HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1105 Certificate of Need/Health Facilities
SPONSOR(S): Murman and others
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 2132 (s), SB 1252 (c)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Standards (Sub)	7 Y, 0 N	Rawlins	Collins
2) Health Care			
3)			
4)			
5)			

SUMMARY ANALYSIS

The Certificate-of-Need (CON) regulatory process under chapter 408, F.S., requires that before specified health care services and facilities may be offered to the public they must be approved by the Agency for Health Care Administration (AHCA). Section 408.036, F.S., specifies which health care projects are subject to review.

Florida's Certificate of Need (CON) Workgroup was established by the 2000 Legislature, directing the Agency for Health Care Administration to staff a workgroup, aimed at studying issues pertaining to the Certificate of Need program. A final report was presented to the Governor and the Legislature, December 31, 2002, which included several recommendations to modify the CON regulatory process. This bill incorporates a limited number of the Workgroup's recommendations that include:

- revising the definition of tertiary care;
- amending the expedited review process;
- amending the exemption process, including an exemption for percutaneous coronary intervention;
- increasing CON application fees; and
- amending the administrative hearing process and the judicial review process.

In addition to the recommendations from the CON Workgroup, this bill authorizes nursing home facilities, subject to approval by the Agency for Health Care Administration, to use licensed nursing home beds for purposes other than nursing home care for extended periods of time exceeding 48 hours. A nursing home is authorized to use a contiguous portion of the facility to meet the needs of the elderly through adult day care, assisted living, extended congregate care, or limited nursing services. A nursing home that converts beds to an alternative use may return those beds to nursing home operations upon notice to the Agency for Health Care Administration.

The bill provides for an effective date of July 1, 2003.

On March 27, 2003, the Subcommittee on Health Standards reported HB 1105 favorably to the Committee on Health Care with 4 amendments. See "Amendments/Committee Substitute Changes" section of bill analysis for an explanation of the amendments.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[x]	No[]	N/A[]
2. Lower taxes?	Yes[x]	No[x]	N/A[]
3. Expand individual freedom?	Yes[x]	No[]	N/A[]
4. Increase personal responsibility?	Yes[x]	No[]	N/A[]
5. Empower families?	Yes[x]	No[]	N/A[]

For any principle that received a "no" above, please explain:

The bill increases the minimum base fee for a CON application for hospitals and increases the caps on the fees based on the proposed capital expenditure. However, the bill eliminates CON fees for nursing homes by providing for licensure requirements in lieu of the CON regulatory process for the utilization of alternative beds uses.

B. EFFECT OF PROPOSED CHANGES:

Certificate-of-Need Regulatory Process

In the past few years, the Legislature has considered proposals related to CON that call into question whether or not CON is still an appropriate market entry and quality control mechanism for Florida hospitals. Several issues are brought to the discussion. One issue is the question of whether the CON process is a mechanism for maintaining quality or an outdated planning mechanism that thwarts competition among providers. CON programs emerged in the late 1960s and early 1970s as a way to regulate growth of facilities and costs in health care at a time when many hospitals were built with federal funds, known as Hill-Burton Grants. After the passage of the National Health Planning and Resources Development Act of 1974 (PL93-641), most states implemented CON programs. After the act was repealed in the 1980s, when the bricks and mortar of hospitals were no longer being federally funded, a number of states abolished their CON programs.

The Certificate-of-Need (CON) regulatory process under chapter 408, F.S., requires that before specified health care services and facilities may be offered to the public they must be approved by the Agency for Health Care Administration (AHCA). Section 408.036, F.S., specifies which health care projects are subject to review. Subsection (1) of that section lists the projects that are subject to full comparative review in batching cycles by AHCA against specified criteria. Subsection (2) lists the kinds of projects that can undergo an expedited review. These include: research, education, and training programs; shared services contracts or projects; a transfer of a certificate of need; certain increases in nursing home beds; replacement of a health care facility when the proposed project site is located in the same district and within a 1-mile radius of the replaced facility; and certain conversions of hospital mental health service beds to acute care beds. Subsection (3) lists projects that may be exempt from full comparative review upon request.

