006(3), F.A.C.
[6] S. 395.0161(3)(a), F.S.
[7] S. 395.1055(2), F.S.
[8] S. 395.1055(1), F.S.

Certificate of Need (CON)

CON programs are designed to restrain health care costs and provide for directed, measured planning for new services and facilities. Such programs were originally established to regulate the addition of new facilities, or new beds in hospitals and nursing homes, for example, and to prevent overbuying of expensive equipment, under the economic theory that excess capacity directly results in health care price inflation. When a hospital or health care service provider cannot meet its obligations, fixed costs must be met through higher charges for the beds that are used or for the number of patients using the service. Larger institutions have higher costs, so CON supporters say it makes sense to limit facilities to building only enough capacity to meet actual needs.[9]

In addition to cost containment, CON regulation is intended to create a "quid pro quo" in which profitability of covered medical services is increased by restricting competition and, in return, medical providers cross-subsidize specified amounts of indigent care, or medical services to the poor that are unprofitable to the provider.[10] Some states require facilities and providers that obtain a CON to provide a certain amount of indigent care to underinsured or uninsured patients.[11]

Studies have found that CON programs do not meet the goal of limiting costs in health care. A literature review conducted in 2004 by the Federal Trade Commission and the Department of Justice concluded that:

> [O]n balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits. Market incumbents can too easily use CON procedures to forestall competitors from entering an incumbent's market. [. . . .] Indeed, there is considerable evidence that CON programs can actually increase prices by fostering anticompetitive barriers to entry. Other means of cost control appear to be more effective and pose less significant competitive concerns.[12]

Studies are split, however, on whether CON regulation has improved access to care for the underinsured and uninsured.[13] While there is a paucity of such research, some studies have found that

[9] National Conference of State Legislators, Certificate of Need: State Laws and Programs, available at http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (last viewed June 8, 2015).

[10] Thomas Stratmann and Jacob Russ, "Do Certificate-of-Need Laws Increase Indigent Care?" Mercatus Center at George Mason University, July 2014, pg. 2, available at: http://mercatus.org/publication/do-certificate-need-laws-increase-indigent-care (last viewed June 8, 2015).

[11] For example, Delaware (Del. Code Ann. tit. 16 § 9303), Georgia (Ga. Code Ann. §111-2-2.40), Rhode Island (R.I. Code R. §6.2.4(B)), and Virginia (12 Va. Admin. Code §5-230-40 and §5-220-270) require CON applicants to comply with such provisions.

[12] "Improving Health Care: A Does of Competition: A Report by the Federal Trade Commission and the Department of Justice," July 2004, available at: https://www.ftc.gov/reports/improving-health-care-dose-competition-report-federal-trade-commission-department-justice (last viewed June 8, 2015): "[t]here is near universal agreement among the authors [of studies on the economic effects of CON programs] and other health economists that CON has been unsuccessful in containing health care costs"); DANIEL SHERMAN, FEDERAL TRADE COMM'N, THE EFFECT OF STATE CERTIFICATE-OF-NEED LAWS ON HOSPITAL COSTS: AN ECONOMIC POLICY ANALYSIS (1988) (concluding, after empirical study of CON programs' effects on hospital costs using 1983-84 data, that strong CON programs do not lead to lower costs but may actually increase costs); MONICA NOETHER, FEDERAL TRADE COMM'N, COMPETITION AMONG HOSPITALS 82 (1987) (empirical study concluding that CON regulation led to higher prices and expenditures); KEITH B. ANDERSON & DAVID I. KASS , FEDERAL TRADE COMM 'N, CERTIFICATE OF NEED REGULATION OF ENTRY INTO HOME HEALTH CARE: A MULTI-PRODUCT COST FUNCTIO N ANALYSIS (1986) (economic study finding that CON regulation led to higher costs, and that CO N regulation did little to further economies of scale); cf. PUBLIC HEALTH RESOURCE GROUP, CERTIFICATE O F NEED PROJECT REPORT 17-18 at 4 (2001) (noting that the "track record of the cost effectiveness of state CON programs is decidedly mixed," and that "[i]n some states, the of effectiveness is at least partially attributable to deficiencies in program operations and to political environments in which legislative or high level executive branch intervention alters or affects CON decision-making"). See also David S. Salkever, Regulation of Prices and Investment in Hospitals in the United States, in 1B HANDBOOK OF HEALTH ECONOMICS, 1489-90 (A.J. Culyer & J.P. Newhouse eds., 2000) (concluding that "there is little evidence that [1970s-era] investment controls reduced the rate of cost growth," even though "inconsistent reports of constraining effects on numbers of beds and diffusion of some specialized services did appear"). See also, Conover, C. and Sloan, F., "Evaluation of Certificate of Need in Michigan", Duke University Center for Health Policy, Law and Management, May 2003, available at http://ushealthpolicygateway.com/vii-key-policy-issues-regulation-and-reform/l-health-care-regulation/health-facilities-regulation/certificate-of-need/ ("the most methodologically sound studies have found that CON has no effect or actually increases both hospital spending per capita and total spending per capita").

