

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 441 Rural Hospitals
SPONSOR(S): Brown and others
TIED BILLS: None. **IDEN./SIM. BILLS:** CS/SB 250 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) <u>Health Standards (Sub)</u>	<u>8 Y, 0 N</u>	<u>Rawlins</u>	<u>Collins</u>
2) <u>Health Care</u>	<u></u>	<u></u>	<u></u>
3) <u>State Administration</u>	<u></u>	<u></u>	<u></u>
4) <u>Commerce & Local Affairs Approp. (Sub)</u>	<u></u>	<u></u>	<u></u>
5) <u>Appropriations</u>	<u></u>	<u></u>	<u></u>

SUMMARY ANALYSIS

As of the 2000 Census, 33 of Florida's 67 counties are considered rural based on the statutory definition of rural which is "an area with a population density of less than 100 individuals per square mile or an area defined by the most recent United States Census as rural." Rural counties and their corresponding rural hospitals are located primarily in the Florida Panhandle, north central Florida, the south central portion of the state, and the Florida Keys. Approximately 1.1 million of Florida's 16 million citizens live in those rural counties.

The designation as a rural hospital ensures favorable reimbursement rates from both the Medicare program and the Medicaid program. As well, the federal government makes available loans and grants for rural hospitals which help meet their special needs.

The bill amends ss. 395.602 and 408.07, F.S., to change the definition of rural hospital to provide that a hospital that received funding under the Medicaid disproportionate share/financial assistance program for rural hospitals prior to July 1, 2002, is deemed to have been a rural hospital and will continue to be a rural hospital through June 30, 2012, provided the hospital continues to have 100 or fewer licensed beds and an emergency room, or is in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency and which has 120 beds or less...(s. 395.602(2)(e), F.S.). The bill provides that an acute care hospital that has not previously been designated as a rural hospital and that meets the criteria shall be granted the designation upon application to the Agency for Health Care Administration (AHCA).

The bill amends s. 395.6061, F.S., to permit a rural hospital to construct a replacement facility without obtaining a certificate of need (CON), provided the replacement hospital is within 10 miles of the current hospital and within the current primary service area. The amendment defines "service area" as the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period.

The bill creates s. 395.6063, F.S., to permit a statutory rural hospital to contract with the Department of Management Services in order to purchase coverage in the state group health insurance plan for the hospital's employees and family members at the same premium cost as that for retirees and surviving spouses. The hospital is responsible for collecting any required employee contribution, making the employer contribution, and paying an annual administrative fee of not less than \$2.61 per enrollee per month.

The bill takes effect on July 1, 2003.

See "Fiscal Comments" and "Drafting Issues or Other Comments" sections of bill analysis.

On March 12, 2003, the Subcommittee on Health Standards adopted a "strike-everything" amendment. See Section IV. for the explanation of the amendment.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives.

STORAGE NAME: h0441a.hc.doc
DATE: March 17, 2003

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

- | | | | |
|--------------------------------------|---|--|---|
| 1. Reduce government? | Yes <input type="checkbox"/> | No <input checked="" type="checkbox"/> | N/A <input type="checkbox"/> |
| 2. Lower taxes? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | N/A <input checked="" type="checkbox"/> |
| 3. Expand individual freedom? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| 4. Increase personal responsibility? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |
| 5. Empower families? | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/> | N/A <input type="checkbox"/> |

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

The designation of "rural hospital" allows a rural hospital to rely on state and federal appropriations for financial assistance.

B. EFFECT OF PROPOSED CHANGES:

As of the 2000 Census, 33 of Florida's 67 counties are considered rural based on the statutory definition of rural which is "an area with a population density of less than 100 individuals per square mile or an area defined by the most recent United States Census as rural." Rural counties and their corresponding rural hospitals are located primarily in the Florida Panhandle, north central Florida, the south central portion of the state, and the Florida Keys. Approximately 1.1 million of Florida's 16 million citizens live in those rural counties.

Rural hospitals typically suffer financial hardships due to small community sizes, lack of health insurance in their communities, overall lower incomes in their communities, lower levels of Medicare reimbursement, outdated/aging physical plants, and constantly increasing costs due to technological innovations and costs of pharmaceuticals and other supplies.