Florida's Certificate of Need (CON) Workgroup was established in 2000 by the Legislature, directing the Agency for Health Care Administration to staff a workgroup, aimed at studying issues pertaining to the Certificate of Need program, including the impact of trends in health care delivery and financing and to "study issues relating to implementation of the CON Program." The workgroup was directed to prepare an interim report by December 31, 2001 and a final report by December 31, 2002. The Governor, the President of the Senate and the Speaker of the House of Representatives appointed Workgroup members.

The group met for the first time in April 2001 in Orlando and again in June and every intervening month through December 2001. Throughout the summer months, sub-committees focusing on hospitals,

nursing homes and hospices met half-days and came together as a full workgroup for the remainder of the meeting. The Workgroup's final report included some of the following recommendations: revising the definition of tertiary care; amending the expedited review process; amending the exemption process that, among other things, integrated an exemption for percutaneous coronary intervention; increasing CON application fees; amending the administrative hearing process; and amending the judicial review process.

This bill incorporates a limited number of those recommendations as follows:

- *Tertiary services*[1]. The bill specifies that adult and pediatric open-heart surgery is a tertiary service which places in the statute clear authority for the current rule, which makes open-heart surgery a tertiary service;

- *Expedited Reviews*. The bill modifies the list of projects subject to expedited review, as follows:

  →Deletes shared service contracts or projects;

  →No CON review would be required for transfer of active CONs issued to a hospital, which has been acquired by a purchaser. The active CONs would automatically become property of the purchaser. It is not clear why this exception to the requirement for transfer of a CON is limited to hospitals. Unless otherwise indicated, the purchaser would become responsible for completion of the project, consistent with any and all commitments, assurances and stipulations made by the original certificate-holder; and

  →An exemption is applicable for proposed conversion of mental health services beds to acute care beds and conversion of acute care beds to mental health service beds;

- Exemptions. The bill modifies the list of projects that may be exempted from CON review by:

  →Increasing the current limitation for an exempt addition of acute care beds from 10 to 30 beds, for hospitals that experience high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.

  →Allowing the addition of Level II or Level III neonatal intensive care beds (NICU beds), limited to 6 beds or 10 percent of the licensed capacity of Level II or Level III beds, as applicable, whichever is greater, with a required prior 12-month occupancy of at least 75 percent;

  →Disallowing the addition of mental health services beds, limited to 10 beds or 10 percent of the licensed capacity of the applicable mental health service beds category, whichever is greater;

  →Allowing for the addition of medical rehabilitation beds or for the addition of mental health service beds, limited to 10 beds or 10 percent of the licensed capacity of the applicable mental health service beds category, whichever is greater. Specifying that the licensed beds being expanded at a facility meets or exceeds 75 percent (down from 80%) for a hospital-based part skilled nursing unit, and that the prior 12-month occupancy rate meets or exceeds 96 percent.

[1] All tertiary health services are subject to CON review under s. 408.036(1) (h), F.S. The term "tertiary health service" is defined in s. 408.032(17), F.S., as a health service that is concentrated in a limited number of hospitals due to the high intensity, complexity, and specialization of the care. The goal of such limitations is the assurance of quality, availability, and cost-effectiveness of the service.

AHCA determines need for the expansion of tertiary health services by health planning district or multi-district service planning area. Health planning districts are comprised of more than one county, with the exception of District 10, Broward County. Section 408.032(17), F.S., requires AHCA to establish by rule a list of all tertiary health services and to review the list annually to determine whether services should be added or deleted.

→Allowing the conversion of mental health services beds between or among the licensed bed categories defined as beds for mental health services.