[13] Supra, FN 10 at pg. 18.

access to care for the underserved populations has increased in states with CON programs,[14] while another has found little, if any, evidence to support such a conclusion.[15] In Florida, the Statewide Medicaid Managed Care (SMMC) program requires all managed care plans to comply with provider network standards to ensure access to care for beneficiaries and imposes significant penalties if access to care is impeded within the program. While Florida maintains a CON program for several types of health care facilities, the imposition of accountability standards within the SMMC program would ensure access to care at those health care facilities for Medicaid patients should the CON program be repealed.

CON programs have been found to restrict entry and limit the provision of regulated medical services.[16] States with hospital CON regulations have 13 percent fewer hospital beds per 100,000 persons than states without hospital CON regulations.[17] The impact of CON regulations in Florida has been examined as well. A study found that, in Miami-Dade County, CON regulations result in approximately 3,428 fewer hospital beds, between 5 and 10 fewer hospitals offering MRI services, and 18 fewer hospitals offering CT scans.[18]

Florida's CON Program

Overview

Florida's CON program has existed since July 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act of 1974 (the "Act), which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.[19] Each state was required to have a CON program in compliance with the Act as a condition for obtaining federal funds for health programs. The Act was repealed in 1986.

In Florida, a CON is a written statement issued by AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service, including hospices. The Florida CON program has three levels of review: full, expedited and exempt.[20] Unless a hospital project is exempt from the CON program, it must undergo a full comparative review. Expedited review is primarily targeted towards nursing home projects.

Projects Subject to Full CON Review

Some hospital projects are required to undergo a full comparative CON review under the statute, including:

- New construction of general hospitals, long-term care hospitals, and freestanding specialty hospitals;
- Replacement of a hospital if the proposed project site is not located on the same site or within one mile of the existing health care facility;
- Increasing the number of beds for comprehensive rehabilitation; and

[14] Tracy Yee, Lucy B. Stark, et al, "Health Care Certificate-of-Need Laws: Policy or Politics?," Research Brief, National Institute for Health Care Reform, No. 4, May 2011, pg. 6, available at: http://www.nihcr.org/index.php?download=119ncfl17 (citing Elana C. Fric-Shamji and Mohammed F. Shamji, "Impact of U.S. Government Regulation on Access to Elective Surgical Care," Clinical & Investigative Medicine, vol. 31, no. 5 (October 2008) and Ellen S. Campbell and Gary M. Fournier, "Certificate-of-Need Deregulation and Indigent Hospital Care," Journal of Health Politics, Policy and Law, vol. 18, no. 4 (Winter 1993)).
[15] Christopher J. Conover and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?," Journal of Health Politics, Policy and Law, vol. 23, no. 3, pg. 478 (June 1998).
[16] Mercatus Center at George Mason University, "How State Certificate-of-Need Laws Affect Access to Health Care," available at: https://medium.com/@mercatus/how-state-certificate-of-need-con-laws-impact-access-to-health-care-b8d3ec84242f (last viewed June 8, 2015).
[17] Id.
[18] Christopher Koopman and Thomas Stratman, "Certificate-of-Need Laws: Implications for Florida," March 2015, pg. 2, available at: http://mercatus.org/sites/default/files/Koopman-Certficate-of-NeedFL-MOP.pdf.
[19] Pub. L. No. 93-641, 42 U.S.C. §§ 300k et seq.
[20] S. 408.036, F.S.

