SFA
BILL ANALYSIS

Senate Fiscal Agency • Lansing, Michigan 48909 • (517) 373-5383

Senate Bill 889 (as enrolled) — PUBLIC ACT 252 of 1990
Senate Bill 890 (as enrolled) — PUBLIC ACT 259 of 1990
Senate Bill 891 (as enrolled) — PUBLIC ACT 260 of 1990
Senate Bill 892 (as enrolled) — PUBLIC ACT 261 of 1990
Sponsor: Senator John J. H. Schwarz, M.D. (S.B. 889 & 892)
Senator Connie Binsfeld (S.B. 890)
Senator James A. Barcia (S.B. 891)
Senate Committee: Health Policy
House Committee: Public Health

Date Completed: 1-31-91

RATIONALE

A decline in operating margins, underutilization of services, increases in uncompensated care, higher malpractice insurance premiums, and a plummet in profits are a few of the ills facing hospitals across the State. While the impact of these circumstances has been felt by hospitals of all sizes, they more acutely affect the State's small and rural hospitals. The prognosis is: Michigan's community and rural hospitals are in critical condition. In a fight for their very existence, many of these health facilities are seeking ways to surmount financial problems that have been brought on by changes in the health care industry. Operational and financial factors more severely affect community and rural hospitals, which are more vulnerable than their larger, urban counterparts because of their lack of size, location, and relative inflexibility due to regulatory constraints. Despite cost-cutting efforts, such as reductions in services and staffs, the outlook for these hospitals is not encouraging. Some people fear that unless steps are taken to ease the financial pressures on community and rural hospitals, Michigan will continue to lose the health care services that these facilities offer.

CONTENT

Senate Bill 889 would amend the Public Health Code to:

- **Require the DPH, consulting with an ad hoc advisory committee, to promulgate rules for the designation of a rural community hospital, the maximum number of beds, and services to be provided by such a hospital.**
- **Permit a hospital with fewer than 100 licensed beds located in a nonurbanized area to apply to the Department for designation as a rural community hospital, and specify the type of services such hospitals could provide.**
- **Establish requirements that a hospital would have to meet to be designated a rural primary care hospital.**
- **Establish requirements that a hospital would have to meet to be designated an essential access community hospital to qualify for the Essential Access Community Hospital Program under the Federal Social Security Act.**
- **Permit the DPH, upon request of a hospital with fewer than 100 beds located in a nonurbanized area, to waive a specified licensure requirement, and set an application fee for that waiver.**
- **Require a rural community hospital to enter into an agreement with the Department of Social Services (DSS) to participate in the Medicaid program and to meet conditions for**

participating in the Medicare program under the Social Security Act.

- -- Permit a hospital that contracted with a community mental health board to establish a mental health crisis stabilization program.
- -- Require the Center for Rural Health to develop a plan creating rural health networks.
- -- Require a hospital to pay a license fee surcharge of $23 per bed, if it requested the DPH to conduct a certification survey for purposes of the Social Security Act's provisions on swing beds or grants to states for medical assistance programs.

Senate Bill 890 would amend the Public Health Code to:

- -- Permit a hospital in a nonurbanized area to apply to the DPH for temporary delicensure of half of its licensed beds for up to five years, and provide for an extension of the delicensure.
- -- Permit a hospital located in a distressed area with an annual patient volume of at least 25% indigent patients to apply for delicensure of half of its licensed beds for up to two years.
- -- Require a hospital applying for delicensure of beds to submit a plan indicating, to the DPH's satisfaction, an alternative use of space that had been occupied by the beds.
- -- Require the DPH to continue to count temporarily delicensed beds in its bed inventory to determine hospital bed need under certificate of need (CON) provisions in the subarea in which the beds were located, but prohibit a hospital from including those beds in the hospital's bed count.
- -- Prohibit a hospital, granted a temporary delicensure of beds, from transferring delicensed beds to another site or hospital without first obtaining a CON.
- -- Prohibit a hospital subject to a hospital bed reduction plan or a DPH action from using temporarily delicensed beds to comply with the bed reduction plan.
- -- Require the DPH to relicense beds if certain requirements were met and to delicense the beds permanently if the requirements were not met or if a hospital decided to allow the beds to be delicensed permanently.
- -- Require the DPH, along with the State Hospital Finance Authority, the Office of Health and Medical Affairs, and other State agencies, to make recommendations concerning the feasibility of a State Hospital Transition Assistance Program to aid hospitals wanting to close, convert, or consolidate their facilities, and require the Authority to contract for a feasibility study.
- -- Require an advisory committee to comment on the study and report to the Governor and Legislature on pursuing options outlined in the study.
- -- Permit the Authority to spend $250,000 to finance the study and staff the committee.