→Allowing the replacement of a statutory rural hospital, within the same district and within 10 miles of the existing facility, and within the hospital's current primary service area (defined by ZIP codes). A current exemption for replacement hospitals is limited to on-site replacement;

→Allowing the establishment of a Level II neonatal intensive care unit with at least 10 beds at a hospital that had at least 1500 births during the prior 12 months. Under current Agency rules, Level II NICU service is defined as a tertiary service. The exemption authorizes a new provider of NICU services without consideration of the availability of this service at any other hospital. This exemption would authorize a new provider of a tertiary service without consideration of the availability and utilization of this service at any other hospital; and

→Allowing hospitals to provide emergency percutaneous interventions[2] for patients presenting with an emergency myocardial infarction in a facility that does not provide open heart surgery. Specifying that the department adopt by rule licensure requirements for these services that are consistent with the American College of Cardiology, and requires the facility to meet specific cardiac care standards relating to personnel and equipment, requires a written transfer agreement, and specifies that if the facility does not meet the volume requirements within 18 months after the program begins offering the service that it will result in the immediate expiration of the exemption.

- *Fees for CON Applications*. The bill increases the current minimum base fee for a CON application from $5,000 to $10,000; and increases the cap on the fees based on the proposed capital expenditure from $22,000 to $50,000. Provides that any increase in fee revenue enacted by the 2003 Legislature must be used only to fund activities of the CON program.

- *Recommended Orders from Administrative Hearings.* The bill compels the Agency to act within 45 days after receipt of a recommended order proposed by an administrative law judge. Failure to do so would mean that the judge's recommended order becomes the Agency's final order. Current law allows the applicant and Agency to agree on an extended deadline for final agency action following an administrative hearing.

- *Judicial Review.* The bill provides that if the losing party in an administrative hearing is a hospital seeking judicial review, the District Court of Appeal must order the losing hospital to pay the reasonable attorney's fees and costs of the prevailing hospital. This includes reasonable fees and costs of the administrative hearing as well as the judicial appeal. Current law provides that the court may award reasonable attorney's fees and costs to the prevailing party, whether a hospital or the agency, but only if the court finds that there was a complete absence of a "justiciable" issue of law or fact raised by the losing party.

Nursing Homes

Over the last 10 years, the Medicaid budget for long-term care has more than doubled. Yet the rate of growth in Medicaid-funded resident days slowed during the years 1991-2000, and there was an absolute decline in the number of Medicaid resident days in 2001. The 2002 Legislature, in CS/SB 1276, directed the Agency for Health Care Administration (AHCA), in consultation with the Department of Elderly Affairs (DOEA), to produce a report on Medicaid funded nursing home bed days. The bill required the report to contain proposals for reducing the number of Medicaid-funded nursing home bed

[2] Also known as: PCI; primary percutaneous coronary interventions; and angioplasty.

days purchased by the state and replacing such nursing home care with care provided in less costly settings.

The report, "Proposals to Reduce Medicaid-Funded Nursing Home Bed Days in Florida," was presented to the Governor, President of the Senate, and Speaker of the House of Representatives on December 1, 2002. The report proposed five ways to reduce Medicaid nursing home utilization:

- Restrict the supply of nursing home beds;
- Promote cost-effective independent living for at-risk older people;
- Increase nursing home diversion and transitioning;
- Make Medicaid a more selective purchaser of long-term care services; and
- Increase private spending for nursing home care.

The report proposed four ways to restrict the supply of nursing home beds:

- Continue the nursing home certificate-of-need moratorium, but allow limited expansions in rural areas where overall occupancy is 95 percent or greater;
- Establish a priority system for the renovation or replacement of existing nursing home beds;
- Allow nursing homes to voluntarily convert underutilized space to assisted living, adult day health care, or other uses through bed banking; and
- Increase regulatory oversight of assisted living facilities and adult day health care.

Bed banking is a way to temporarily convert licensed nursing home beds to another use without losing the ability to use the beds as nursing home beds at a later time. Two options for bed banking are suggested in the report. The first option allows a nursing home with low occupancy rates to convert unoccupied nursing home beds to assisted living facility (ALF) beds, adult day health care services, adult day care services, or other uses. The second option allows a nursing home to convert an occupied bed to an ALF bed when the resident's need for care decreases to levels below skilled nursing care. The report also suggests the possibility of using banked beds in an emergency situation, such as when a nursing home closes and its residents must find a new placement.

