House Legislative Analysis Section

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DPH REVIEW FEES/RURAL BED BANKING

House Bill 4978 as enrolled
Third Analysis (1-14-91)

Sponsor: Rep. Michael J. Bennane
House Committee: Public Health
Senate Committee: Health Policy

THE APPARENT PROBLEM:

The state construction code (Public Act 230 of 1972) delegates review and approval of health facility construction plans to the Department of Public Health (DPH), which established an engineering section in the Bureau of Health Facilities in 1963 to help architects and engineers in the design of health facilities. The Public Health Code of 1978 created a system of "construction permits" for health facilities which requires state review of health facility construction plans for any project requiring a certificate of need (CON). Engineering staff in the Bureau of Health Facilities review plans for proposed health care facilities (including renovations), issue permits, and provide assistance to architects and engineers to assure that health care facilities are constructed to appropriate approved standards.

Although the recent revision of CON provisions (which increased the dollar thresholds to $750,000 and $1.5 million) has reduced the number of health facility projects legally subject to construction permit review, a number of other factors — including changes in federal policies regarding matching funds, a flat $50 fee for all projects (regardless of the size or complexity of a project) that has not changed in 20 years, and staff reductions — have resulted in a backlog of projects to be reviewed. The DPH has taken steps to reduce this backlog (such as returning projects no longer subject to review, waiving review of other projects, and suspending the review of design changes made during the construction phase of projects), but the construction industry is concerned that these restrictions of construction permit activities not only will raise project costs and delay the opening of projects, but also may raise architect and construction firm insurance fees.

At the department's request, legislation has been introduced to create a sliding scale fee structure for both mandatory plan reviews and voluntary reviews.

In an unrelated issue, when Public Act 259 of 1990 (enrolled Senate Bill 890) was enacted, it was given immediate effect. The act allows "bed banking" under certain circumstances by rural hospitals. However, several provisions of the act require data that is not available. As a result, the act cannot be implemented unless some changes are made in the kinds of data required under the act. Legislation has been introduced that would make these necessary changes.

THE CONTENT OF THE BILL:

The bill would amend the Public Health Code to assess new sliding scale fees for project plan reviews (with a maximum fee of $30,000) and to change some of the kinds of data required to implement Public Act 259 of 1990, which allows rural hospitals to "bank" some of their beds under certain circumstances.

Project plan reviews. The bill would set project plan review fees for the first $1 million of capital expenditure at one-half of one percent; for any amount over $1 million, the fee would be .85 of one percent, with a maximum fee of $30,000. (The bill would specify that "capital expenditure" would not include the cost of "fixed equipment," such as heating and ventilation equipment.) The bill also would allow the Department of Public Health to conduct, upon the request of the person initiating the construction project, non-mandatory reviews if the department determined that the review would promote the public health, safety, and welfare.

Rural hospital bed banking. Public Act 259 of 1990 allows hospitals located in nonurbanized areas to temporarily delicense up to 50 percent of their licensed beds for two to five years. In order to delicense beds for up to two years, a hospital must be located in a distressed area, have an annual patient volume consisting of at least 25 percent indigent patients, and apply for the delicensure within 90 days after the effective date of the act. The act defines "distressed area," "indigent patient," and "urbanized area." "Distressed area" means a city or village that meets certain requirements: a negative population change and a greater than statewide average poverty level for the period from 1970 to the "most recent" decennial census, an increase in state equalized valuation less than the state average since 1972, eligibility for urban development assistance grants from the federal Department of Housing and Urban Development, and a higher than statewide average unemployment rate for three of the five years immediately preceding the application for delicensure. "Indigent patient" means "an individual who is unable to pay for health care services or a medically indigent individual" as defined by the Social Welfare Act. And "urbanized area" is defined by reference to the federal definition in an October, 1989, notice of the federal census bureau titled "Urbanized Areas for the 1990 Census Proposed Criteria."

The bill would replace the definitions of "indigent patient" and "urbanized area" and would make a number of changes to the definition of "distressed area." The bill would delete villages from the definition of "distressed area," base the unemployment rate used in the definition on the years from 1981 to 1985, base the population change and poverty level on the 1980 census, and specify that eligibility would be for an urban development action (rather than "assistance") grant listed in certain 1984 federal documents. The bill would redefine "urbanized area" by reference to a January, 1980, definition set forth by the Office of Federal Statistical Policy and Standards of the United States Department of Commerce (in an appendix titled "General Procedures and Definitions"). It also would replace the definition of "indigent patient" with a definition of "indigent volume," which would be defined as "the ratio of a hospital's indigent charges to its total charges." The ratio would be in the form of a percentage, and would be determined by the Department of Social Services after November 12, 1990, in accordance with the department's "medical assistance program manual" guidelines.