Part III of ch. 395, F.S., governs rural hospitals. Florida law defines a rural hospital as a licensed acute care hospital having 100 or fewer licensed beds and an emergency room which is:

1. The sole provider in a county with a population density no greater than 100 persons per square mile;
2. An acute care hospital in a county with a population density no greater than 100 persons per square mile which is at least 30 minutes of travel time from any other acute care hospital in the same county;
3. A hospital supported by a tax district or subdistrict whose boundaries encompass an area of 100 persons or fewer per square mile;
4. A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency and which has 120 beds or less;
5. A hospital with a service area of fewer than 100 persons per square mile, with service area being defined as the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period; or

6. A hospital designated as a Critical Access Hospital by the Department of Health.

Population densities must be based upon the most recently completed United States census.

Currently there are twenty-nine (29) hospitals listed as rural hospitals:

Baptist Medical Center – Nassau, Fernandina Beach
Calhoun Liberty Hospital, Blountstown
Campbellton-Graceville Hospital, Graceville
Desoto Memorial Hospital, Arcadia
Doctor’s Memorial Hospital – Bonifay, Bonifay
Doctor’s Memorial Hospital, Inc., Perry
Ed Fraser Memorial Hospital, MacClenny
Fishermen’s Hospital, Marathon
Florida Hospital Flagler, Palm Coast
Florida Hospital Wauchula, Wauchula
Gadsden Community Hospital, Quincy
George E. Weems Memorial Hospital, Apalachicola
Glades General Hospital, Belle Glade
Gulf Pines Hospital, Port St. Joe
Healthmark Regional Medical Center, Defuniak Springs
Homestead Hospital, Homestead
Hendry Regional Medical Center, Clewiston
Jackson Hospital, Marianna
Jay Hospital, Jay
Madison County Memorial Hospital, Madison
Mariners Hospital, Tavernier
Nature Coast Regional Hospital, Williston
Northwest Florida Community Hospital, Chipley
Ramadan Hand Institute/Lake Butler Hospital, Lake Butler
Shands at Lake Shore, Lake City
Shands at Live Oak, Live Oak
Shands at Starke, Starke
South Lake Hospital, Clermont
Trinity Community Hospital, Jasper

The 2002 General Appropriations Act, in line item 217 appropriated over 12 million dollars for the federally-matched Rural Hospital Disproportionate Share program and a state funded Rural Hospital Financial Assistance program as provided for in s. 409.9116, F.S.

Rural hospitals are eligible to participate in the rural hospital Medicaid disproportionate share (DHS)¹ and financial assistance programs under s. 409.9116, F.S. These hospitals also receive a rural special Medicaid payment. Rural hospitals’ inpatient and outpatient rates are exempt from ceilings.

Likewise, on the federal level, the designation as a “rural hospital “ makes available to hospitals grants and loans, helping to meet the special needs of rural hospitals. As well, the Medicare Rural Hospital Flexibility Program presents a new reimbursement category for rural hospitals, that of the Critical Access Hospital. This new type of hospital is an acute care facility that provides emergency, outpatient, and limited inpatient services.

¹ What is Medicaid disproportionate share? Federal law requires state Medicaid programs to “take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs” when determining payment rates for inpatient hospital care. Expenditures for DSH have increased significantly in recent years: Between 1990 and 1996, for example, DSH payments grew nationally from \$1.4 billion to \$15 billion. By 1996, DSH payments accounted for 1 of every 11 (federal and state) dollars spent on Medicaid.

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 Florida Office of Rural Health applies for, receives, and administers these grant funds.

State law requirements to be considered a rural hospital necessitate meeting specific population criteria. The current language in ss. 395.602(2) and 408.07(42), F.S., stipulate that "Population densities used in this paragraph must be based upon the most recently completed United States census." The most recent United States census data, 2000, is now available. However, the 1998 Legislature required an advisory group to redefine the definition of rural hospitals. The 1999 Rural Hospital Redefinition Report defined twenty-eight (28) providers who remain classified as rural hospitals. One provider, Shands at Lake Shore, was added in 2000.

Although the criteria to be considered in defining a rural hospital exist in law, there currently is no timetable for evaluating whether hospitals continue to meet the criteria. The Agency for Health Care Administration (AHCA) recommends evaluation every 10 years.

According to the Florida Hospital Association, "the designation of rural hospital is important because these small facilities are often dependent on the additional funding provided to assist these vulnerable hospitals. In FY 2000, the 29 rural hospitals ended the year with nearly \$20 million in losses and 16 of the 29 hospitals had negative total margins in this same year. Clearly, these hospitals are on the edge and sudden changes in status can potentially be devastating."