Nursing homes, governed by part II of ch. 400, F.S., provide nursing care, personal care or custodial care to residents. Assisted living facilities, under part III of ch. 400, F.S., provide housing, meals, and one or more personal services to residents. Adult day care centers, under part V of ch. 400, F.S., provide basic services to adults in a protective, noninstitutional setting for a part of a day. The services provided in adult day care centers may include therapeutic social and health programs, leisure activities, self-care training, rest, and respite care.

There are approximately 660 nursing homes in Florida. The total number of beds in Florida nursing homes is approximately 82,000. The number of nursing home beds decreased from a total of 84,012 at the end of 2001 to a total of 82,138 at the end of 2002. The overall occupancy rate is 85 percent, with the Medicaid bed occupancy being 85.4 percent and the non-Medicaid bed occupancy being 70.1 percent.

The bill creates s. 400.244, F.S., to authorize nursing home facilities to use licensed nursing home beds for purposes other than nursing home care for extended periods of time exceeding 48 hours. A nursing home is authorized to use a contiguous portion of the facility to meet the needs of the elderly through less restrictive and less institutional methods of long-term care, including, but not limited to, adult day care, assisted living, extended congregate care, or limited nursing services.

Funding under assisted living Medicaid waivers may be used to provide extended congregate care or limited nursing services only to residents who have resided in the facility for a minimum of 90 consecutive days.

Nursing home beds that are used to provide alternative services may share common areas, services, and staff with beds that are designated for nursing home care. The fire and life safety codes applicable to nursing homes would apply to the portion of the facility that is used for alternative services. In addition, if the facility were used for an alternative service, it would have to meet the requirements specified by law for that use.

Before using nursing home beds for an alternative service, a nursing home must submit a written request to AHCA in a format specified by the Agency, and AHCA is required to approve the request unless it is determined that the alternative use of the nursing home beds adversely affects access to nursing home care in the geographical area in which the nursing home is located.

C. SECTION DIRECTORY:

Section 1. Amends s. 408.032, F.S., revising the definition of "tertiary heath service" as it relates to the CON regulatory process.

Section 2. Amends s. 408.036, F.S., relating to health –care-related project subject to review for a certificate of need; removing certain projects from expedited review and revising requirements for other projects subject to expedited review; and removing the exemption from review for certain projects.

Section 3. Amends s. 408.038, F.S., increasing fees to fund activities of the certificate of need program, and specifying that increase in fees are used only for agency certificate of need activities.

Section 4. Amends s. 408.039, F.S., providing for approval of recommended orders of the Division of Administrative Hearings when the Agency for Health Care Administration fails to take action on an application for a certificate of need within 45 days of receipt; and specifying that when a party loses in a judicial review, the court shall order the losing party to pay the reasonable attorney's fees and cost, which shall include fees and cost incurred as a result of the administrative hearing and the judicial appeal of the prevailing hospital party.

Section 5. Creates s. 400.244, F.S., allowing nursing homes to convert beds to alternative uses as specified; providing restrictions on uses of funding under assisted-living Medicaid waivers; providing procedures; providing for applicability of certain fire and life-safety codes; providing applicability of certain laws; requiring a nursing home to submit a request to the Agency for Health Care Administration; providing conditions for disapproving such request; providing for periodic review; providing for retention for nursing home licensure for converted beds; and providing for reconversion of the beds.

Section 6. Provides for an effect date of July 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See "Fiscal Comments" section of the bill analysis.

2. Expenditures:

   See "Fiscal Comments" section of the bill analysis.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

Counties are responsible for a percentage of Medicaid nursing homes days. By allowing nursing home facilities to utilize existing resources to provide alternative levels of care that are less costly; this bill may reduce a small portion of the overall contribution counties pay for Medicaid nursing home expenditures.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

With regard to the nursing home provisions of this bill, staffing costs and other nursing home costs may be reduced when the beds are used for a less costly service.