- Establishing tertiary health services.[21]

Projects Subject to Expedited CON Review

Section 408.036(2), F.S., permits certain projects to undergo expedited CON review. Applicants for expedited review are not subject to the application deadlines associated with full comparative review and may submit an application at any time. Projects subject to an expedited review include:

- Transfer of a CON;
- Replacement of a nursing home within the same district;
- Replacement of a nursing home if the proposed site is within a 30-mile radius of the existing nursing home;
- Relocation of a portion of a nursing home's beds to another facility or to establish a new facility in the same district, or a contiguous district, if the relocation is within a 30-mile radius of the existing facility and the total number of nursing home beds in the state does not increase; and
- Construction of a new community nursing home in a retirement community under certain conditions.[22]

Exemptions from CON Review

Section 408.036(3), F.S., provides many exemptions to CON review for certain hospital projects, including:

- Adding swing beds[23] in a rural hospital, the total of which does not exceed one-half of its licensed beds.
- Converting licensed acute care hospital beds to Medicare and Medicaid certified skilled nursing beds in a rural hospital, as defined in s. 395.602, F.S., so long as the conversion of the beds does not involve the construction of new facilities.
- Adding hospital beds licensed under chapter 395, F.S., for comprehensive rehabilitation, the total of which may not exceed 10 total beds or 10 percent of the licensed capacity, whichever is greater.
- Establishing a level II neonatal intensive care unit (NICU) if the unit has at least 10 beds, and if the hospital had a minimum of 1,500 births during the previous 12 months.
- Establishing a level III NICU if the unit has at least 15 beds, and if the hospital had a minimum of at least 3,500 births during the previous 12 months.
- Establishing a level III NICU if the unit has at least 5 beds, and is a verified trauma center,[24] and if the applicant has a level II NICU.
- Establishing an adult open heart surgery program in a hospital located within the boundaries of a health service planning district, which:
  - Has experienced an annual net out-migration of at least 600 open heart surgery cases for 3 consecutive years; and
  - Has a population that exceeds the state average of population per licensed and operational open-heart programs by at least 25 percent.
- For the provision of percutaneous coronary intervention for patients presenting with emergency myocardial infarctions in a hospital that does not have an approved adult open-heart-surgery program.

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[21] S. 408.032(17), F.S., defines "tertiary health service" as a health service which, due to its high level of intensity, complexity, specialized or limited applicability, and cost, should be limited to, and concentrated in, a limited number of hospitals to ensure the quality, availability, and cost-effectiveness of such service. Examples of such service include, but are not limited to, pediatric cardiac catheterization, pediatric open-heart surgery, organ transplantation, neonatal intensive care units, comprehensive rehabilitation, and medical or surgical services which are experimental or developmental in nature to the extent that the provision of such services is not yet contemplated within the commonly accepted course of diagnosis or treatment for the condition addressed by a given service. Pursuant to this section, AHCA established a list of all tertiary health services in Rule 59C-1.002, F.A.C.

[22] S. 408.036(2), F.S.

[23] S. 395.602(2)(g), F.S., defines "swing bed" as a bed which can be used interchangeably as either a hospital, skilled nursing facility (SNF), or intermediate care facility (ICF) bed pursuant to 42 C.F.R. parts 405, 435, 440, 442, and 447.

[24] S. 395.4001(14), F.S., defines "trauma center" as a hospital that has been verified by the Department of Health to be in substantial compliance with the requirements in s. 395.4025, F.S., and has been approved to operate as a Level I trauma center, Level II trauma center, or pediatric trauma center, or is designated as a Level II trauma center pursuant to s. 395.4025(14), F.S.