The bill amends ss. 395.602 and 408.07, F.S., to change the definition of rural hospital to provide that a hospital that received funding under the Medicaid disproportionate share/financial assistance program for rural hospitals prior to July 1, 2002, is deemed to have been a rural hospital and will continue to be a rural hospital through June 30, 2012, provided the hospital continues to have 100 or fewer licensed beds and an emergency room, or is in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency and which has 120 beds or less...(s. 395.602(2)(e), F.S.). The bill provides that an acute care hospital that has not previously been designated as a rural hospital and that meets the criteria shall be granted the designation upon application to AHCA.

Certificate of Need

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 and need determined 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 allowable projects for 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 services beds to acute care beds. Subsection (3) lists projects that may be exempt from full comparative review upon request.

The CON Workgroup² produced a final report in December 2002, which includes a recommendation to create an exemption from CON review for the replacement of a statutory rural hospital within the same district, provided the replacement hospital is within 10 miles of the current hospital and within the

² Section 15 of Chapter 2000-318, Laws of Florida, established a workgroup on CON to study issues pertaining to the CON program, including the impact of trends in health care delivery and financing.

current primary service area, defined as the fewest number of zip codes that account for 75 percent of the hospital's inpatient admissions.

The National Advisory Committee on Rural Health (2000) has expressed concern that rural hospitals built with Hill-Burton grants are aging and in need of repair or replacement. From 1946 through 1974 when the program was abolished, Hill-Burton funds were used to construct or modernize 5,787 hospitals nationally. In exchange for Hill-Burton funds, the hospital made certain commitments to provide charity care. Obtaining Hill-Burton grants was particularly important for hospitals in markets with low patient volumes because hospitals in these types of markets often have difficulty generating enough operating revenue to cover their capital costs. Decades later, many rural community hospitals have found that due to modernized building codes, it is more cost effective to build a replacement hospital rather than renovating an older facility.

The bill amends s. 395.6061, F.S., to permit a rural hospital to construct a replacement facility without obtaining a CON, provided the replacement hospital is within 10 miles of the current hospital and within the current primary service area. The amendment defines "service area" as the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period. This section elevates the hospital from applying for an exemption under 408.036, F.S., which is open to all legal challenges of the CON review process.

State Employee Health Insurance Program

Officers and employees of agencies of the State of Florida are given the opportunity to receive employee benefits such as health, prescription drug, life, dental, and vision insurance products under a cafeteria plan consistent with Section 125, Internal Revenue Code.³ Persons eligible to enroll include state officers and employees, surviving spouses of deceased state officers and employees, retired state officers and employees, terminated employees and individuals with continuation coverage, e.g., COBRA, and eligible dependents. For purposes of this program, enrollees associated with the State University System are considered State "employees" and therefore eligible.

By law, the governing body of a small county or small municipality or the district school board of a small county may apply for participation in the state group health insurance program,⁴ with extensive terms and conditions to which a small county, small municipality or district school board must agree before being authorized to participate in the state group health insurance program. Since the implementation of the law in 2001, no governing body or school board of a small county or governing body of a small municipality has applied for participation in the state employee health insurance program.

The bill creates s. 395.6063, F.S., to permit a statutory rural hospital to contract with the Department of Management Services in order to purchase coverage in the state group health insurance plan for the hospital's employees and family members at the same premium cost as that for retirees and surviving spouses. The hospital is responsible for collecting any required employee contribution, making the employer contribution, and paying an annual administrative fee of not less than \$2.61 per enrollee per month.

The bill takes effect July 1, 2003.

C. SECTION DIRECTORY:

Section 1. Amends s. 395.602, F.S., revising the definition of rural hospital, provides circumstances under which a rural hospital may continue their rural hospital designation through June 30, 2012, and allows for additional hospitals to be designated as a rural hospital.

³ s. 110.123, F.S.

⁴ s. 110.1228, F.S.

Section 2. Amends s. 395.6061, F.S., providing that a rural hospital replacement facility is not subject to CON review.

Section 3. Creates s. 395.6063, F.S., allowing any rural hospital to participate in the state self-insured health plan, covering hospital employees and qualified family members at the same premium cost as that of retirees and surviving spouses, requiring the hospital to collect premiums or other remuneration from employees, and requires the hospital to make employer contributions.

