HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7215 PCB HCR 06-06 Rural Health Care
SPONSOR(S): Health Care Regulation Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care Regulation Committee	8 Y, 0 N	Mitchell	Mitchell
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SUMMARY ANALYSIS

HB 7215 reorganizes existing rural health support functions of the Department of Health, to provide planning and support for the development of networks of rural health providers. It creates a joint advisory board appointed by the Secretaries of the Department of Health and the Agency for Health Care Administration, to coordinate efforts of the agencies and stakeholders. The bill moves grant programs that support rural hospitals under the purvue of the Agency for Health Care Administration, and establishes provisions to assist financially distressed rural hospitals and development of Rural Provider Service Networks. The bill establishes provisions for Rural Hospital Receivership, similar to nursing homes and other facilities, to give AHCA options to keep a facility open to continue care, instead of having to close a failing facility by removing its license.

Health care providers in Florida's rural areas continue to face major challenges in establishing and maintaining services. The relative isolation, lack of community resources, and high proportion of uninsured and government funded patients make rural health care delivery a continual struggle to maintain financial solvency.

As in the rest of the country, small, rural hospitals especially face declining public and private reimbursements and a poor and aging population with a greater likelihood of being uninsured and unhealthy. Often they are taken advantage of by unqualified outside management companies. Two North Florida rural hospitals have recently closed--Gulf Pines in Port St. Joe, Gulf County, and Gadsden Memorial Hospital in Quincy.

Because the underlying system of health care financing and delivery, including Florida's Medicaid Reform, is changing from fee-for-service payments to capitation and other risk-sharing payment methods, and cost containment is moving away from regulatory to more market-based strategies, the development of provider service networks are needed to strengthen the rural health care infrastructure and improve access to services. Currently financially stressed rural health providers, especially the hospitals that serve as critical anchors to rural health care, are not prepared to meet these challenges and communities face the prospect of losing access to care.

The bill includes grant programs that use existing state and federal funding. Additional capacity is dependent on any specific appropriations.

The enacting date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited Government – The bill provides for better coordination of existing efforts to help health care providers meet the needs of rural communities. It provides assistance in establishing Provider Service Networks and financially viable hospitals to meet changes in managed care financing and regulation of health care, including Florida's Medicaid Reform.

Empower Families – The bill increases the opportunity for rural families to access quality health care in their communities.

B. EFFECT OF PROPOSED CHANGES:

HB 7215 reorganizes existing rural health support functions of the Department of Health to provide planning and support for the development of rural health provider networks, and creates a joint advisory board appointed by the Secretaries of the department and the Agency for Health Care Administration to coordinate efforts of the agencies and stakeholders. The bill moves grant programs that support rural hospitals to the Agency for Health Care Administration and establishes two new programs to support the development of Rural Provider Service Networks and financially distressed small rural hospitals.

The bill:

Amends s. 381.0405, F.S., Office of Rural Health to:

- Provide for the Office of Rural Health to coordinate its activities with and administer grants to Rural Health Networks.
- Increase technical assistance in planning.
- Establish an advisory council appointed by the Secretaries of the Department of Health and Agency for Health Care Administration and require recommendations for establishing provider service networks in rural counties.

Amends s. 381.0406, F.S., Rural Health Networks, to:

- Reorganize and specify functions related to planning and coordination of service providers and remove requirements to provide health care services.
- Add findings related to rural preparation for managed care and capitation-reimbursement methodologies.
- Encourage participation by Federally Qualified Health Centers, EMS providers and County Health Departments in rural networks.
- Clarify network functions to improve quality and access to services.
- Require rural health infrastructure development plans.
- Require coordination with other entities including health education centers, health planning councils & regional college & university education consortia.
- Establish a grant program to support network operations and rural infrastructure development.
- Delete obsolete language related to network implementation in two phases.

Amends s. 395.602(2), F.S., Rural Hospitals, to:

- Remove definitions for obsolete federal programs.
- It retains and amends the definition for "rural primary care hospitals" to continue to allow for licensure of smaller facilities that provide emergency care and temporary inpatient care.

