SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: SB 1308

SPONSOR: Senator Pruitt

SUBJECT: Health Care

DATE: February 3, 2004 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harkey	Wilson	HC	Favorable
2.			AP	
3.				
4.				
5.				
6.				

I. Summary:

This bill exempts from Certificate-of-Need (CON) review the provision of adult open-heart services in a hospital located within the boundaries of Health Service Planning District 9, as defined in s. 408.032(5), F.S., or Acute Care Subdistrict 6-2, as defined in Rule 59C-2.100(3)(f)2., F.A.C., provided the hospital meets specified requirements. The bill deletes from the statute the exemption granted to hospitals in Palm Beach, Polk, Martin, St. Lucie, and Indian River Counties and deletes the statement that those exemptions must be based on objective criteria and address the twin problems of geographical and temporal access.

The bill amends the requirement that the Agency for Health Care Administration (AHCA or agency) must submit an annual report to the Legislature regarding the requests for exemptions, and AHCA's decisions regarding the request, to clarify that each annual report would include requests and decisions made during the calendar year.

This bill amends s. 408.036, F.S.

II. Present Situation:

The 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 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 services beds to acute care beds. Subsection (3) lists projects that may be exempt from full comparative review upon request. Exemptions from CON review may be granted for:

- Replacement of a licensed health care facility on the same site, provided that the number of beds in each licensed bed category will not increase.
- Hospice services or for swing beds in a rural hospital, as defined in s. 395.602, F.S., in a number that does not exceed one-half of its licensed beds.
- The conversion of 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. The total number of skilled nursing beds, including swing beds, may not exceed one-half of the total number of licensed beds in the rural hospital as of July 1, 1993. Certified skilled nursing beds designated under this paragraph, excluding swing beds, shall be included in the community nursing home bed inventory. A rural hospital which subsequently decertifies any acute care beds exempted under this paragraph shall notify the agency of the decertification, and the agency shall adjust the community nursing home bed inventory accordingly.
- The addition of nursing home beds at a skilled nursing facility that is part of a retirement community that provides a variety of residential settings and supportive services and that has been incorporated and operated in this state for at least 65 years on or before July 1, 1994. All nursing home beds must not be available to the public but must be for the exclusive use of the community residents.
- An increase in the bed capacity of a nursing facility licensed for at least 50 beds as of January 1, 1994, under part II of chapter 400, F.S., which is not part of a continuing care facility if, after the increase, the total licensed bed capacity of that facility is not more than 60 beds and if the facility has been continuously licensed since 1950 and has received a superior rating on each of its two most recent licensure surveys.
- An inmate health care facility built by or for the exclusive use of the Department of Corrections as provided in chapter 945, F.S. This exemption expires when such facility is converted to other uses.
- The termination of an inpatient health care service, upon 30 days' written notice to the agency.
- The delicensure of beds, upon 30 days' written notice to the agency. A request for exemption submitted under this paragraph must identify the number, the category of beds, and the name of the facility in which the beds to be delicensed are located.
- The provision of adult inpatient diagnostic cardiac catheterization services in a hospital.
- Mobile surgical facilities and related health care services provided under contract with the Department of Corrections or a private correctional facility operating pursuant to chapter 957, F.S.
- State veterans' nursing homes operated by or on behalf of the Florida Department of Veterans' Affairs in accordance with part II of chapter 296, F.S., for which at least 50 percent of the construction cost is federally funded and for which the Federal Government pays a per diem rate not to exceed one-half of the cost of the veterans' care in such state nursing homes. These beds shall not be included in the nursing home bed inventory.
- Combination within one nursing home facility of the beds or services authorized by two or more certificates of need issued in the same planning subdistrict. An exemption granted

under this paragraph shall extend the validity period of the certificates of need to be consolidated by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption. The longest validity period among the certificates shall be applicable to each of the combined certificates.