CON Determination of Need and Application and Review Process

A CON is predicated on a determination of need. The future need for services and projects is known as the "fixed need pool"[25], which AHCA publishes for each batching cycle. Rule 59C-1, F.A.C., provides need formulas[26] to calculate the fixed need pool for certain services, including NICU services[27], adult and child psychiatric services[28], adult substance abuse services[29], and comprehensive rehabilitation services.[30]

Upon determining that a need exists, AHCA accepts applications for CON based on batching cycles. A batching cycle is a means of grouping of, for comparative review, CON applications submitted for beds, services or programs having a like CON need methodology or licensing category in the same planning horizon and the same applicable district or subdistrict.[31] Section 408.032(5), F.S., establishes the 11 district service areas in Florida, illustrated in the chart below.

[25] Rule 59C-1.002(19), F.A.C., defines "fixed need pool" as the identified numerical need, as published in the Florida Administrative Register, for new beds or services for the applicable planning horizon established by AHCA in accordance with need methodologies which are in effect by rule at the time of publication of the fixed need pools for the applicable batching cycle.

[26] Rule 59C-1.039(5), F.A.C., provides the need formula for comprehensive medical rehabilitation inpatient beds as follows: ((PD/P) x PP / (365 x .85)) – LB – AB = NN where: 1. NN equals the net need for Comprehensive Medical Rehabilitation Inpatient Beds in a District. 2. PD equals the number of inpatient days in Comprehensive Medical Rehabilitation Inpatient Beds in a district for the 12-month period ending 6 months prior to the beginning date of the quarter of the publication of the Fixed Bed Need Pool.
3. P equals the estimated population in the district. For applications submitted between January 1 and June 30, P is the population estimate for January of the preceding year; for applications submitted between July 1 and December 31, P is the population estimate for July of the preceding year. The population estimate shall be the most recent estimate published by the Office of the Governor and available to the Department at least 4 weeks prior to publication of the Fixed Bed Need Pool.
4. PP equals the estimated population in the district for the applicable planning horizon. The population estimate shall be the most recent estimate published by the Office of the Governor and available to the Department at least 4 weeks prior to publication of the Fixed Bed Need Pool. 5. .85 equals the desired average annual occupancy rate for Comprehensive Medical Rehabilitation Inpatient Beds in the district. 6. LB equals the district's number of licensed Comprehensive Medical Rehabilitation Inpatient Beds as of the most recent published deadline for Agency initial decisions prior to publication of the Fixed Bed Need Pool.
7. AB equals the district's number of approved Comprehensive Medical Rehabilitation Inpatient Beds.

[27] Rule 59C-1.042(3), F.A.C.

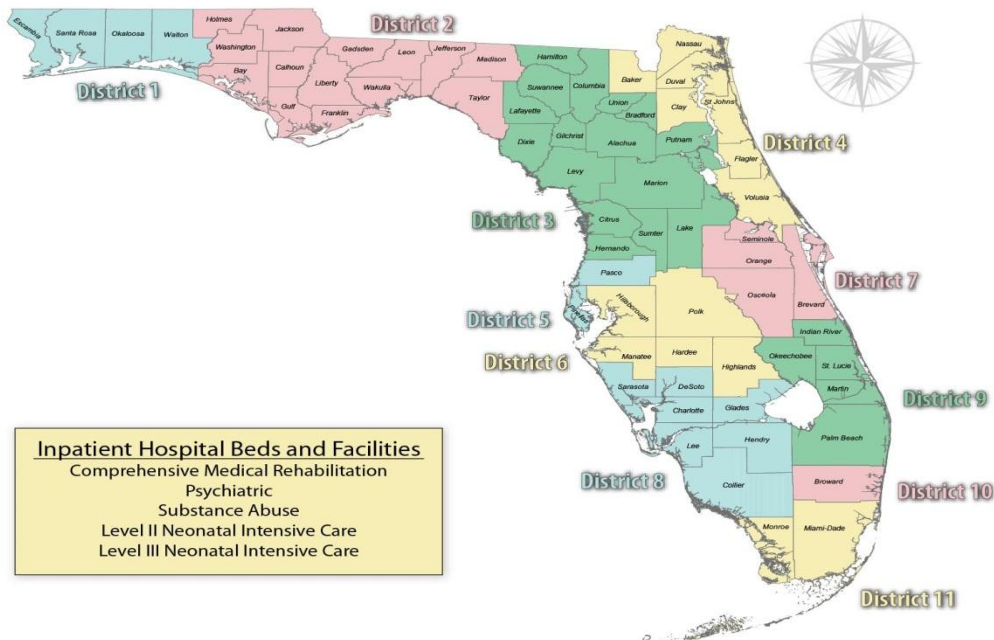
[28] Rule 59C-1.040(4), F.A.C.