Amends s. 395.603(1), F.S., relating to Deactivation of Hospital Beds, to remove provisions for obsolete federal programs, and it repeals s. 395.605, F.S., relating to an obsolete federal rural hospital programs.

Amends s. 395.604, F.S., relating to Rural Primary Care Hospitals, to establish provisions for funding and support for very small rural primary care hospitals that provide only emergency and temporary care, including expedited CON review and certain exemptions.

Amends s. 395.6061, F.S., relating to Rural Hospital Capital Improvement Grants, to:

- Clarify that the purpose of the program is to assist hospitals in adapting to changes in delivery of care and funding, assist financially distressed hospitals, and ensure accountability for state funds.
- Require agency technical assistance.
- Remove requirement that all rural hospitals receive an equal grant amount of $100,000 regardless of need or purpose, and specify criteria for awarding grants.
- Establish assistance to Financially Distressed Rural Hospitals, that is limited to critical access hospitals and rural hospitals with an annual occupancy rate of less than 30 percent; and requires a participation agreement and other requirements to receive funding.

Creates s. 408.7074, F.S., relating to the Provider Service Network Development Program, to:

- Establish the program in the Agency for Health Care Administration:
- Require the program to administer the Rural Hospital Capitalization Grant program in s. 395.6061, F.S.
- Establish requirements for Rural Provider Service Network Development grants.

Amends s. 408.07, F.S., relating to Reimbursement of Medicaid Providers, to require a 10 percent reimbursement bonus to physicians who have provider agreements with a rural health network.

The bill establishes the enacting date to be July 1, 2006.

CURRENT SITUATION

Rural Counties in Florida

Although Florida is the fourth most populous state in the U.S., it has substantial areas that are rural. As of the 2000 U.S. Census, 33 of Florida's 67 counties are considered rural based on the statutory definition of "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." In area, these 33 counties cover just over 42 percent of Florida's nearly 54,000 square miles of land area. Rural counties are located primarily in the Florida Panhandle, north central Florida, the south central portion of the state, and the Florida Keys.

As of 2000, approximately 1.1 million of Florida's 16 million residents live in rural counties. Portions of other Florida counties also contain large, rural areas that are not classified as rural. Many of the counties bordering on the Atlantic Ocean and Gulf of Mexico have populations concentrated near the coast, but thinly populated interiors (e.g., Collier, Palm Beach, or Escambia counties).

Rural Health Infrastructure and Outcomes

In general, rural residents have more health problems than urban residents. Rural communities have:

- Higher rates of chronic illnesses, such as hypertension and cardiovascular disease;
- Problems unique to rural occupations, such as machinery accidents, skin cancer from sun exposure, and breathing problems from exposure to agricultural chemicals; and
- Lower rates of having health insurance with pharmacy coverage plans.

The relative disparity between the health and access to health care of Florida's urban and rural residents is an ongoing concern for policymakers. Florida has been involved in a variety of state and federal efforts to address the health care needs of rural residents over the past half-century that include:

- Hill-Burton program that provided federal funding for the construction of community hospitals during the 1950s and 60s;
- Establishment of state and regional comprehensive health planning and health systems agencies from the 1960s through 1985;
- Regional health planning efforts by local health councils from 1985 to present;
- Establishment of the Office of Rural Health in 1991;
- Authorization of rural health networks in 1993;
- Implementation of the federal critical access hospital program in 1997;
- Provision of rural emergency medical and hospital capital improvement grants to sustain essential services in rural communities and enhance the development of coordinated health care delivery in rural communities; and
- Legislative approval in 2000, for a new medical school at Florida State University to train primary care physicians to practice in underserved and rural communities.