- Division into two or more nursing home facilities of beds or services authorized by one certificate of need issued in the same planning subdistrict. An exemption granted under this paragraph shall extend the validity period of the certificate of need to be divided by the length of the period beginning upon submission of the exemption request and ending with issuance of the exemption.
- The addition of hospital beds licensed under chapter 395, F.S., for acute care, mental health services, or a hospital-based distinct part skilled nursing unit in a number that may not exceed 10 total beds or 10 percent of the licensed capacity of the bed category being expanded, whichever is greater. Beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, or at a long-term care hospital, may not be increased under this paragraph.
- The addition of acute care beds, as authorized by rule consistent with s. 395.003(4), F.S., in a number that may not exceed 10 total beds or 10 percent of licensed bed capacity, whichever is greater, for temporary beds in a hospital that has experienced high seasonal occupancy within the prior 12-month period or in a hospital that must respond to emergency circumstances.
- The addition of nursing home beds licensed under chapter 400, F.S., in a number not exceeding 10 total beds or 10 percent of the number of beds licensed in the facility being expanded, whichever is greater.
- Establishment of a specialty hospital offering a range of medical service restricted to a defined age or gender group of the population or a restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical illnesses or disorders, through the transfer of beds and services from an existing hospital in the same county.
- The conversion of hospital-based Medicare and Medicaid certified skilled nursing beds to acute care beds, if the conversion does not involve the construction of new facilities.
- An adult open-heart-surgery program to be located in a new hospital provided the new hospital is being established in the location of an existing hospital with an adult open-heart-surgery program, the existing hospital and the existing adult open-heart-surgery program are being relocated to a replacement hospital, and the replacement hospital will utilize a closed-staff model. A hospital is exempt from the CON review for the establishment of an open-heart-surgery program if the application for exemption complies with specified criteria.
- The provision of adult open-heart services in a hospital located within the boundaries of Palm Beach, Polk, Martin, St. Lucie, and Indian River Counties. The exemption must be based upon objective criteria and address and solve the twin problems of geographic and temporal access. A hospital shall be exempt from the certificate-of-need review for the establishment of an open-heart-surgery program when the application for exemption submitted under this paragraph complies with the following criteria:

    - The applicant must certify that it will meet and continuously maintain the minimum licensure requirements adopted by the agency governing adult open-heart programs, including the most current guidelines of the American College of Cardiology and American Heart Association Guidelines for Adult Open Heart Programs.

- The applicant must certify that it will maintain sufficient appropriate equipment and health personnel to ensure quality and safety.
- The applicant must certify that it will maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.
- The applicant can demonstrate that it is referring 300 or more patients per year from the hospital, including the emergency room, for cardiac services at a hospital with cardiac services, or that the average wait for transfer for 50 percent or more of the cardiac patients exceeds 4 hours.
- The applicant is a general acute care hospital that is in operation for 3 years or more.
- The applicant is performing more than 300 diagnostic cardiac catheterization procedures per year, combined inpatient and outpatient.
- The applicant's payor mix at a minimum reflects the community average for Medicaid, charity care, and self-pay patients or the applicant must certify that it will provide a minimum of 5 percent of Medicaid, charity care, and self-pay to open-heart-surgery patients.
- If the applicant fails to meet the established criteria for open-heart programs or fails to reach 300 surgeries per year by the end of its third year of operation, it must show cause why its exemption should not be revoked.

By December 31, 2004, and annually thereafter, AHCA must submit a report to the Legislature providing information concerning the number of requests for exemption from CON review for the provision of adult open-heart services in a hospital located within the boundaries of Palm Beach, Polk, Martin, St. Lucie, and Indian River Counties received and the number of exemptions granted or denied.

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.

Adult open-heart surgery is on the list of tertiary health services under rule 59C-1.002(41)(h), F.A.C. The procedure of open-heart surgery is defined under rule 59C-1.033(2)(g), F.A.C., as surgical procedures that are used to:

> treat conditions such as congenital heart defects, heart and coronary artery diseases, including replacement of heart valves, cardiac vascularization, and cardiac trauma. . . . Open-heart surgery operations are classified under the following diagnostic related groups (DRGs): DRGs 104, 105, 106, 107, 108, and 109.

An open-heart-surgery program is defined as a program established in a room or suite of rooms in a hospital, equipped for open-heart surgery operations and staffed with qualified surgical teams and support staff.

The formula for projecting the need for additional adult open-heart-surgery programs in each of the 11 health planning districts is contained in rule 59C-1.033, F.A.C. The projections apply to each district as a whole and the revised rule provides a method by which to authorize county-specific special circumstances for additional adult open-heart-surgery programs.

Current CON Need Methodology

Hospitals operating more than one hospital on separate premises under a single license must obtain a separate CON for the establishment of adult open-heart-surgery services in each facility. Separate CONs are required for the establishment of adult and pediatric open-heart-surgery programs.

In addition to numerical need calculations, criteria used by the agency in evaluating adult open-heart-surgery CON applications include service availability, service accessibility, service quality, and comparable patient charges.

