SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Date: December 19, 1997 Revised: 1/6/98

Subject: Rural Hospitals

	Analyst	Staff Director	Reference	Action
1.	Munroe	Wilson	HC	Fav/2 amendments
2.			WM	
3.				
4.				
5.				

I. Summary:

Senate Bill 288 modifies the definition of the term "rural hospital" to increase the allowable number of licensed beds that a hospital that is designated as a rural hospital may have from 85 to 100. The bill revises provisions relating to Medicaid rural hospital disproportionate share funding to provide that any rural hospital designated after July 1, 1998, may not be included in the rural hospital disproportionate share program or the rural hospital financial assistance program unless additional appropriations are provided for the disproportionate share program or the financial assistance program for rural hospitals.

This bill substantially amends sections 95.602, 408.07, and 409.9116, Florida Statutes.

II. Present Situation:

Chapter 395, Florida Statutes, provides for the licensing and regulation of hospitals and ambulatory surgical centers. Part III of chapter 395 provides legislative intent and findings in support of the efforts of rural hospitals. Section 395.602, F.S., defines a "rural hospital" to mean a licensed acute care hospital having 85 or fewer licensed beds and an emergency room, that is located in an area defined as rural by the United States Census, and which is: 1) the sole provider within a county with a population density of no greater than 100 persons per square mile; or 2) an acute care hospital, in a county with a population density of no greater than 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; or 3) a hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or less per square mile. Section 408.07, F.S., provides an identical statutory definition of "rural hospital."

Facilities that maintain the statutory designation of "rural hospital" may receive additional benefits as a result of the designation which include: the receipt of additional funding through participation in the Medicaid disproportionate share program; the ability to apply for and receive additional grants to establish and participate in a certified rural health network; an exemption from hospital budget review; and an exemption from certificate-of-need regulation of hospice and home health services provided by the statutory rural hospital.

Section 381.0406, F.S., provides for the establishment of rural health networks to provide a continuum of care and to ensure the availability of certain core services for residents of rural areas such as disease prevention, health promotion, comprehensive primary care, emergency medical care, and acute inpatient care. "Rural health networks" or "networks" are defined to mean a nonprofit legal entity, consisting of rural and urban health care providers and others, that are organized to plan and deliver health care services on a cooperative basis in a rural area. Rural health networks may be developed and implemented in two phases. Under Phase I, interested entities may apply for network planning and development grants from the Department of Health, so that they may organize networks, incorporate network boards, and develop provider agreements. Under phase II, rural health networks that meet specified criteria and that become certified may be eligible to receive grant funds that may be used to help defray the costs of network infrastructure development, patient care, and network administration.
Section 408.043, F.S., authorizes certificate-of-need preferences for hospitals that are members of a certified rural health network, if need is shown and the proposed project strengthens health care services in rural areas through partnerships between rural health care providers, or increases access to inpatient health care services for Medicaid patients or other low-income persons who live in a rural area.

Pursuant to s. 20.42, F.S., the Health Care Board is established under the Agency for Health Care Administration and is delegated the responsibility for hospital budget review, nursing home financial analysis, and special studies. Section 408.072, F. S., provides requirements for hospital budget review and requires a hospital to submit a budget letter at least 90 days before the start of its next fiscal year that acknowledges its permissive maximum allowable rate of increase (MARI) in gross and net revenues per adjusted admission. The section requires any hospital whose budget exceeds its MARI in its next fiscal year to receive approval from the Health Care Board to implement that budget. The Health Care Board is required to subject a hospital that requests to exceed its MARI to a detailed budget review. Section 408.072, F.S., exempts any rural hospital as defined in s. 408.07, F.S., from filing a budget and from the budget review and approval for exceeding its MARI. However, the rural hospital must submit to the Health Care Board its audited actual experience.

Prior to the enactment of chapter 93-214, Laws of Florida, section 408.036 (3) (h), F.S., exempted from certificate-of-need regulation both hospice and home health services provided by a rural hospital, as defined in s. 395.605, F.S., or swing beds in such a rural hospital if the number did not exceed one-half of its licensed bed capacity. Chapter 93-214, L.O.F., repealed certificate-of-need regulation of Medicare-certified home health agencies effective July 1, 1995. Section 143, chapter 95-418, L.O.F., extended from July 1, 1995 to July 1, 1997, the prospective repeal of

certificate-of-need regulation of Medicare-certified home health agencies enacted in ch. 93-214, L.O. F. Chapter 97-270, L.O.F., saved certificate-of-need regulation of Medicare-certified home health agencies from the repeal that was to take effect on July 1, 1997, and provided for future certificate-of-need regulation of such home health agencies. Chapter 97-270, L.O.F., also redesignated s. 408.036 (3)(h), F.S., as s. 408.036(3)(d), F.S., however the reference to home health services was inadvertently left out of the provision exempting rural hospitals from certificate-of-need review when such hospitals decide to offer home health services.