Insufficient Health Services

While Florida has made considerable progress through these efforts, more still needs to be done to ensure that rural residents continue to have reasonable access to quality health services. These investments in Florida's health care infrastructure have not provided the significant return on investment that was anticipated. Despite advances over the past decade in reducing morbidity and mortality, the health of Florida's rural population remains at risk. Rural Florida residents have a higher mortality rate than urban residents for motor vehicle accidents, infant mortality, diabetes, Alzheimer's disease, and chronic lower respiratory disease.

Health care providers in Florida's rural areas continue to face major challenges in establishing and maintaining services. The relative isolation, lack of community resources, and high proportion of uninsured and government funded patients make rural health care delivery for many health care providers a continual struggle to maintain financial solvency. Some of Florida's 29 rural hospitals lack sufficient patient revenue to meet operating expenses, forcing the hospitals to make decisions about reducing or eliminating essential health services. Although recent federal and state programs have eased the financial burden for rural hospitals, future attempts to curb government health spending will pose an ongoing challenge for rural providers.

Approximately 20 percent of the adult population in rural areas is without health insurance coverage. This is primarily because during economic downturns, rural areas have higher levels of unemployment, and rural residents have greater difficulty obtaining health insurance coverage.

Rural Hospital Financial Problems

Rural hospitals are the hub of health care for their service areas. Skilled-nursing, home, clinical, and primary-care services often are available solely due to the presence of a hospital. The hospitals are also critical for the economic development of rural communities, as employers of skilled professionals and hospital access are needed to attract outside investment.

As in the rest of the country, small, rural hospitals in Florida face numerous challenges. Among them are declining public and private reimbursements, workforce shortages and a poor and aging population with a greater likelihood of being uninsured and unhealthy. Often they are taken advantage of by unqualified outside management companies. Two North Florida rural hospitals have recently closed--Gulf Pines in Port St. Joe, Gulf County, and Gadsden Memorial Hospital in Quincy.

The mission of the rural hospitals is to provide appropriate, life-saving health care in rural/isolated areas of the state. By definition, rural hospitals have 100 or fewer beds. Nineteen rural hospitals have

50 or fewer beds. The majority of rural hospitals are located in the Panhandle. Rural hospitals represent approximately two percent of hospital admissions statewide.

Small rural hospitals may be designated as Critical Access Hospitals and receive additional federal support. These hospitals must have no more than 25 beds of which only 15 may be acute care beds. Eleven of Florida's 29 rural hospitals are Critical Access Hospitals.

According to information provided by the Agency for Health Care Administration, the 29 rural hospitals in Florida have an overall average operating margin of 2.4 percent. The Critical Access Hospitals have an average operating margin of -.2 percent. Specific hospitals, such as Cambellton-Graceville Hospital in Jackson County, which has a -6.5 percent operating margin and Hendry Regional Medical Center in Hendry Co, with a -4.8 percent operating margin, are in very difficult financial and operating circumstances. (Hospital Bed and Service Utilization 1/17/06, Rural Hospital Payer Mix for FY 2004 based on data reported 2/2006.)

Occupancy rates are low. Information on bed days reported by rural hospitals for the second quarter of 2005 shows an overall average rural occupancy rate of 37 percent. Critical Access Hospitals have an overall occupancy rate of 25 percent. Three Critical Access Hospitals had much lower occupancy rates. Cambellton-Graceville Hospital in Jackson County reported an occupancy rate of 11 percent; George Weems Memorial Hospital in Franklin County reported an occupancy rate of 15 percent; and Gadsden County Community Hospital in Quincy, which is now closed, had an occupancy rate of only 6 percent.

Critical Access Hospitals disproportionately depend on federal programs, especially Medicare, for funding. While rural hospitals overall have a payer mix that is 60 percent Medicare Days and 14 percent Medicaid Days, Critical Access Hospitals overall have a mix that is 66 percent Medicare Days and 16 percent Medicaid Days. Hospitals with very low operating margins, such as George Weems Memorial Hospital in Appalachicola, which has a mix of 81 percent Medicare and 4.3 percent Medicaid, and Gadsden Memorial, which had a mix of 75 percent Medicare and 3 percent Medicaid, are uniquely dependent on increasingly restricted sources of reimbursement. Furthermore, they receive very little Disproportionate Share Hospital Funds that are based on Medicaid.