Service Availability
Each adult or pediatric open-heart-surgery program must have the capability to provide a full range of open-heart-surgery operations, including at a minimum: repair or replacement of heart valves; repair of congenital heart defects; cardiac revascularization; repair or reconstruction of intrathoracic vessels; and treatment of cardiac trauma. Each adult or pediatric open-heart-surgery program must document its ability to implement and apply circulatory assist devices such as intra-aortic balloon assist and prolonged cardiopulmonary partial bypass. A health care facility with an adult or pediatric open-heart-surgery program is required to provide the following services: cardiology, hematology, nephrology, pulmonary medicine, and treatment of infectious diseases; pathology, including anatomical, clinical, blood bank, and coagulation laboratory services; anesthesiology, including respiratory therapy; radiology, including diagnostic nuclear medicine; neurology; inpatient cardiac catheterization; non-invasive cardiographics, including electrocardiography, exercise stress testing, and echocardiography; intensive care; and emergency care available 24 hours per day for cardiac emergencies.

Service Accessibility
Open-heart-surgery programs must be available within a maximum automobile travel time of 2 hours under average travel conditions for at least 90 percent of the district's population, and are required to be available for elective open-heart operations 8 hours per day, 5 days a week. Each open-heart-surgery program must possess the capability for rapid mobilization of the surgical and medical support teams for emergency cases 24 hours per day, 7 days a week and emergency open-heart-surgery operations must be available within a maximum waiting period of 2 hours. All open-heart procedures are required by rule to be available to all persons in need. A patient's eligibility for open-heart surgery must be independent of his or her ability to pay. Applicants for adult or pediatric open-heart-surgery programs must document the manner in which they will meet this requirement. Adult open-heart surgery must be available in each district to Medicare, Medicaid, and indigent patients.

Service Quality
Any applicant proposing to establish an adult or pediatric open-heart-surgery program must document that adequate numbers of properly trained personnel will be available to perform in the

following capacities during open-heart surgery: a cardiovascular surgeon, board-certified by the American Board of Thoracic Surgery, or board-eligible; a physician to assist the operating surgeon; a board-certified or board-eligible anesthesiologist trained in open-heart surgery; a registered nurse or certified operating room technician trained in open-heart surgery to perform circulating duties; and a perfusionist to perform extracorporeal perfusion, or a physician or a specially trained nurse, technician, and physician assistant under the supervision of the operating surgeon to operate the heart-lung machine.

Following open-heart surgery, patients must be cared for in an intensive care unit that provides 24 hour nursing coverage with at least one registered nurse for every two patients during the first hours of post-operative care for both adult and pediatric cases. There must be at least two cardiac surgeons on the staff of the hospital, at least one of whom is board-certified and the other at least board-eligible. One of these surgeons must be on call at all times. A clinical cardiologist must be available for consultation to the surgical team and responsible for the medical management of patients as well as the selection of suitable candidates for surgery along with the cardiovascular surgical team. Backup personnel in cardiology, anesthesiology, pathology, thoracic surgery and radiology must be on call in case of an emergency. Twenty-four hour per day coverage must be arranged for the operation of the cardiopulmonary by-pass pump. All members of the team caring for cardiovascular surgical patients must be proficient in cardiopulmonary resuscitation. Charges for open-heart surgery in a hospital must be comparable with the charges established at similar institutions in the service area, when patient mix, reimbursement methods, cost accounting methods, labor market differences and other extenuating factors are taken into account.

Numerical Need Calculation

Rule 59C-1.033, F.A.C., provides that in order for an applicant to be granted a CON for a new open-heart-surgery program, there must be a demonstration of minimum requirements for staffing and equipment, and the agency must find numeric need for a new program under the rule formula. Regardless of whether numeric need is calculated for a new adult open-heart-surgery program, a new program will not normally be approved if: there is an approved adult open-heart-surgery program in the district; or if any well-established adult open-heart programs in the district are performing less than 300 surgeries annually; or if any new adult open-heart programs in the district are performing less than an average of 25 surgeries monthly.

Provided that the above requirements are met, the agency determines need for a new adult open-heart-surgery program based on the following formula:

$$\mathbf{NN = [(POH/500) - OP] \geq 0.5}$$

Where:

NN is the need for an additional adult open-heart-surgery program in the district for the applicable planning horizon.

POH is the projected number of adult open-heart-surgery operations that will be performed in the district in the 12-month period beginning with the planning horizon. The POH is calculated as COH/CPOP x PPOP, where:

COH is the current number of adult open-heart surgeries performed in the district during the 12 months ending 3 months prior to the beginning date of the quarter of the publication of the fixed need pool.

CPOP is the current population age 15 and over in the district.

PPOP is the projected population age 15 and over in the district.

OP is the number of currently operational adult open-heart-surgery programs in the district.