Section 409.9116, F. S., requires the Agency for Health Care Administration to administer a federally-matched Medicaid disproportionate share program and a state-funded financial assistance program for statutory rural hospitals. The agency makes disproportionate share payments to statutory rural hospitals that qualify for such payments and financial assistance to statutory rural hospitals that do not qualify for disproportionate share payments. The payments are based on a formula that includes charity care, uncompensated care to medically indigent patients, and Medicaid inpatient days. During the fiscal year 1997-1998, $3,720,185 in state general revenue and $6,825,135 in federal funds are appropriated for statutory rural hospitals under the program. According to the Agency for Health Care Administration, 27 hospitals have been designated as “rural hospitals.”

III. Effect of Proposed Changes:

The bill modifies the definition of the term “rural hospital” to increase the allowable number of licensed beds that a hospital that is designated as a rural hospital may have from 85 to 100. The modified definition allows hospitals that already have been designated as statutory “rural hospitals” to increase the number of licensed beds from 85 to 100 and allows additional hospitals to become eligible for the statutory designation of “rural hospital.” The bill amends s. 409.9116, F.S., relating to the rural hospital disproportionate share and financial assistance program to provide that any rural hospital designated after July 1, 1998, may not be included in the rural hospital disproportionate share or financial assistance program unless additional appropriations are provided for the disproportionate share program or the financial assistance for rural hospitals program.

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 Section 24(a) of Article 1 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, Section 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill imposes a limitation on the availability of funds from the rural hospital disproportionate share and financial assistance program to any hospital that is defined as a statutory rural hospital on or after July 1, 1998, unless additional funds are provided by the General Appropriations Act for hospitals that have already been defined as statutory hospitals, or their successor in interest hospitals, prior to July 1, 1998. Under the bill, if any additional funds are provided by the General Appropriations Act for hospitals that have already been defined as statutory hospitals prior to July 1, 1998, the amount of fixed funds available to rural hospitals through the rural hospital disproportionate share and financial assistance program may be distributed to all hospitals which are otherwise designated as statutory rural hospitals regardless of when they were initially defined as a statutory rural hospital. The Agency for Health Care Administration has identified two hospitals, Jackson County Hospital with 107 beds (Jackson County) and Columbia Raulerson Hospital with 101 beds (Okeechobee County) that are located in counties with a population density of 100 or less persons and have bed limits between 86 and 110 licensed beds. Both facilities would be required to delicense beds in order to decrease their bed count below the 100-bed limit to qualify for the statutory designation of “rural hospital” under the bill. According to the Agency for Health Care Administration, such delicensure would not be subject to certificate-of-need review. The Agency for Health Care Administration projects that the number of rural hospitals will increase from 27 to 29 under the bill’s revised definition of a statutory rural hospital. To the extent additional hospitals will be eligible for rural hospital disproportionate share and financial assistance payments, each rural hospital currently participating in the program may receive a smaller allocation of any available state funds than that hospital would otherwise receive.

C. Government Sector Impact:

Under the bill, additional hospitals could be eligible for rural hospital disproportionate share and financial assistance payments, if the Legislature appropriates additional funds. During the fiscal year 1997-1998, $3,720,185 in state general revenue and $6,825,135 in federal funds are appropriated for statutory rural hospitals under the program. The bill does not require any additional appropriations.

VI. Technical Deficiencies:

The intent of the new language in the bill limiting the ability of newly designated rural hospitals to receive disproportionate share or financial assistance payments is not clear. If the intent is to hold harmless the existing rural hospitals with respect to the level of funding they currently receive from the program, then the bill should be amended to more clearly state that intent.

VII. Related Issues:

None.

VIII. Amendments:

#1 by Health Care:
Corrects a glitch in the law that inadvertently left out a provision exempting rural hospitals from certificate-of-need review when such hospitals decide to offer home health services.

#2 by Health Care:
Provides that newly designated rural hospitals may not receive disproportionate share or financial assistance payments unless each year additional appropriations are made to prevent any reduction in payments to existing rural hospitals with respect to the level of funding that the existing rural hospitals currently receive from the program.