Case Study of the Failure of Gadsden Memorial Hospital in Quincy Florida
In November 2005, the state closed the 25-bed hospital in Quincy, Florida, as a threat to public health. As reported in the Tallahassee Democrat, February 23, 2006, county officials have been trying ever since to reopen it by getting its existing state operating license transferred from Ashford Community Health Care Systems, the management company that ran it. Ashford filed for bankruptcy protection shortly after the hospital was closed, and the license has become a valuable asset to creditors, including GE HFS Holdings Inc., a company which gave Ashford a nearly $3 million secured loan, so that Ashford is not willing to give up its lease to the hospital. Two other rural North Florida hospitals that were also run by Ashford are also in trouble, Weems Hospital in Appalachiacola, and Calhoun-Liberty Hospital in Blountstown.

The county still has to evict Ashford from the hospital, an effort begun last April and interrupted by Ashford's bankruptcy filing. County officials plan now to push ahead with terminating the lease. Gadsden County is trying to set up a temporary urgent-care clinic to meet residents' health-care needs, while officials begin the arduous process of getting a new operating license for Gadsden Memorial Hospital.

CURRENT STATE PROGRAMS

Office of Rural Health
Florida's Office of Rural Health, ORH, is located within the Department of Health and has been the focal point for the development and administration of Florida's rural health policy since 1991 (s. 381.0405, F.S.). Currently, the office is staffed by two full-time positions: the Director of the Office of Rural Health and a Critical Access Hospital Coordinator.

The office's mission is to actively foster the provision of health care services in rural areas and serve as a catalyst for improved health services to citizens in rural areas of the state. The office works with other state and federal programs as Florida's rural health representative, disseminates information on Florida's rural health services, and acquires and distributes state and federal funds to assist in maintaining a coordinated and sustainable system of rural health services. Specifically, ORH is assigned responsibility for the following:

- Coordinating with other state programs and agencies (e.g., Medical Quality Assurance, Emergency Medical Services, Planning, Evaluation and Data Analysis within the larger Department of Health; the Agency for Health Care Administration; the Department of Children and Families), area health education centers, state universities, and rural health interest groups such as the Florida Hospital Association and the Florida Rural Health Association;
- Providing technical assistance to rural providers;
- Collecting and disseminating information about rural health;
- Acquiring grant funds for rural health programs and providers; and
- Working to improve access to emergency medical services in rural areas.

Since 1997, the office has focused on three key programs within rural health, the Medicare Rural Hospital Flexibility Program, the Rural Hospital Capital Improvement Grant Program, and the development and support of the state's rural health networks.

Rural Health Networks
In 1993, the Legislature established the basis for the formation of cooperative, nonprofit health networks in rural areas of Florida in s. 381.0406, F.S. These organizations were directed to address the fundamental problems in rural health: inadequate financing, problems with recruitment and retention of health personnel, and migration of patients from rural providers to urban providers, thus undermining the abilities of rural hospitals to continue to provide timely and effective care. The networks are intended to integrate public and private health resources, to emphasize cooperation over competition, and to increase usage of statutory rural hospitals in an effort to support rural economies.

Nine rural health networks have been formed in Florida. Currently, these cover 28 of the 33 rural counties as well as parts of 13 non-rural counties. The department has the responsibility for certifying the networks and for distributing grant funds to eligible participants. Florida's rural health networks have been in operation since 1993 and serve as the regional organizations responsible for carrying out much of Florida's rural health policy. Rural health networks work closely with rural communities and providers to encourage, organize, and coordinate actions to provide increased health access and improved health care services to rural communities.