Senate Bill 891 would amend the Public Health Code to provide that a certificate of need would not be required for a reduction in licensed bed capacity or services at a licensed site; require the Office of Rural Health Care to designate a CON ombudsman to assist rural hospitals and communities with CON proposals and applications; require the ombudsman to advocate for rural health concerns in the development of CON review standards; revise the definition of "short-term nursing care"; and, revise current CON provisions on short-term nursing care, including increasing from 20 days to 100 days the length of time allowed for each post-hospital extended care admission.

Senate Bill 892 would amend the Social Welfare Act to permit an eligible person to receive nursing home services, to the extent found necessary by the attending physician when the combined length of stay in the acute care bed and short-term nursing care bed exceeded the average length of stay for Medicaid hospital diagnostic related group reimbursement,

under a short-term nursing care program established under the Public Health Code.

A more detailed description of the bills follows.

Senate Bill 889

Ad Hoc Committee on Rural Community Hospitals

Not later than three months after the bill's effective date, the Director of the DPH would be required to appoint an ad hoc advisory committee to develop recommendations for rules to designate the maximum number of beds and services to be provided by a rural community hospital. In developing recommendations, the committee would be required to review Public Health Code provisions pertaining to hospital licensure to determine which provisions should apply to rural community hospitals. The Director would be required to direct the committee to report its recommendations to the Department within 12 months after the committee was appointed.

Representatives from each of the following groups would make up 25% of the ad hoc committee: hospitals with fewer than 100 licensed beds; health care provider organizations others than hospitals; organizations whose membership included consumers of rural health care services or members of local governments located in rural areas; and, purchasers or payers of rural health care services.

Rural Community Hospital

The DPH, in consultation with the ad hoc advisory committee, would be required to promulgate rules for designation of a rural community hospital, maximum number of beds, and the services provided by such hospitals. Under the rules, a hospital designated as a rural community hospital could not provide more than the following services: emergency care, stabilization care for transfer to another facility, inpatient care, radiology and laboratory services, ambulatory care, obstetrical services, outpatient services, and other services determined appropriate by the ad hoc advisory committee. The rules also could specify the following: maximum bed size, the level of services to be provided, and requirements for transfer with other hospitals to assure efficient and appropriate patient care.

The Director would be required to submit proposed rules, based on the committee's recommendations, for public hearing not more than six months after receiving the committee's report on recommendations for rules designating the number of beds and services to be provided by a rural community hospital.

Application

After the rules' effective date, a hospital with fewer than 100 licensed beds located in a nonurbanized area that either was licensed on or before the bill's effective date, or was licensed after the bill's effective date and was located in a county that did not have a hospital on that effective date, could apply to the Department for designation as a rural community hospital. The term "rural community hospital" could not describe or refer to a health facility or agency unless that facility or agency were designated by the Department as a rural community hospital.

A hospital designated as a rural community hospital would be a limited service hospital directed toward the delivery of basic acute care services only in order to assure appropriate access in the rural area. A rural community hospital also would be required to develop and implement a transfer agreement between the rural community hospital and one or more appropriate referral hospitals.

The designation as a rural community hospital would have to be shown on a hospital's license and would have to be for the same term as the hospital license. Except as otherwise provided in the bill or rules promulgated under it, a rural community hospital would have to be licensed and regulated in the same manner as a hospital otherwise licensed under the Code's Article 17 (which regulates facilities and agencies). Provisions of Part 222 (certificate of need) applicable to hospitals would apply to a rural community hospital and to a hospital designated by the Department under Federal law as an essential access community hospital. These provisions and rules promulgated under them would not preclude the establishment of differential reimbursement for rural community hospitals, essential access community hospitals, and rural primary care hospitals.