Section 4. Amends s. 408.07, F.S., revising the definition of rural hospital as it relates to the CON review process.

Section 5. Provides for an effective date of July 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

See "Fiscal Comments."

2. Expenditures:

According to the Department of Management Services, under the current benefit design and funding structure, for Fiscal Year 2003-2004, the State Employees' Group Health Self-Insurance Trust Fund deficit equates to approximately a \$938 per subscriber annual loss. Therefore, for each additional enrollee under this legislation, the FY 03-04 Trust Fund deficit would be increased by approximately \$938. Depending on other factors, the adverse impact could be greater.

According to the Department of Management Services, there are many uncertain factors with extending health insurance benefits to eligible participants of these rural hospitals that need this determination in order to calculate the State's administrative costs and impact on future State premium costs. The bill provides that the premium cost would be the same as that for retirees and surviving spouses. However, it is silent as to whether that is "pre-65" or "post-65" or a blend of both. Also, the rate of participation and level of service utilization or risk profile of these newly-eligible enrollees is unknown. The magnitude of cost impact to the contract with the Human Resources (HR) outsourcing vendor is unknown. Should subsequent legislative amendment or revision provide for an HMO option, all of the challenges cited previously would be exacerbated.

See "Fiscal Comments."

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

See "Fiscal Comments."

2. Expenditures:

See "Fiscal Comments."

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A privately-owned rural hospital would be eligible for the special funding arrangements available to rural hospitals under DSH and the rural special Medicaid payment and the Medicare Rural Hospital Flexibility Program.

As well, a for-profit hospital will extend to their employees the same health benefits that are currently provided to state employees.

D. FISCAL COMMENTS:

A preliminary review by AHCA of whether the existing rural hospitals would continue to meet the criteria for designation as a rural hospital using the 2000 Census data revealed that two providers potentially would no longer meet the rural hospital definition. It is highly likely that these two providers would no longer meet the requirements based on population data for the specific zip code areas representing "75 percent of the hospital's discharges for the most recent 5-year period" (s. 395.602(2)(e)5., F.S.). Both providers are listed as not-for-profit providers. The loss of the rural hospital designation will result in a reduction of Medicaid revenue for both providers as the providers would no longer be exempt from inpatient/outpatient ceilings. If the providers no longer met the definition as a rural hospital, they would also be removed from participating in the rural hospital disproportionate share (DSH) and financial assistance programs and the rural special Medicaid payment (SMP) program. The projected total loss for one provider would be \$931,298 and the projected total loss for the other provider would be \$843,580.

If the two providers did not qualify as "rural hospitals," the appropriated monies for rural DSH and rural SMP would be redistributed among the remaining rural hospitals. If the existing DSH and SMP programs remained at their current levels, the redistribution could result in an increase of up to 6.5 percent for some providers. Therefore, the loss of revenue to the facilities would not necessarily translate into a savings to the state as the funds would be redistributed (assuming total funding at current levels).

If the two providers did not qualify as "rural hospitals", Medicaid would save approximately \$448,202 per year in program expenditures by not exempting them from ceilings. A reduction in Medicaid expenditures would also reduce the amount of Federal Title XIX match by approximately \$264,081 per year, resulting in a net state general revenue savings of approximately \$184,121.

According to the Department of Management Services, the hospitals would be required to pay an annual administrative fee of at least \$2.61 per enrollee per month. The mechanism for determining if an amount greater than \$2.61 is required is not specified.

Although an administrative fee is provided for, the bill does not provide budget authority and appropriations for additional full time equivalent (FTE) positions that may be required for DMS administration of the program.⁵

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:

⁵ Department of Management Services 2003 Substantive Bill Analysis, *HB 441, Rural Hospitals, March 5, 2003.*

Chapters 395 and 408, F.S., provide rulemaking authority for the Agency for Health Care Administration; however, this bill does not provide rulemaking authority for the Department of Management Services.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The language in the bill states, "An acute care hospital that has not previously been designated as a rural hospital...shall be granted such designation upon application...to the Medicaid program office of the Agency for Health Care Administration." Designation as a rural hospital means the hospital will be exempt from ceilings in its inpatient and outpatient rate calculations, dependent of their status as a Medicaid provider. The Medicaid Program Office calculates hospital inpatient and outpatient rates. Note that the same office that performs hospital rate calculations, in addition to preparing and requesting funds (such as rural DSH), would be determining rural eligibility status for hospitals.