Rural Hospital Capital Improvement Grant Program
In 1999, the Florida Legislature established the rural hospital capital improvement grant program through which statutory rural hospitals, as defined by s. 395.602, F.S., may apply for financial assistance to "acquire, repair, improve, or upgrade systems, facilities, or equipment" (s. 395.6061, F.S.). Upon fulfilling basic application conditions, each qualifying rural hospital receives a minimum of $100,000 per year for such capital improvements, if funds have been appropriated by the Legislature. The application, review, and administration procedures for this program are responsibilities of ORH.

Receivership Proceedings for Failing Health Care Facilities
In its regulation of several residential facilities, including nursing homes, the Agency for Health Care Administration has statutory authority to initiate receivership action in the courts in the event conditions in those facilities present a threat to the health, safety or welfare of the residents or patients. Receivership proceedings are provided in:

- s. 394.903, F.S., for mental health facilities.
- s. 400.126, F.S., for nursing home facilities.

- s. 400.422, F.S., for assisted living facilities.
- s. 400.966, F.S., for intermediate care facilities for persons with developmental disabilities.

Currently chapter 395, Florida Statutes, the statutory chapter governing licensure and regulation of hospitals, does not include provisions for imposing a receivership on any hospitals.

Receivership is initiated through a petition to the court requesting that a qualified person, receiver, be given authority over all operations of a facility for a specified period. The Agency is responsible for providing a list of qualified receivers to the court for selection of a receiver. The receiver is charged with using the resources available to the facility to resolve the problems that have resulted in the dangerous or unhealthy conditions; either allowing for an orderly transition to a change of ownership or to closure. The receiver must report to the court and provide evidence to the court that the facility is operating satisfactorily, or request that the period of receivership be extended.

Receivership is a form of bankruptcy in which a company can avoid liquidation by reorganizing with the help of a court-appointed trustee. Receivership takes place through a court order and is utilized only in exceptional circumstances and with or without the consent of the owner of the property. A court orders receivership to place property subject to dispute in a legal action under the control of an independent person known as a receiver. Receivership is an extraordinary remedy to preserve property during the time needed to prosecute a lawsuit, if a danger is present that such property will be dissipated or removed from the jurisdiction of the court if a receiver is not appointed.

Trust Funds for Receivership Proceedings for Failing Health Care Facilities
As amended the bill creates the Rural Hospital Patient Protection Trust Fund to provide funding for receivership for rural hospitals through a $1 fee on each discharge from a rural hospital. This mirrors statutory provisions for trust funds established in conjunction with current provisions for receivership proceedings for other types of facilities. According to information on discharges provided by the Agency for Health Care Administration, the total number of discharges from all rural hospitals for the 5.5 year period from 1/2000 to 6/2006 averaged only 57,682 per year. This would provide an average of $57,682 funding per year for any receiverships of rural hospitals.

BACKGROUND

PROBLEMS FACING RURAL HOSPITALS

While many rural hospitals have survived by shifting to outpatient services such as skilled nursing, home health and hospice, the shift has made them more vulnerable to changes in reimbursement and other policies as federal and state programs seek to constrain the increasing costs of health care.

Aging Facilities and Professional Shortages
Within the context of changing health care economics, small rural hospitals face several critical problems that include the need for capital improvements to many aging hospitals and the need to recruit and retain a skilled workforce. Many of America's small rural hospitals were built with the support of 1946-1970s era Hill-Burton Act funds. These facilities are collectively beginning to show their age and obsolescence. In a survey of rural hospitals conducted by the Florida Hospital Association, eight rural hospitals reported their facilities were 40-50 years old. Rural hospitals face a chronic and critical problem recruiting and retaining nurses, technicians, midlevel practitioners, and physicians.

Lack of Information Infrastructure
There is a growing need for telemedicine services between rural hospitals and specialists to provide remote consultation for treating individual patients. Many rural hospitals do not have full-time radiologists to interpret X-rays. Most rural hospital telemedicine now involves only telephone service and faxing to other physicians at hospitals that might receive patients transferred from rural hospitals to provide services not available in the rural settings. Most Florida health insurance does not provide compensation for telemedicine consultations.