Rural Primary Care Hospital

To be eligible for designation as a rural primary care hospital, a hospital would have to meet the following requirements:

- -- Be located outside of a metropolitan statistical area, as defined by the U.S. Office of Management and Budget.
- -- Make available 24-hour emergency services.
- -- Provide up to six inpatient beds for inpatient care for up to 72 hours to patients requiring stabilization before discharge or transfer to a hospital.
- -- Have a transfer agreement with at least an essential access community hospital.
- -- Meet other requirements established by the DPH and approved by the U.S. Secretary of Health and Human Services.
- -- Be a nonprofit or public hospital.

The Department would have to indicate preferential designation for an eligible hospital that was located over 30 minutes travel time away from the next closest hospital. The Department could modify these requirements to conform with changes in Federal requirements, or possible waivers, as provided in Federal law or regulation for the designation of a rural primary care hospital. The Department would be required to designate an eligible hospital as a rural primary care hospital in order to qualify the facility for the Essential Access Community Hospital Program under the Social Security Act.

Essential Access Hospital Program

The Department would be required to designate an eligible hospital as an essential access community hospital in order to qualify the facility for the Essential Access Community Hospital Program.

To be eligible for designation as an essential access community hospital, a hospital would have to meet the following requirements:

- -- Be located outside of a metropolitan statistical area, as defined by the U.S. Office of Management and Budget.
- -- Be located over 35 miles from an essential access community hospital, or a facility classified by the Secretary of Health and Human Services as a rural referral center or a regional referral center under the Social Security Act.
- -- Have at least 75 inpatient beds or be located more than 35 miles from any other hospital.
- -- Have a transfer agreement with at least a facility designated as a rural primary care hospital under the Social Security Act.
- -- Meet other requirements established by the Department with the approval of the Secretary of Health and Human Services.
- -- Be a nonprofit or public hospital.

The Department could modify these requirements to conform with changes in the Federal requirements, or possible waivers, as provided in Federal law or regulation for the designation of an essential access community hospital.

Waiver

Upon request of a hospital with under 100 beds located in a nonurbanized area, the DPH could waive the applicability of a specified licensure requirement if the Department determined that strict compliance with this requirement was not necessary to protect the public health, safety, and welfare in light of the health care provided by or in the hospital. The Department could impose conditions upon a waiver to protect the public health, safety, and welfare.

A waiver granted by the Department could not be for more than two years, except that the Department could renew the waiver for subsequent periods if the hospital continued to meet the bill's requirements.

The application fee for a waiver would be $200 plus $40 per hour for the professional services and travel expenses directly related to processing the application. The travel expenses would have to be calculated in accordance with the State standardized travel regulation of the Department of Management and Budget in effect at the time of the travel.

Mental Health Crisis Program

A hospital that had contracted with a community mental health board could establish a mental health crisis stabilization program for voluntary admission with a maximum length of

stay of 72 hours.

Rural Health Network

The Center for Rural Health, as part of the development of the biennial rural health plan, would be required to develop a plan creating a set of rural health networks. Each rural health network would have to consist, at a minimum, of one essential access community hospital, rural referral center, or regional referral center and one rural primary care hospital. Other rural health care providers including, but not limited to, primary care centers, community health centers, licensed nursing homes, and local public health departments also could be included in a rural health network to develop a continuum of patient care.

MCL 333. 20161 et al.

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Delicensure

A hospital located in a "nonurbanized area" could apply to the Department to delicense temporarily up to 50% of its licensed beds for up to five years. ("Nonurbanized area" would mean an area that was not an urbanized area. "Urbanized area" would mean that term as defined by the U.S. Bureau of the Census in the notice: "Urbanized Areas for the 1990 Census - Proposed Criteria".)

Except as otherwise provided in the bill, for 90 days after the bill's effective date, if a hospital were located in a "distressed area" and had an annual patient volume of at least 25% "indigent" patients, the hospital could apply to the Department to delicense temporarily up to 50% of its licensed beds for up to two years. Upon receiving a completed application, the Department would be required to delicense temporarily the beds indicated in the application. The Department would be prohibited from granting an extension of temporary delicensure under this provision. ("Distressed area" would mean a city or village that met the following criteria: had had a negative population change from 1970 to the date of the most recent Federal decennial census; since 1972, had had an increase in its State equalized valuation that was less than the Statewide average; had a poverty level above the Statewide average, according to the most recent Federal decennial census; had been eligible for an urban development assistance grant from the U.S. Department of Housing and Urban Development; and, had an unemployment rate that was higher than the Statewide average for three of the five years immediately preceding the date of an application for delicensure of beds. "Indigent patient" would mean an individual who was unable to pay for health care services or a medically indigent person as defined in the Social Welfare Act.)