The state employee group health insurance program operates in compliance with federal law and provides that employer-paid premiums are not considered constructive compensation subject to tax. The plan includes only tax-supported agencies. The inclusion of non-governmental agencies, especially those organized on a proprietary basis, may jeopardize that status and result in significant penalties to the insured population retroactively or prospectively.⁶

According to the Department of Management Services:

- Any new subscribing entity to the state health plan will be governed by its operating parameters and will be assigned a separate risk pool for premium calculation. This premium will be likely close to that charged existing employer-participants. The incidence of payment will vary by employer based on its own personnel policies but the total premium will reflect the very generous benefit features provided.
- The authorization created for rural hospitals to contract with the Department of Management Services, allowing their employees and qualified family members to purchase coverage in the "State Group Health Insurance Plan" (defined as the PPO plan pursuant to s. 110.123, F.S.) at the same premium cost as state retirees and surviving spouses creates ambiguity since pre-65 year olds and post-65 year old premiums are not the same.
- Current state program infrastructure is not designed with administrative linkages between Division of State Group Insurance (DSGI) and non-state entities, which present challenges in administrative activities like enrollment maintenance and coordination, eligibility determination, COBRA administration, enrollment periods, status treatment of rural hospital retirees and premium collection. Even though the hospitals are responsible for collection of premium, the hospitals and the Division will have to reconcile premiums transmitted with eligibility information. According to DMS, management of these issues must be identified and studied for establishing appropriate infrastructure and processes prior to accepting rural hospitals into the State Program.
- The magnitude of impact on the Human Resources (HR) outsourcing vendor is unknown. Many of the transaction activities currently conducted by DSGI will be the responsibility of Convergys.⁷ Adding additional enrollees over the contractual threshold will increase the cost of the contract and result in automatic modification of the performance metrics.
- The proposed effective date of July 1, 2003, provides for potential changes to occur during the transition of processed and functions from DMS to Convergys, at a time when there could also

⁶ Senate Staff Analysis and Economic Impact Statement, *CS/SB 250 Rural Hospitals, Health, Aging and Long-Term Care Committee, February 20, 2003.*

⁷Convergys is an integrated billing and customer care services, and employee care services. See:

www.convergys.com.employeeecare/html.

be legislatively authorized changes to the health insurance benefit design and premium structure.

- Determining eligibility for state government and university employees may be different than for rural hospitals. It is unclear how eligibility rules and requirements would be handled should these hospitals elect to participate. The legislation is silent regarding the status of current and future rural hospital retirees.
- To effectuate the bill, the state group health insurance program will need to be modified into a multiple employer welfare arrangement. Such a modification is prohibited by Section 624.438, F.S.
- The legislation creates a potential conflict with section 110.123, F.S. The state group insurance program is designed to provide various insurance coverage to officers and employees of “state agencies.” As used in s. 110.123, F.S., the term “state agency” means an executive agency of state government. Except for those few hospitals that are state institutions, hospitals, including rural hospitals, are not state agencies. Rather, they are usually supported by a special taxing district, by local governments or operated as a private enterprise.
- Section 112.08(2)(a), F.S., authorizes every local government and special district to provide health as well as other types of insurance to its officers and employees. In light of sections 110.123 and 112.08 (2)(a), F.S., Florida’s Attorney General Opinion 2002-06, concluded that a hospital district that was an independent special district was not a state agency for the purpose of participating in the state health insurance program authorized under section 110.123, F.S. Further, AGO 2002-06, indicated the absence of any specific legislation authorizing the participation of the hospital district in question. In order to prevent a conflict between the legislation and section 110.123, F.S., it is necessary to interpret the present legislation as providing that specific authority for rural hospitals to participate in the state plan, as does section 110.1228, F.S., for small counties, small municipalities and district school boards in small counties under certain conditions.

The provisions in s. 395.6061(5), F.S., (section 2 of the bill) allows a rural hospital to construct a replacement facility without obtaining a CON, provided the replacement hospital is within 10 miles of the current hospital and within the current primary service area. However, the language as written in this subsection does not specify that the replacement facility has to maintain the current authorized number of beds. Counties experiencing areas of high growth may use this section of law to build a larger replacement facility, up to 100 beds; in the future when need increases.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 12, 2003, the Subcommittee on Health Standards adopted a strike-all amendment to HB 441. The amendment was technical in nature, creating a new section of law in lieu of amending existing law, conforming the bill to the senate companion.