MCL 333.20145 and 333.21551

OVER

FISCAL IMPLICATIONS:

The House Fiscal Agency reports that there will be fiscal implications for the state, but at this time there is no way to determine specific amounts, since no one knows how many projects will be requesting voluntary reviews and since the number and size of projects subject to mandatory review is unknown. (9-29-89) The Department of Public Health estimates that the bill could bring in $150,000 in revenues this year from the increased fees, if the department were able to hire four additional engineers to do the increased number of project plan reviews necessary to bring in these revenues. In light of the current hiring freeze and state budget uncertainties, however, the department may not be able to hire additional staff, in which case fiscal implications would remain unknown. (1-3-91)

ARGUMENTS:

For:

Issuance of a construction permit by the Department of Public Health (DPH) upon review of proposed health facility plans certifies that the design is in compliance with state laws and assures the provider (and architects) that a health facility will be able to open once it is constructed. Without state engineering support and review, providers and architects must proceed at their own risk in the construction of buildings and face the possibility that expensive construction may not meet required code requirements when the facility is otherwise ready to open. Corrections of design problems at this point usually are extremely expensive, as well as involving delays in project completion while non-conforming portions of the project are removed and rebuilt. Allowing voluntary reviews upon request would help those projects that fall below the certificate of need dollar threshold (or that for other reasons are not required to have the DPH review their plans) by helping them avoid the major expense and costly delay caused by non-compliance with complex construction code requirements.

For:

Fee increases are badly needed in order to bring the engineering staff back up to levels adequate to handle the demand for plan reviews, to counteract reduced federal support of the program, and to allow reviews of projects no longer formally subject to review.

For the past twenty years, the fee for all plan reviews regardless of the size of the project, has been a flat $50. Yet even as fees have remained unchanged, projects have increased in size and complexity, federal support for plan review has been reduced, and a hiring freeze has drastically reduced the number of engineers on staff. Larger projects require more staff time to complete the complex review of plans, specifications and regulations, while, during the 1980s, the engineering staff has been reduced from eleven to only four (the chief and three supporting engineers). In addition, federal matching funds have been reduced as the result of a decision at the federal level that the issuance of state construction permits before a building is built is not federally required (except in the case of Medicare design requirements) and therefore will not be recognized for federal matching funds.

A sliding scale fee, under which larger projects would pay more for the more complex review required and which could be capitalized over the life of a project, would be more equitable than the existing flat $50 fee. If the fee increases resulted in the hiring of more engineers to review project plans, they also would ensure more timely plan reviews, would reduce delays costly to the industry and public, and would allow voluntary "courtesy" reviews of projects that do not require certificates of need (but that still request state assistance).

Against:

While fees for plan reviews may well be needed, the amount of the increase for some projects is staggering to contemplate. Even with the $30,000 "cap," the jump from the existing $50 fee to this maximum is considerable, to say the least. Surely lower and more equitable caps could be set without damaging the review program.

Response: First, the proposed fees are quite reasonable, especially when compared to engineering design fees, which typically range from 8 to 12 percent of a project's costs. Secondly, few projects would require the highest fee, since 60 to 80 percent of health construction projects fall below the certificate of need thresholds. If the $30,000 maximum possible fee were to be put in terms of a percentage of a project's costs, it would come out to only one-half of one percent of a twelve million dollar project. This still is very reasonable, particularly considering the large amounts of staff time required to review such large projects. Finally, as pointed out above, these plan reviews can, in the end, pay for themselves many times over by ensuring that there will be no costly opening day "surprises."

For:

Public Act 259 of 1990, which is part of a "rural health care package" passed by the legislature in the 1989-90 session, allows rural hospitals to temporarily delicense or "bank" some of their beds under certain circumstances. However, without the technical changes proposed by the bill, the act as currently written cannot be given immediate effect, as ordered by the legislature, because the necessary information is not available.

For example, in order for a hospital to qualify for the act's bed banking program, it has to be in a "distressed area," which the act defines as a city or village that meets certain requirements that depend on information from "the most recent" federal census or on unemployment rates for three of the five years immediately preceding an application for bed banking. The act also requires that such hospitals have annual patient volumes consisting of at least 25 percent indigent patients. But, the Michigan Employment Security Commission does not have information on unemployment rates for villages, information from the 1990 federal census is not yet available, and, at the time the law was being drafted, unemployment statistics for the five years (1985-1989) immediately preceding the law's enactment were not available. In addition, the Department of Social Services does not collect information on the percentage of indigent patients relative to a health facility's patient volume, though it does collect information on indigent patient charges relative to a facility's total charges. Changes in the act's data requirements are necessary if the act is to be implemented immediately, as the legislature charged.