An application under these provisions would have to be on a form provided by the Department, and would have to contain the following information: the number and location of the specific beds to be delicensed, the period of time during which the beds would be delicensed, and the alternative use proposed for the space occupied by the beds to be delicensed. A hospital could file an amended application with the Department, and would have to state the purpose of the amendment. If the hospital met the bill's requirements, the Department would have to amend the hospital's original application.

The DPH would be required to continue to count beds temporarily delicensed in the Department's bed inventory to determine hospital bed need under the Code's certificate of need provisions in the subarea in which the beds were located. The Department would have to indicate in the bed inventory which beds were licensed and which were temporarily delicensed. The DPH could not include a hospital's temporarily delicensed beds in the hospital's bed count.

A hospital that was granted a temporary delicensure of beds could not transfer the beds to another site or hospital without first obtaining a CON. A hospital that had beds subject to a hospital bed reduction plan or to a DPH action to enforce Article 17 of the Code could not use beds temporarily delicensed, under the bill, to comply with the bed reduction plan.

Alternative Use of Space

The bill specifies that an alternative use of space made available by the delicensure of beds could not result in a violation of Article 17 or the rules promulgated under it. Along with the application, an applicant for delicensure would

have to submit to the DPH plans indicating to the Department's satisfaction that the space occupied by the beds proposed for temporary delicensure would be used for one or more of the following:

-- An alternative use that over the proposed period of temporary delicensure would defray the depreciation and interest costs that otherwise would be allocated to the space along with the operating expenses related to the alternative use.
-- Correction of a licensing deficiency previously identified by the Department.
-- Nonhospital purposes including, but not limited to, community service projects, if the depreciation and interest costs for all capital expenditures that otherwise would be allocated to the space, as well as any operating costs related to the proposed alternative use, would not be considered as hospital costs for reimbursement.

Delicensure Extension

A hospital that was granted a delicensure of beds, under provisions pertaining to a hospital located in a nonurbanized area, could apply to the Department for an extension of temporary delicensure for those beds for up to an additional five years to the extent that the hospital met the bill's requirements on alternative use of space during the initial period of delicensure. The DPH would be required to grant an extension unless it determined under the Code's CON provisions that there was demonstrated need for the delicensed beds in the subarea in which the hospital was located. If the Department did not grant an extension, the hospital could request relicensure of the beds or allow the beds to become permanently delicensed.

Relicensure

The Department would be required to relicense beds that were temporarily delicensed if the following requirements were met:

-- The hospital filed with the DPH a written request for relicensure at least 90 days before the earliest of the following: the expiration of the period for which delicensure was granted, the date upon which the hospital was requesting relicensure, or the last hospital license renewal date in the delicensure period.
-- The space to be occupied by the relicensed beds was in compliance with Article 17 and the rules promulgated under it, including all licensure standards in effect at the time of relicensure, or the hospital had a plan of corrections that had been approved by the Department.

If a hospital did not meet both of the requirements, or if a hospital decided to allow beds to become permanently delicensed, then all of the temporarily delicensed beds would be automatically and permanently delicensed effective on the last day of the period for which the Department granted temporary delicensure.

Hospital Transition Assistance Program

In cooperation with the State Hospital Finance Authority, the Office of Health and Medical Affairs, and other State agencies the Department considered appropriate, the DPH would be required to develop recommendations regarding the appropriateness and feasibility of a State Hospital Transition Assistance Program to provide voluntary assistance to hospitals wanting to close, convert, or consolidate their facilities with another hospital, to eliminate excess capacity while maintaining common access to critical health care services and assist displaced employees. The program would have to include at least the following elements:

-- Assistance in retiring all or some appropriate portion of the principal and interest applicable to the outstanding debt of a hospital applying to participate in the program.
-- Assistance, through relocation or retraining, to workers displaced as a result of a hospital closure, conversion, or consolidation under the program.
-- Maintenance of community access to critical health care services, especially for the uninsured and underinsured, that could be endangered because of assistance provided under the program.
-- Assistance with license termination, cessation of operations, and disposition of assets to help defray the outstanding indebtedness of a hospital applying to participate in the program, as appropriate to hospitals wanting to close, convert, or consolidate.