[29] Rule 59C-1.041(4), F.A.C.

[30] Rule 59C-1.039(5), F.A.C.

[31] Rule 59C-1.002(5), F.A.C.

Certificate of Need Service Areas



The CON review process consists of four batching cycles each year, including two batching cycles each year for two project categories: hospital beds and facilities, and other beds and programs.[32] The "hospital beds and facilities" batching cycle includes applicants for new or expanded:

- Comprehensive medical rehabilitation beds;
- Adult psychiatric beds;
- Child and adolescent psychiatric beds;
- Adult substance abuse beds;
- NICU level II beds; and
- NICU level III beds.[33]

The "other beds and programs" batching cycle includes:

- Nursing home beds;
- Hospice beds;
- Pediatric open heart surgery;
- Pediatric cardiac catheterization services; and
- Organ transplantation services.[34]

Requests for an expedited review or exemption may be made at any time and are not subject to batching requirements.[35]

At least 30 days prior to the application deadline for a batch cycle, an applicant must file a letter of intent with AHCA.[36] A letter of intent must describe the proposal, specify the number of beds sought, and identify the services to be provided and the location of the project.[37]

[32] Rule 59C-1.008(1)(g), F.A.C.
[33] Rule 59C-1.008(1), F.A.C.
[34] Id.
[35] S.408.036, F.S., and Rule 59C-1.004(1), F.A.C.
[36] S. 408.039(2)(a), F.S.
[37] S. 408.039(2)(c), F.S.

Applications for CON review must be submitted by the specified deadline for the particular batch cycle.[38] AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application.[39] The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.[40]

Within 60 days of receipt of the completed applications for that batch, AHCA must issue a State Agency Action Report and Notice of Intent to grant a CON for a project in its entirety, to grant a CON for identifiable portions of a project, or to deny a CON for a project.[41] AHCA must then publish the decision, within 14 days, in the Florida Administrative Weekly.[42] If no administrative hearing is requested within 21 days of the publication, the State Agency Action Report and the Notice of Intent become a final order of AHCA.[43]

CON Fees

An applicant for CON review must submit a fee to AHCA at the time of application submission. The minimum CON application filing fee is $10,000.[44] In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure, however the total fee may not exceed $50,000.[45] A request for a CON exemption must be accompanied by a $250 fee payable to AHCA.[46]