If the computation of **NN** yields a number of 0.5 or greater, an additional program may be approved for the district. Regardless of the numerical need calculation, an additional program is not normally approved for a district if the approval would reduce the 12-month total of surgeries at an existing district program below 300 open-heart-surgery operations.

If there is a demonstrated numeric need for an open-heart-surgery program in a district, preference will be given to an applicant for a county in which none of the hospitals has an open-heart-surgery program and where residents of the county are projected to generate at least 1,200 annual hospital discharges with a principal diagnosis of ischemic heart disease. AHCA's projection of the need for adult open-heart-surgery programs for the January 2005 planning horizon does not indicate a need for a new adult open-heart-surgery program anywhere in the state.

Challenges to Applications

Section 408.039(5)(c), F.S., allows existing hospitals to initiate or intervene in an administrative hearing upon a showing that an established program will be substantially affected by the issuance of any certificate of need. Applicants competing for a CON may also challenge the agency's intended issuance or denial of a certificate of need. Challenges to an application and the cost of defending against challenges are a major reason for the perception that the CON process is burdensome.

Certificate-of-Need Workgroup

As required by Section 15 of Chapter 2000-318, Laws of Florida, a workgroup on CON was established to study issues pertaining to the CON program, including the impact of trends in health care delivery and financing. The group produced a final report in December 2002, which included a recommendation to amend s. 408.032(17), F.S., to add adult and pediatric open-heart surgery to the list of tertiary health services. This recommendation would place in the statute clear authority for the current rule which makes open-heart surgery a tertiary service. The workgroup considered but did not adopt a proposal to exempt adult open-heart surgery from CON review.

Issues

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. After the passage of the National Health Planning and Resources Development Act of 1974 (PL 93-641) most states implemented CON programs. After the act was repealed in the 1980s, a number of states abolished their CON programs. Fourteen states (Arizona, California, Colorado, Idaho, Indiana, Kansas, Minnesota, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah and Wyoming) no longer have CON laws.

There is research to show that CON may be ineffective as a mechanism for cost control and other research to show that it is an effective mechanism for maintaining quality of patient outcomes. In a study published in the *Journal of Health Politics, Policy and Law* in 1998, Christopher Conover and Frank Sloan looked at the effects of lifting CON through the year 1993. The authors found that mature CON programs are associated with a modest long-term reduction in acute care spending per capita, but with no significant reduction in total per capita spending. Further, they found that lifting CON requirements did not result in a surge in health care costs. In a current study of the potential impact of CON on outcomes for patients, Gary Rosenthal and Mary Sarrazin at the University of Iowa, examined the delivery of care to Medicare patients undergoing coronary artery bypass graft (CABG) surgery in all 50 states for a 6-year period. Patients fared better in CON regulated states on measures of in-hospital mortality and deaths within 30 days after surgery. The undesirable outcomes were 21 percent more likely in states that do not regulate the procedure through CON review.

Many studies have shown that the volume of procedures performed at a facility is related to quality of outcomes for patients. However, the length of time that a patient in need of open-heart surgery must wait before receiving the surgery is also related to quality. In an August 2003 article in *The New England Journal of Medicine,* Henning R. Andersen, et. al., compared coronary angioplasty with fibrinolytic therapy in acute myocardial infarction. Danish researchers randomly assigned 1,572 patients with acute myocardial infarction to treatment with angioplasty or accelerated treatment with intravenous alteplase. The patients who were treated with angioplasty were less likely to die or suffer reinfarction or a stroke than the patients who were treated with fibrinolytic therapy (8.5 percent of the patients in the angioplasty group as compared with 14.2 percent of patients in the fibrinolysis group). This research indicates that treatment with angioplasty within 60 minutes of the onset of the heart attack is preferable to treatment with intravenous drugs, and the researchers suggested changing the existing triage procedure accordingly. Instead of taking a patient to the nearest hospital, a better emergency procedure would be to take the patient to a center where angioplasty could be performed.

Changes in Medical Treatment for Heart Disease

Traditional adult open-heart surgery and related interventional cardiology procedures such as angioplasty have been one of the most competitive areas of hospital operations in recent years.

Rapidly changing technology is decreasing the percentage of adult open-heart procedures and increasing the percentage of less invasive procedures such as angioplasty and stent insertion. This change could be accompanied by a change in the prevailing medical opinion about the need for open-heart backup when providing the less invasive procedures. Open-heart backup has traditionally been seen as essential for the less invasive procedures, but this medical opinion appears to be changing. If prevailing medical opinion supports angioplasty and stent procedures without open-heart backup, it is reasonable to predict that the competitive environment among hospitals will change.