Where telemedicine consults are available, it has been reported anecdotally that approximately 80 percent of patients can be successfully treated at the rural hospitals without incurring patient transfer costs. Rural clinics are often formally affiliated with larger hospitals that accept transfer patients with serious ailments.

Rural hospitals lack the technology and equipment to support the delivery and management of these health care services. They lack building wiring for networking and other resources typically employed for distance learning. To date:

- A majority of rural hospitals have implemented some form of automated billing, but very few have automated patient records.
- Many of the computer workstations in rural hospitals are not networked and billing and patient care records systems are generally not integrated.
- Most rural hospitals have no satellite or Instructional Television Fixed Service capability for receiving video signals for accessing continuing education training material.

EFFORTS TO ADDRESS THE PROBLEMS OF SMALL RURAL HOSPITALS

A 2001 report by the National Advisory Committee for Rural Hospitals offered several suggestions to address these problems, including:

- Incentive programs for nurses working in underserved rural areas to help alleviate nursing shortages.
- Training and technical assistance to rural providers as they try to keep up with reimbursement and regulatory demands.
- Careful analysis of the effects of proposed reimbursement and regulatory changes on small rural communities prior to enactment.
- Addressing sustainability for rural telemedicine applications through additional funding for site coordinators and/or communication charges.

Managed Care

Traditionally, improving access to health care services has been addressed by increasing payments to providers and creating special programs to recruit and retain health professionals. Even as these efforts continue, however, the underlying system of health care financing and delivery is changing across the entire health system—marked by the move to managed care and the rise of more integrated health care organizations. Most major health care purchasers are switching from fee-for-service payments to capitation and other risk-sharing payment methods, and policymakers in general are moving away from regulatory to more market-based strategies for containing costs. It appears that the development of provider networks and managed care systems holds some promise for strengthening the rural health care infrastructure and improving access to health care services.

Many rural providers perceive managed care organizations (MCOs) as a threat, because they:

- May impose more financial risk on rural providers than they are capable of bearing;
- May not make concessions for circumstances particular to rural areas (e.g., transportation barriers, larger caseloads for practitioners, and limited infrastructure in general); and
- May absorb most or all the new primary care practitioners and give them incentives to locate in urban and suburban areas, draining health care resources away from rural areas and exacerbate the shortage of primary care providers.

On the other hand, because many MCOs are large organizations with considerable resources, they have the potential to invest in building adequate rural health care delivery systems. They may enable rural providers to participate in more sophisticated medical management information systems. They

can provide a steady income stream via capitation and other contracts to physicians and hospitals, which may be especially welcome in more economically depressed areas. It has also been argued that MCOs can better use mid-level and non-physician practitioners than can independent providers. They may also improve access to relevant medical technologies by linking rural providers to urban health centers through telecommunications and mobile health units.

In this context, states need to consider the special effects on rural areas as they implement new regulations for managed care, such as rules for provider networks that bear insurance risk, and integrate rural network development into other initiatives, such as network demonstration projects with Medicaid managed care expansion.

FEDERAL PROGRAMS

Medicare Rural Hospital Flexibility Program

Beginning with the Balanced Budget Act of 1997 (Public Law 105-33), the U.S. Congress started a process designed to improve the financial viability of small, rural hospitals. The initial program was "fine-tuned" through provisions of the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000. Rural hospitals suffer not only from small, relatively poor patient populations but they have also been penalized by Medicare which provided service reimbursement rates lower than those provided to urban hospitals for the same services. Oftentimes, the reimbursement was for less than the actual cost of care, thereby actually costing the hospital money. This is especially important for rural hospitals since they have proportionally more Medicare patients than do urban hospitals. The Medicare Rural Hospital Flexibility Program was intended to rectify some of these imbalances. The program presented 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.