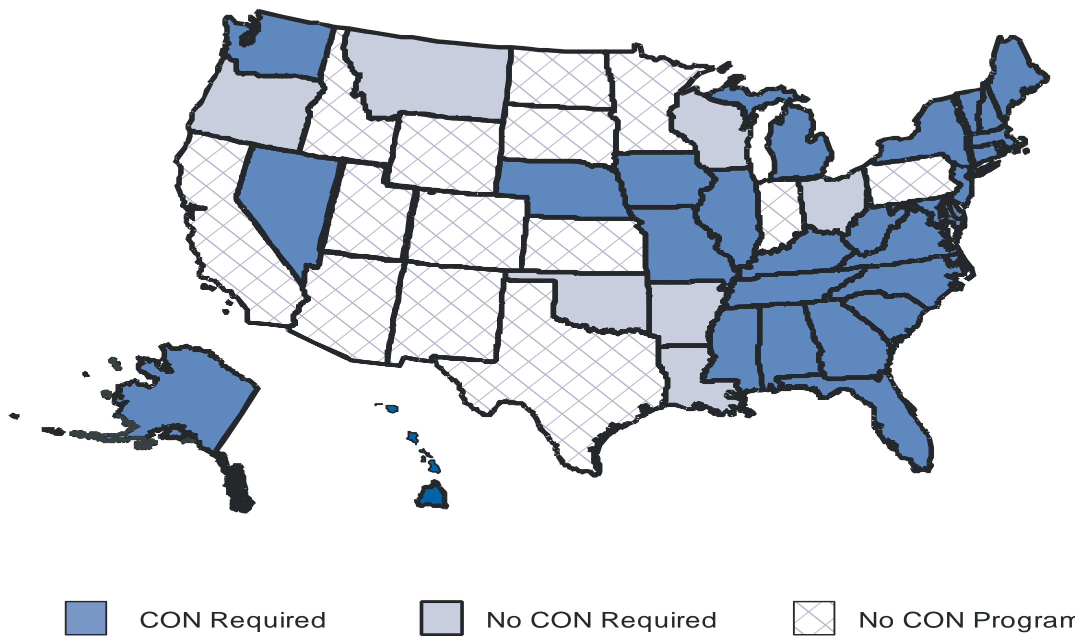
CON Litigation

Florida law authorizes competitors to challenge CON decisions. A Notice of Intent to Award may be challenged by a competing applicant in the same review cycle or an existing provider in the same district by submitting evidence that they will be substantially affected if the CON is awarded.[47] A challenge to a CON decision is heard by an Administrative Law Judge under the Division of Administrative Hearings.[48] AHCA must render a Final Order within 45 days of receiving the Recommended Order of the Administrative Law Judge.[49] A party to an administrative hearing may challenge a Final Order to the District Court of Appeals for judicial review within 30 days of receipt of a Final Order.[50]

CON Nationwide

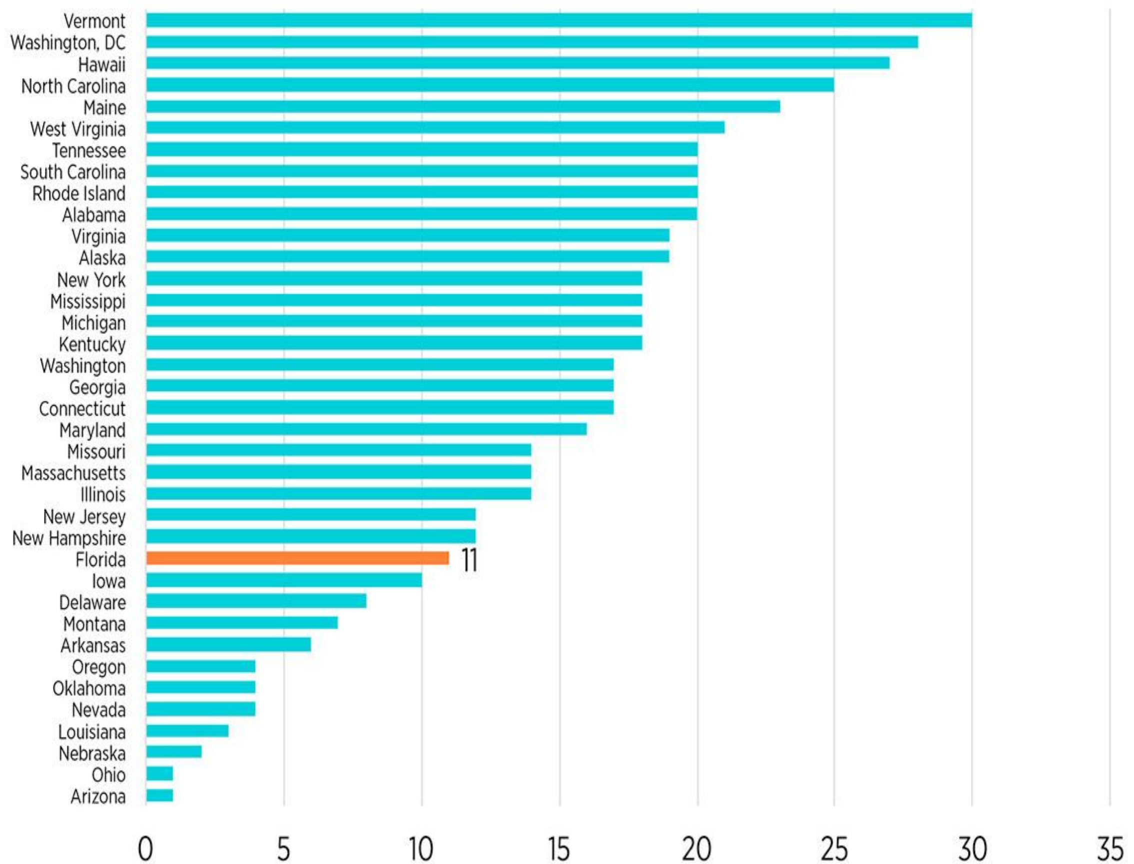
14 states do not have CON requirements for any type of health care facility or service.[51] There are 8 additional states do not have CON requirements relating specifically to the addition of hospital beds.[52]