Health Service Planning Districts

Section 408.032(5), F.S., identifies 11 health service planning districts in Florida used by AHCA in its CON program. These districts include the following counties:

District 6: Hillsborough, Manatee, Polk, Hardee, and Highlands.
District 9: Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach.

Current administrative rules for the CON program, in 59C-2.100(3)(f), F.A.C., identify the counties that constitute Acute Care Subdistricts, including:

Acute Care Subdistrict 6-2: Polk County

III. Effect of Proposed Changes:

The bill provides 20 WHEREAS clauses establishing the critical state importance of access to adult cardiac care for all citizens of the state; a lack of geographic and temporal access to such care in Health Service Planning District 9 and Acute Care subdistrict 6-2; and the critical importance to the whole state of timely access to adult cardiac care in these districts for residents, tourists, and migrant workers, including the working poor and indigents. The clauses note that advanced interventional treatment for heart attack must be accessed by the patient within one hour of the onset of the attack for the treatment to be most effective, and in Florida, a hospital cannot provide these advanced interventions unless it has an open-heart-surgery program. The clauses point out that the temporal access to advanced cardiac care is limited not only by the geographic distance of the patient from the facility but also by the length of time it takes to transfer a patient from a hospital that does not have an open-heart-surgery program to one that does.

This bill amends s. 408.036(3)(t), F.S., to exempt from CON review the provision of adult open-heart services in a hospital located within the boundaries of Health Service Planning District 9, as defined in s. 408.032(5), F.S., or Acute Care Subdistrict 6-2, as defined in Rule 59C-2.100(3)(f)2., F.A.C.

The bill deletes from the statute the exemption granted to hospitals in Palm Beach, Polk, Martin, St. Lucie, and Indian River Counties and deletes the statement that those exemptions must be based on objective criteria and address the twin problems of geographical and temporal access.

The bill requires the applicant for an exemption to certify, not simply demonstrate, that it is referring 300 or more patients per year from the hospital, including the emergency room, for cardiac services at a hospital with cardiac services, or that the average wait for transfer for 50 percent or more of the cardiac patients exceeds 4 hours.

The bill amends the requirement that AHCA must submit an annual report to the Legislature regarding the requests for exemptions, and AHCA's decisions regarding the requests, to clarify that each annual report would include requests and decisions made during the calendar year.

The bill will take effect upon becoming a law.

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 Art. I, s. 24(a) and (b) 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, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

The 2003 Legislature passed SB 460 (ch. 2003-289, L.O.F.) which provided an exemption from CON review for adult open-heart-surgery programs in Palm Beach, Polk, Martin, St. Lucie, and Indian River Counties, an exemption quite similar to the one provided in this bill. The law required the exemption to address and solve the twin problems of geographic and temporal access to open-heart-surgery programs by individuals experiencing a heart attack. The provisions of ch. 2003-289, L.O.F, were challenged on the grounds that the law violated Article 3, Section 10 of the Florida Constitution, i.e., that it was a local bill and that no prior notice had been published prior to its enactment. Those defending the law argued that it was a general law under the provisions of Article 3, Section 11(b) of the Florida Constitution, i.e., one in which political subdivisions or governmental entities could be classified on a basis reasonably related to the subject of the law. The circuit court upheld the challenge, finding that the five counties named in the law constituted a closed classification and therefore the bill was a local law (*Tenet Healthsystem Hospitals, dba Delray Medical Center; Lifemark Hospitals of Florida, Inc., dba Palmetto General Hospital; and Laura Cillo v. AHCA*, Case no. 03-CA-1584). This decision is being appealed.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Qualifying hospitals in the affected counties could establish adult open-heart-surgery programs without the necessity of CON review. To the extent that additional adult open-heart-surgery programs are established because of the exemption, existing programs would face increased competition for the specialized staff needed for an open-heart-surgery program. If hospitals need to increase salaries and benefits to attract or retain specialized staff, health care costs could increase.

C. Government Sector Impact:

AHCA anticipates a minimal fiscal impact associated with the proposed bill of potentially as much as $43,500. Four of the 6 hospitals that have previously indicated an interest in pursuing the exemption have already been approved by AHCA, through the regular CON review process, to operate an adult open-heart-surgery program. These include Winter Haven Hospital, Indian River Memorial Hospital, Martin Memorial Medical Center and Boca Raton Community Hospital. Other hospitals that have expressed an interest in the exemption that have not been previously approved by the agency include Heart of Florida Regional Medical Center and Bethesda Memorial Hospital. The possible loss in state revenue assumes that the two remaining programs will seek CON exemption.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.