D. FISCAL COMMENTS:

Pursuant to the nursing home provisions of this bill, it is anticipated that a less costly use of licensed nursing home beds should result in the reduction of the state's cost for Medicaid nursing home bed days.

AHCA was not able to estimate a cost for implementing the nursing home provisions of this bill since it is unknown how many facilities might seek to convert nursing home beds. The Agency's annual expenditures to regulate assisted living facilities (ALFs) are well over $5 million while fees associated with ALF licensure generate only a little over $2.6 million annually.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Agency for Health Care Administration is directed to adopt rules pursuant to ss.120.436(1) and 120.54, F.S., regarding licensure requirements for facilities providing emergency percutaneous coronary interventions at facilities that do not have an open heart surgery program, consistent with the recommendations from the American College of Cardiology.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The provision authorizing shared staffing for nursing homes does not make the shared staffing contingent upon the nursing home continuing to meet its minimum staffing requirements under s. 400.23(3), F.S.

As drafted, the bill does not specify the number of beds that will be calculated in the licensure fee after the conversion of beds in a nursing home.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 27, 2003, the Subcommittee on Health Standards reported the bill favorably with 4 amendments.

Amendment 1. Provides for a Hospital Statutory and Regulatory Reform Council located, for administrative purposes only, within the Agency for Health Care Administration. The council shall consist of no more than 15 members, including:

- Nine members appointed by the Florida Hospital Association who represent acute care, teaching, specialty, rural, government-owned, for-profit, and not-for-profit hospitals;
- Two members appointed by the Governor who represent patients;
- Two members appointed by the President of the Senate who represent private businesses that provide health insurance coverage for their employees, one of whom represents small private businesses and one of whom represents large private businesses; and
- Two members appointed by the Speaker of the House of Representatives who represent physicians.

Furthermore, the amendment provides that the Council members shall be appointed to serve 2-year terms and may be reappointed. The council shall meet at least twice a year and shall hold additional meetings as it considers necessary. Members appointed by the Florida Hospital Association may not receive compensation or reimbursement of expenses for their services. Members appointed by the Governor, the President of the Senate, or the Speaker of the House of Representatives may be reimbursed for travel expenses by the agency.

In addition, the amendment specifies that the council:

- As its first priority, shall review chapters 395 and 408, Florida Statutes, and shall make recommendations to the Legislature for the repeal of regulatory provisions that are no longer necessary or that fail to promote cost-efficient, high-quality medicine; and
- As its second priority, shall recommend to the Secretary of Health and the Secretary of the Agency for Health Care Administration regulatory changes relating to hospital licensure and regulation to assist the Department of Health and the Agency for Health Care Administration in carrying out their duties and to ensure that the intent of the Legislature as expressed in this subsection is carried out.

The amendment specifies that in determining whether a statute or rule is appropriate or necessary, the council shall consider the following:

- The statute or rule is necessary to prevent substantial harm, which is recognizable and not remote, to the public health, safety, or welfare;
- The statute or rule restricts the use of new medical technologies or encourages the implementation of more cost-effective medical procedures;
- The statute or rule has an unreasonable effect on job creation or job retention in the state;
- The public is or can be effectively protected by other means;
- The overall cost-effectiveness and economic effect of the proposed statute or rule, including the indirect costs to consumers, will be favorable; and
- A lower-cost regulatory alternative to the statute or rule could be adopted.

Amendments 2 & 3. Provide that the funding for local health councils shall be at the same amount that was funded in July 2002, henceforth.

Amendment 4. Amends s. 400.244, F.S., conforming the house bill to the senate version, by requiring that the converted beds shall continue to be maintained as part of the total licensed beds for a nursing home for the purposes of health planning and for the calculation of licensing fees which are based “per bed.” The amendment requires reports by nursing homes to the Agency at the end of each calendar quarter, the total number of patient days that occurred in each month of the quarter and the number of such days that were Medicaid patient days.