[38] Rule 59C-1.008(1)(g), F.A.C.
[39] S. 408.039(3)(a), F.S.
[40] Id.
[41] S. 408.039(4)(b), F.S.
[42] S. 408.039(4)(c), F.S.
[43] S. 408.039(4)(d), F.S.
[44] S. 408.038, F.S.
[45] Id.
[46] S. 408.036(4), F.S., and Rule 59C-1.005(2)(g), F.A.C.
[47] S. 408.039(5)(c), F.S.
[48] Id.
[49] S. 408.039(5)(e), F.S.
[50] S. 408.039(6), F.S.
[51] National Conference of State Legislators, Certificate of Need: State Laws and Programs, available at http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (last viewed June 8, 2015).
[52] Id.



On average, states with CON programs regulate 14 different services, devices, and procedures.[53] Florida's CON program currently regulates 11, which is slightly below the national average.[54] Vermont has the most CON laws in place. Arizona has the least number of CON laws.[55]

State Ranking by Number of CON Laws



Effect of Proposed Changes

[53] Supra, FN 18 at pg. 3.
[54] Id.
[55] Id.

The bill eliminates CON review requirements for hospitals and hospital services and makes necessary conforming changes throughout part I of chapter 408, F.S. The bill also removes the CON review requirement for increasing the number of comprehensive rehabilitation beds in a facility that offers comprehensive rehabilitation services. Hospitals will be able to expand the number of beds and the types of services without seeking prior authorization from the state. Similarly, facilities that offer comprehensive rehabilitation services will be able to increase the number of beds to meet demand without first seeking prior authorization from the state.

B. SECTION DIRECTORY:

Section 1: Amends s. 408.032, F.S., relating to definitions relating to Health Facility and Services Development Act.
Section 2: Amends s. 408.034, F.S., relating to duties and responsibilities of the agency; rules.
Section 3: Amends s. 408.035, F.S., relating to review criteria.
Section 4: Amends s. 408.036, F.S., relating to projects subject to review; exemptions.
Section 5: Amends s. 408.037, F.S., relating to application content.
Section 6: Amends s. 408.039, F.S., relating to review process.
Section 7: Amends s. 408.043, F.S., relating to special provisions.
Section 8: Amends s. 395.604, F.S., relating to other rural hospital programs.
Section 9: Amends s. 395.605, F.S., relating to emergency care hospitals.
Section 10: Provides for any law amended by a law enacted during the 2015 Regular Session also amended by this act to be construed as enacted in the same session of the Legislature, and full effect given to each if possible.
Section 11: Provides an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   AHCA will experience a reduction in revenue resulting from the loss of CON application and exemption fees for hospital services. Fees collected in 2014 resulted in revenue of approximately $650,000.[56] An indeterminate amount of the reduction in revenue will be negated by an increase in fees collected for hospital licensure.

2. Expenditures:

   AHCA may experience increased workload resulting from an increase in hospital licensure applications. The expenditure associated with any increase in workload is indeterminate yet likely insignificant. The increased workload will likely be offset by the reduced workload resulting from the repeal of the CON review process for hospitals.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

[56] AHCA, Agency Bill Analysis of HB 31A, p. 5, May 21, 2015 (on file with Health Innovation Subcommittee staff).

Hospitals will experience a significant positive fiscal impact resulting from the elimination of CON fees, which range from $10,000 to $50,000.

By removing the CON review program for hospitals, the hospital industry is likely to realize increased competition in services offered by hospitals.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On June 9, 2015, the Health Innovation Subcommittee adopted an amendment and reported the bill favorable as a committee substitute. The amendment removes the CON review requirement for increasing the number of comprehensive rehabilitation beds.

The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.