After consultation with experts knowledgeable about the approaches listed in the bill, the State Hospital Finance Authority would be required to contract for a feasibility study of the Program elements. The feasibility study would have to include the following information:

-- The outstanding hospital bonded indebtedness and associated interest for all the hospitals in the State and the amounts payable in principal and interest per year until the bonds were retired.
-- The financial benefits and costs to the State, health care purchasers, and other hospitals of assisting in defraying portions of the indebtedness and interest according to the different options.
-- Criteria for prioritizing assistance to hospitals applying to participate in the program.
-- Options for, and estimated benefits and costs of, providing relocation and retraining assistance to workers displaced by a hospital closure, conversion, or consolidation assisted by the program.
-- The possibility of including a requirement that the assistance would result in a net reduction of beds at least equal to the number licensed to the hospital applying to participate in the program, in cases of proposed conversions or consolidations.
-- Interest among hospitals and purchasers regarding participation in the program.

An advisory committee, appointed by the Director of the DPH, would have to comment on the feasibility study and report to the Governor and Legislature on the appropriateness of pursuing the options described in the study. The committee would be composed of 15 members equally divided among representatives of health consumers, health providers, and health care purchasers. The Authority could spend up to $250,000 from its operating fund to finance the feasibility study and to staff the advisory committee.

The study would have to be completed within nine months after the effective date of the contract for the study. The advisory committee would have to submit its report to the Governor and Legislature within four months after the committee received the study.

Proposed MCL 333.21551 and 333.21552

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Certificate of Need

Under the Code, a person cannot take certain actions, such as making a change in the bed capacity of a health facility, without first obtaining a CON. Under the bill, a CON would not be required for a reduction in licensed bed capacity or services at a licensed site.

CON Ombudsman

The bill would require the Office of Rural Health, created by Public Act 138 of 1990, to designate a CON ombudsman to provide technical assistance and consultation to rural hospitals and rural communities regarding CON proposals and applications. The ombudsman also would be required to act as an advocate for rural health concerns in the development of CON review standards under the Code's CON provisions.

Short-Term Nursing Care

"Short-term nursing care" currently is defined in the Code as nursing care provided in a hospital to a patient who has been discharged from an acute care bed and cannot be placed in a nursing home bed, or hospital long-term care unit located within a 50-mile radius of the patient's residence. The bill would revise the definition to delete reference to an acute care bed, refer to a patient who was discharged or was ready for transfer from a licensed hospital bed other than a hospital long-term care unit bed, and include a county medical care facility bed among the types of beds in which a patient could not be placed within a 50-mile radius of the patient's residence.

Under the Code, a hospital that applies to the DPH for a CON and meets certain criteria must be granted a CON for a short-term nursing care program with up to 10 licensed beds. Among the criteria is the requirement that a hospital be eligible for and in compliance with swing-bed provisions of the Federal Social Security Act, except for the CON requirement. Under the bill, a hospital would have to be eligible to apply for certification as a provider of swing-bed services under the Social Security Act. The bill would delete reference to the CON requirement.

Currently, a hospital that applies for a CON for a short-term nursing care program also must have under 100 licensed beds, not counting beds used for newborns, psychiatric patients, and inpatient substance abuse patients. The bill would revise this provision to require the hospital to have fewer than 100 licensed beds, not counting beds excluded under Section 1883 of Title XVIII of the Social Security Act. (This section of the Act allows a hospital to run a swing-bed program under Medicare.) The bill also would delete the reference to beds used for newborns, psychiatric patients, and inpatient substance abuse patients.

Under the Code, a hospital granted a CON for a short-term nursing care program must comply with certain provisions. The bill also would require that such hospitals achieve and maintain Medicare certification under Title XVIII of the Social Security Act.

