SFA BILL ANALYSIS

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

Senate Bill 889 (Substitute S-2 as passed by the Senate)
Senate Bill 890 (Substitute S-1 as passed by the Senate)
Senate Bill 891 (Substitute S-2 as passed by the Senate)
Senate Bill 892 (Substitute S-1 as passed by the Senate)
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)
Committee: Health Policy

Date Completed: 7-23-90

RATIONALE

A decline in operating margins, underutilitzation 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 (S-2) would amend the Public Health Code to:

- **Permit a hospital with fewer than 100 beds in a county with a population under 200,000 to apply to the Department of Public Health (DPH) for designation as a primary care hospital.**
- **Specify services that a hospital would have to provide in order to be designated a primary care hospital.**
- **Require primary care hospitals to enter into an agreement with the Department of Social Services (DSS) to participate in the Medicaid program.**
- **Require the DPH Director to appoint an ad hoc advisory committee to develop recommendations for rules for the services to be provided by a primary care hospital, and require the DPH to promulgate such rules.**
- **Permit the DPH, upon request of a hospital with fewer than 100 beds in a county with a population under 200,000, to waive a specified licensure requirement, and set an application fee for that waiver.**
- **Require a hospital to pay a license fee surcharge of $23 per bed, if it requested DPH certification in lieu of accreditation by a private body.**

Senate Bill 890 (S-1) would amend the Public Health Code to do the following:

- **Require the temporary delicensure for up to five years of certain beds in a hospital, upon application by the hospital to the Department of Public Health.**
- **Require a hospital to specify the alternative use for delicensed beds, if known.**
- **Provide for a extension of a temporary delicensure of beds.**
- **Require the DPH to relicense beds if certain requirements were met and to delicense the beds permanently if these requirements were not met or if a hospital decided to allow beds to become permanently delicensed.**
- **Prohibit a hospital from transferring delicensed beds to another site or hospital without first obtaining a certificate of need (CON).**
- **Specify that a transfer of delicensed beds would be considered a transfer of licensed hospital beds for purposes of the Code's CON provisions.**
- **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 continue to count temporarily delicensed beds in its bed inventory for purposes of determining hospital bed need in the subarea in which the beds were located, but provide that the DPH could not include the beds in a hospital's bed count.**

Senate Bill 891 (S-2) 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 (S-1) 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, under a short-term nursing care program established under the Public Health Code.

A more detailed description of the bills follows.

Senate Bill 889 (S-2)

Application

After the effective date of the rules required under the bill, a hospital with fewer than 100 licensed beds in a county with a population of less than 200,000 could apply to the DPH for designation as a "primary care hospital". The bill specifies that the term "primary care hospital" could not be used to describe or refer to a health facility or agency unless the health facility or agency were designated a primary care hospital by the Department.

Hospital Services

A hospital designated as a primary care hospital would have to provide at least all of the following services: emergency care, stabilization care for transfer to another facility, inpatient care, radiology and laboratory services, and ambulatory care. Primary care hospitals would have to enter into an agreement with the DSS to participate in the Medicaid program, as defined in the Code.

Not more 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 for the services to be provided by a primary care hospital. The Director would be required to direct the committee to report its recommendations to the Department within 12 months after the committee was appointed. The Director would be required to submit the

proposed rules to the Joint Committee on Administrative Rules not more than three months after receiving the report. The ad hoc committee would be required to include representatives from all of the following:

-- Hospitals with fewer than 100 licensed beds. These members would have to constitute a majority of the ad hoc advisory committee.
-- Health care provider organizations other than hospitals with fewer than 100 licensed beds.
-- Organizations whose membership included consumers of rural health care services, members of local governmental units located in rural areas, or purchasers or payers of rural health care services.

Designation as a Primary Care Hospital

The DPH, in consultation with the ad hoc advisory committee, would be required to promulgate rules for designation of a primary care hospital and the services provided by such hospitals.

The designation as a primary care hospital would have to be shown on a hospital's license and would be for the same term as the hospital license. Except as expressly provided in Part 215 of the Code (which governs the operation of hospitals) or in rules promulgated under the bill, a primary care 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). The bill specifies that the provisions of Part 222 (certificate of need) applicable to hospitals would apply to a primary care hospital.

Waiver

Upon request of a hospital with under 100 beds in a county with a population under 200,000, the DPH could waive the applicability of a specified licensure requirement if the Department determined that strict compliance with the licensure 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. An application for a waiver would have to be on a form provided by the DPH.

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.

MCL 333. 20161 et al.

Senate Bill 890 (S-1)

Delicensure

Except as otherwise provided in the bill, the DPH, upon receipt of an application from a hospital, would be required to delicense temporarily certain beds in the hospital for up to five years.

The application would have to be on a form provided by the Department, and would have to contain all of 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, if known. A hospital could file an amended application with the Department on a form provided by the Department. If the hospital met the bill's requirements, the Department also could amend the hospital's original application.

The DPH would be required to continue to count beds temporarily delicensed in the Department's bed inventory in order to determine hospital bed need in the subarea in which the beds were located. The hospital 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 transfer of delicensed beds would have to be considered a transfer of licensed hospital beds for purposes of Part 222 (certificate of need) of the Code. A hospital that had beds subject to a hospital bed reduction plan or to a DPH action to enforce Article 17 of the Code (concerning facilities and agencies) could not use beds temporarily delicensed, under the bill, to comply with the bed reduction plan.

Alternative Use of Beds

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 that Article. Alternative uses could include, but would not be limited to, senior respite care, senior day care, mental health services, and the leasing of space to health care providers.

Delicensure Extension

A hospital that was granted a delicensure of beds could apply to the Department for an extension of temporary delicensure for those beds for up to an additional five years. The Department would be required to grant an extension unless it determined 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 earlier of the following occurred: 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.

Proposed MCL 333.21551

Senate Bill 891 (S-2)

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 discharge 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 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.

MCL 333.22208 et al.

Senate Bill 892 (S-1)

Senate Bill 892 (S-1) 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, 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 (S-2)

The bill would have an indeterminate impact on State revenues and expenditures. The increase in hospital certification 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 primary care hospital designation 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 primary care hospital and its function; the number of hospitals seeking primary care hospital certification; the extent to which services provided through a primary care hospital were reimbursable under the State plan; the degree to which facilities designated primary care hospitals 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.

Senate Bill 890 (S-1)

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. However, if the delicensed beds were utilized for swing beds (pursuant to Senate Bill 891), which resulted in increased utilization of long-term services, then the State could incur a net increase in costs.

Senate Bill 891 (S-2)

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. (Hospitals that would reduce licensed bed capacity to fewer than 100 beds pursuant to the delicensure provisions of Senate Bill 890 (S-1) are not included.)
- -- 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 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 (S-1)

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 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. Senate Bill 889 (S-2) would permit a hospital with fewer than 100 beds in a county with a population under 200,000 to apply to the DPH for a designation as a primary care hospital. This bill would create a new classification of hospital and would require that an ad hoc advisory committee develop recommendations for rules for the services to be provided by such hospitals. These new rules could provide more flexibility than current standards. 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 (S-1), a hospital could apply for delicensure of certain 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 (S-2) 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 (S-1) 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 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.

Legislative Analyst: L. Arasim
Fiscal Analyst: P. Graham
J. Walker

A8990\S889A