Critical Access Hospitals may have no more than 15 acute care beds and another 10 "swing beds" (these are inpatient beds that may also be used for other services such as part of a Skilled Nursing Facility). Average annual length of stay for all inpatients must be 96 hours (4 days) or less. Emergency services must be available 24 hours per day, seven days per week. Certain other regulations must be followed concerning physical location, relations with larger, tertiary care hospitals, and credentialing and quality assurance procedures. In return, these hospitals will be reimbursed on a "reasonable cost" basis for inpatient, outpatient, and laboratory services delivered to Medicare patients. For small hospitals with significant numbers of Medicare patients this, at the very least, allows them to stop losing money on services delivered. The office oversees the conversion applications, financial feasibility studies; community needs assessments, and conversion of rural hospitals to Critical Access status.

The vast majority of CAHs are located in health professional shortage areas, are the only hospitals in the county, and are located in counties where the over-65 population is higher than the state average. The states with the largest number of CAHs are Kansas, Nebraska, Iowa, Texas, Minnesota, and Montana. Out of 31 rural hospitals in Florida, 12 are Critical Access Hospitals. The three North Florida hospitals currently in financial crisis are all Critical Access Hospitals.

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 office applies for, receives, and administers these grant funds.

Medicare and Medicaid Bonus Payments

In addition to the challenges facing rural hospitals, another issue limiting health care access in rural communities is the sparse number of physicians in practice in rural counties. The persistent shortage of primary care physicians in rural and underserved areas of the nation has become one of the most challenging health care policy issues facing medical educators and health care policymakers in the U.S. in the past half century. Incentives, both financial and personal, have combined to create a

modern-day physician workforce overloaded with specialists who choose to practice primarily in metropolitan and suburban markets. The ultimate consequence of this skewed distribution of physician location and services is a shortage of basic health care services for certain groups of the U.S. population, particularly in rural areas.

The federal government, recognizing the need for economic incentives to facilitate this process, has established several key programs that promote the provision of primary care services to those of greatest need. Of these, two programs involve bonus payments in the Medicare program for physicians practicing in Health Professional Shortage Areas and Physician Scarcity Areas.

Health Professional Shortage Areas Bonus Payments
The federal Health Professional Shortage Area designation identifies an area or population as having a shortage of dental, mental, and primary health care providers. Those designations are used to qualify for state and federal programs aimed at increasing primary care services to underserved areas and populations.

Among these programs is a ten percent bonus Medicare payment for providers practicing medicine in a Health Professional Shortage Area. The bonus is paid for all Medicare services provided in the shortage area and may be billed along with other incentives programs.

Physician Scarcity Areas Bonus Payments
The Medicare Modernization Act of 2003, §413(a), requires that a new 5 percent bonus payment be established and paid for services rendered by physicians in geographic areas designated as Physician Scarcity Areas. Under the program, physician scarcity designations are based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in a particular county. Medicare will pay a 5 percent bonus on a quarterly basis based on where the service is performed and not on the address of the beneficiary. The bonus may be billed in conjunction with other bonus payments under Medicare.

Both of these Medicare bonus programs are authorized under the federal physician payment regulations found in 42 CFR 447.200 and 42 CFR 447.203. A similar bonus payment system in Medicaid would require a state plan amendment that clearly explains how the bonus payment is provided.

C. SECTION DIRECTORY:

Section 1. Amends s. 381.0405, F.S., Office of Rural Health to provide for rural health networks planning and technical assistance and establish a joint DOH and AHCA advisory council that will make recommendations on rural provider service networks.
Section 2. Amends s. 381.0406, F.S., Rural Health Networks, to reorganize and specify functions related to planning and coordination of service providers and remove requirements to provide health care services and establish a grant program to support network operations and rural infrastructure development.
Section 3. Amends s. 395.602(2), F.S., Rural Hospitals, to remove definitions for obsolete federal programs and amends the definition for “rural primary care hospitals” to continue to allow for smaller facilities that provide emergency.
Section 4. Amends s. 395.603(1), F.S., relating to Deactivation of Hospital Beds, to remove provisions for obsolete federal programs.
Section 5. Amends s. 395.604, F.S., relating to Rural Primary Care Hospitals, to establish provisions for funding and support for very small rural primary care hospitals, including expedited CON review and certain exemptions.
Section 6. Amends s. 395.6061, F.S., relating to Rural Hospital Capital Improvement Grants, to clarify the purpose of the program, remove the requirement that all rural hospitals receive an equal grant amount of $100,000, regardless of need or purpose, include provisions for assistance to financially distressed rural hospitals, and specify criteria for awarding grants.
Section 7. Creates s. 395.6070, F.S., establishing provisions for rural hospital receivership.