Currently, hospitals granted a CON must not charge or attempt to recover the cost of a length of stay for a patient in the short-term nursing care program that exceeded 20 days for each hospital admission. The bill would prohibit a hospital from charging or recovering the cost of a patient's length of stay that exceeded the length of time allowed for post-hospital extended care under the Social Security Act, and would delete reference to 20 days. In addition, such hospitals currently cannot discharge a patient from an acute care bed and admit that patient to the short-term nursing care program unless the action is determined to be medically appropriate by the attending physician. The bill would delete reference to an acute care bed and refer to a licensed hospital bed other than a hospital long-term care unit bed, and would provide for the transfer and admission as well as discharge of a patient.

A hospital granted such a CON currently is required to transfer a patient in the short-term nursing care program to an appropriate nursing home bed or hospital long-term care unit located within a 50-mile radius of the patient's residence within five business days after the hospital has been notified that a nursing home bed has become available. The bill would require that the nursing home bed be "appropriately certified" and would permit a patient to be transferred to a county medical care facility bed.

The bill would delete provisions on CON applications and review criteria statements (MCL 333.22223).

MCL 333.22208 et al.

Senate Bill 892

The bill would amend the Social Welfare Act to permit an eligible person to receive nursing home services, to the extent found necessary by the attending physician when the combined length of stay in the acute care bed and short-term nursing care bed exceeded the average length of stay for Medicaid hospital diagnostic related group reimbursement, under a short-term nursing care program established under the Public Health Code.

(The Act currently permits an eligible person to receive nursing home services, to the extent found necessary by the attending physician, dentist, or certified Christian Science practitioner, in a State-licensed nursing home, a medical care facility, other facility or identifiable unit of that facility, certified by the appropriate authority as meeting established standards for a nursing home under the laws and rules of the State and the U.S. Department of Health and Human Services.)

MCL 400. 109

FISCAL IMPACT

Senate Bill 889

The bill would have an indeterminate impact on State revenues and expenditures. The increase in hospital certification surcharge fee revenues would be between $0 and $900,000 and would depend on the number of hospitals seeking State certification over private accreditation. The level of revenues from licensure waiver application fees would depend on the number of applications submitted to the Department. The Department estimates that the fee levels proposed in the bill would cover the costs of certification and administration activities.

The provisions of the bill related to rural community, rural primary care, and essential access community hospital designations would have an indeterminate impact on State Medicaid program expenditures. The magnitude and

direction of the impact would depend on the contents of promulgated rules defining a rural community hospital and its function; the number of hospitals seeking any of the special rural hospital certifications; the extent to which services provided through these specially designated hospitals were reimbursable under the State plan; the degree to which these facilities experienced a reduction in costs, and the lower costs translated into a reduction in the reimbursement rate to the facility; and the extent to which hospitals, that might otherwise have closed, would be able to continue to operate and receive reimbursement.

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The bill would result in an indeterminate reduction in State licensure fee revenues. The magnitude of the reduction would depend on the number of beds delicensed pursuant to the bill. The bill could result in a savings in the State Medicaid program to the extent that the delicensure of beds resulted in a reduction in hospital operating costs, and that the lower costs translated into a reduction in the Medicaid reimbursement rate to hospitals with delicensed beds.

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The bill would have an indeterminate impact on State Medicaid program expenditures, depending on the demand for post-hospital extended care services; the availability of nursing home beds; the degree to which swing-beds represented an expansion in nursing home bed capacity, as opposed to a substitute for nursing home beds; and the extent to which recipients of swing-bed services are, or became Medicaid-eligible. Given the following "worst case" assumptions, the potential Medicaid cost could be $3.6 million gross; $1.6 million GF/GP:

- -- All hospitals with fewer than 100 beds would successfully apply for a certificate of need for 10 swing-beds.
- -- The annual occupancy at each hospital would reach the maximum 1,825 days.
- -- Swing-bed utilization would represent additional nursing home capacity, as opposed to a substitute for nursing home care.
- -- 50% of the recipients of swing-bed services are Medicaid eligible.
- -- The Medicare coinsurance reimbursed by the State Medicaid program would be $52/day.

It should be noted that of the nearly 100 hospitals currently eligible for swing-bed services, approximately 20% have received certification to date, while approximately 50% have not applied. Also, to date, there have been 20 cases, or approximately 8.6% of the people served, that exceeded the 20-day length-of-stay reimbursed by Medicare before a nursing home bed became available.

The bill also would have an impact on Department of Public Health expenditures. If the cost of the Rural Health Certificate of Need Ombudsman were a Department of Public Health responsibility, the cost to the DPH would be between $75,000 and $80,000 annually.