Section 8. Creates s. 395.6071, F.S., establishing the Rural Hospital Patient Protection Trust Fund to provide funding for rural hospital receivership.
Section 9. Creates s. 408.7054, F.S., to establish the Rural Provider Service Network Development Program in AHCA, that will administer the rural hospital capital improvement program in s. 395.6061, F.S.; and the created Rural Provider Service Network Development Grant program.
Section 11. Amends s. 409.908, F.S., relating to Reimbursement of Medicaid Providers, to require a 10 percent bonus to physicians who have provider agreements with a rural health network.
Section 10 and Sections 12 and 13. Amend ss. 408.07(43), 409.9116, and 1009.65, F.S., to conform cross-references.
Section 14. Repeals s. 395.605, F.S., relating to an obsolete federal rural hospital programs.
Section 15. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments below.

2. Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will provide increase funding to rural health care providers, including physicians, hospitals and provider service networks.

D. FISCAL COMMENTS:

Grant programs established in the bill are contingent on funding from General Revenure. According to the Department of Health, existing funding for current programs in 2005-2006 includes:

Office of Rural Health	$ 150,000	state
Rural Health Networks	$ 500,000	state
Rural Hospital Capital Improvement Program	$ 3,500,000	state
Small Hospital Improvement Program (SHIP)	$ 177,460	federal
Medicare Rural Hospital Flexibility Program (FLEX)	$ 540,000	federal

In addition, some rural hospitals and some rural health networks receive funds that do not flow through the DOH Office of Rural Health. State funds include Rural Hospital Disproportionate Share funds and member projects. Federal funds include Office of Rural Health Policy Grants for rural health outreach and network development. In addition, there are federal funds for bioterrorism.

As amended the bill creates the Rural Hospital Patient Protection Trust Fund to provide funding for receivership for rural hospitals, through a $1 fee on each discharge rural hospitals similar to provisions

for receivership for other types of health care facilities. According to information on discharges provided by the Agency for Health Care Administration, the total number of discharges from all rural hospitals for the 5.5 years from 1/2000 to 6/2006 averaged only 57,682 per year. This would provide $57,682 funding per year for any receiverships of rural hospitals. See status of this provision in drafting comments, below.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Department of Health and Agency for Health Care Administration have rule making authority to administer existing programs and specific authority is provided in the bill for new responsibilities.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Amendment 2 of the bill introduced section 8, which creates the Rural Hospital Patient Protection Trust Fund. This appears to put the bill in violation of s. 19(f)(1), Art. III of the State Constitution, which requires trust funds to be created in a separate bill for that purpose only.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 28, 2006, the Health Care Regulation Committee adopted three amendments offered by Chairman Garcia, and reported the bill favorably as amended.

Amendment 1: Requires the advisory council to make recommendations on establishing Provider Service Networks in rural counties

Amendment 2: Clarifies that the purpose of the Rural Hospital Capital Improvement Grant program to:

- Assist hospitals in adapting to changes in delivery of care and funding;
- Assist financially distressed hospitals; and
- Ensure accountability for state funds.

Moves the Provider Service Network Development Grant program out of the Office of Health Statistics, to give ACHA flexibility in its use of existing resources and removes a required study.

Amendment 3: Establishes provisions for Rural Hospital Receivership and a trust fund to give AHCA options to keep a facility open to continue care, instead of having to close a failing facility by removing its license. These provisions mirror existing statues for nursing homes, assisted living facilities, and facilities for persons with mental illness and developmental disabilities.

The analysis is drafted to the amended bill.