Senate Bill 892

The bill would have an indeterminate impact on State Medicaid program expenditures. The magnitude of the impact would depend on the demand for post-hospital extended care services; the availability of nursing home beds; the degree to which swing-beds represented an expansion in nursing home bed capacity, as opposed to a substitute for nursing home beds; the number, occupancy rate, and average length of stay of swing-beds; and the number of Medicaid-only eligible clients who would receive swing-bed services.

Under the following "worst case" assumptions, the potential cost to the Medicaid program would be $4.5 million gross; $2.0 million GF/GP:

- -- All hospitals currently with fewer than 100 beds would receive swing-bed certification for 10 beds.
- -- The annual occupancy at each hospital would reach the current maximum 1,825 days.
- -- The recipients of swing-bed services would be 50% Medicaid-eligible only.
- -- The Medicaid reimbursement rate would be approximately $52 per day.
- -- Swing-bed utilization would represent additional nursing home capacity, as opposed to a substitute for nursing home care.

ARGUMENTS

Supporting Argument

A profile of the State's health care system shows that 41 counties have only one hospital and eight counties have no hospital at all. The role played by small hospitals, especially those located in rural areas, is crucial to the entire health care system in the State. Today, there are 106 small hospitals in the State compared to 131 in 1970, according to the Michigan Hospital Association. The health and vitality of these hospitals, however, is uncertain. Many rural hospitals are teetering on the edge of financial collapse and are looking to the State for help. The bills do not present a solution to all the problems confronting many community and rural hospitals, nor do the bills offer a bail-out by the State. Rather, the bills would offer these hospitals an opportunity to take interim measures as they attempt to meet the challenges of a changing health care industry.

Supporting Argument

The bills could help ease financial pressures facing many community and rural hospitals by giving them more flexibility in the services they could offer and potentially more revenues. Many hospitals, in general, and community and rural hospitals, in particular, have low occupancy rates. Consequently, many administrators of these hospitals would like to try alternative uses for unoccupied space in a hospital, without jeopardizing the hospital's license. Under Senate Bill 890, a hospital could apply for temporary delicensure of a certain number of beds. Known as "bed banking", this procedure would permit hospitals to convert unoccupied space for other uses, such as leasing the space to a local health department, providing a day care service for ill children, or offering other nonmedical services. As a result, a hospital could generate new revenues by providing a new service, without risking delicensure. Senate Bill 891 would allow small hospitals that participate in the "swing-bed" program to be reimbursed by Medicaid for short-term nursing bed stays beyond 20 days. (The "swing-bed" program permits a hospital acute-care bed to be used as a long-term care bed whenever a long-term care bed is not available in another facility.) Federal law currently allows patients to stay in such beds for up to 100 days, and the bill would make the State program of reimbursement consistent with the Federal Medicare program. Senate Bill 892 would amend the Social Welfare Act to permit an eligible person to receive nursing home services under a short-term nursing care program, thus mandating Medicaid participation in the program. In cases involving patients who needed skilled nursing care but couldn't be discharged to a nursing home because of a lack of nursing home beds within 50 miles of the hospital, these patients could remain at the hospital until a bed became available, as provided in the Code. This bill would benefit hospitals that serve the elderly in parts of the State where there is an insufficient number of nursing home beds. Patients could remain in the hospital until a nursing home bed became available, under conditions provided in the Code, and the hospitals would be compensated beyond the current 20-day limit. While not the sole solution to concerns about community and rural health care in the State, these bills would offer strategies that could help to revitalize the health delivery system to these areas in the State.

Opposing Argument

While there is general agreement that some regions in the State are facing an erosion of their health delivery system, views differ on what measures should be taken to address these concerns. Clearly, where a community or rural hospital is the sole provider of health services in an area, then efforts should be undertaken to keep that facility operating. There are cases, however, in which maintaining the continued operation of a hospital in its present form may not be appropriate. For example, there may be areas where small hospitals should be encouraged to affiliate with large metropolitan health facilities. Such affiliations could benefit rural areas by giving them a means to obtain physicians and support staff to practice in the rural hospitals, thus improving patient access to health services. Thus, efforts should focus on designing a health care delivery system that services the needs of rural residents in ways that are effective, efficient, and economical.

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