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BILL ANALYSIS

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House Bill 5490 (Substitute H-2 as reported without amendment)
House Bill 5491 (Substitute S-3 as reported)
Sponsor: Representative Gerald Law
House Committee: Health Policy
Senate Committee: Health Policy and Senior Citizens

Date Completed: 5-7-96

RATIONALE

The Public Health Code provides for the licensure of a hospice, and defines a hospice as a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis. The medical components of hospice care must be under the direction of a physician, while the patient's physical, psychological, social, and spiritual needs are met through a coordinated interdisciplinary team that may include trained volunteers. The Code provides that if a hospital, nursing home, home for the aged, county medical care facility, or other health care facility or agency operates a hospice, it must be licensed as a hospice; further, if a licensed hospice provides inpatient services that meet the definition of a hospital, nursing home, home for the aged, county medical care facility, or other health care facility or agency, the hospice must obtain a separate license as one (or more) of those entities. It has been pointed out that the latter requirement may be causing a gap in the availability of hospice coverage.

Reportedly, there are currently 110 hospice programs in Michigan, and the vast majority of the care they provide is rendered in patient's homes. Apparently, however, there are increasing numbers of hospice-eligible patients, particularly aged persons with no caregiver in the home, AIDS patients, or homeless people, who simply cannot be cared for at home. While these persons need institutional care, there are few facilities with a hospice program; conversely, there are hospice programs that could care for such people but cannot because they would have to obtain the necessary facilities' licenses (a process for which many volunteer-oriented hospice programs are not equipped) and, further, would have to conform to the many rules and regulations the Code prescribes for health facilities. It has been suggested that the Code be amended to provide for the creation and licensure of "hospice residences", that is, hospices programs operated in a facility.

CONTENT

House Bill 5490 (H-2) would amend Article 17 of the Public Health Code, which governs health facilities and agencies, to exempt from the definition of "nursing home" a hospice residence licensed under Article 17, and a hospice certified under the applicable Federal regulation. House Bill 5491 (S-3) also would amend Article 17 to exempt a hospice residence from the definition of "health facility or agency"; provide for the licensure of a hospice residence; and establish a fee of $200 per license survey and $20 per licensed bed for hospice residences.

The bills are tie-barred to each other. A detailed description of House Bill 5491 (S-3) follows.

"Hospice residence" would mean a facility that provided 24-hour hospice care to two or more patients at a single location, and that provided either home care as described in Article 17, or inpatient care directly in compliance with Article 17 and with the standards set forth in the applicable Federal regulation (42 CFR 418.100). In addition, a hospice residence would have to be owned, operated, and governed by a hospice program that was licensed under Article 17 and provided aggregate days of patient care on a biennial basis to at least 51% of its hospice patients in their own homes. This reference to "home" would not

include a residence established by a patient in a licensed health facility or agency, or a residence established by a patient in an adult foster care facility licensed under the Adult Foster Care Facility Licensing Act.

The bill provides that a person could not represent itself as a hospice residence unless that person were licensed as a hospice residence by the Department of Commerce (which will become part of the Department of Consumer and Industry Services on May 15, 1996, pursuant to Executive Order 1996-2). Currently, a hospice must be licensed unless it provides services to not more than seven patients per month on a yearly average, does not charge or receive fees for goods or services provided, and does not receive third party reimbursement for goods or services provided. If a hospice provides inpatient services that meet the definition of hospital, nursing home, home for the aged, or county medical care facility, the hospice must obtain a separate license for that hospital, home, or facility. A hospital, nursing home, home for the aged, or county medical care facility that operates a hospice must be licensed as a hospice. Under the bill, a hospice also would have to obtain a separate license if it provided services that met the definition of hospice residence, and a hospital, nursing home, home for the aged, or county medical care facility would have to be licensed as a hospice residence if it operated a hospice residence.

The Code provides that the owner, operator, and governing body of a licensed hospice are responsible for all phases of the operation of the hospice and for the quality of care and services rendered, and must cooperate with the Department in the enforcement of the law. The bill would extend these provisions to the owner, operator, and governing body of a licensed hospice residence. In addition, the owner, operator, and governing body of a licensed hospice or hospice residence could not discriminate because of race, religion, color, national origin, or sex, in the operation of the hospice or hospice residence, including employment, patient admission and care, and room assignment.

As a condition of licensure as a hospice residence, an applicant would have to have been licensed under Article 17 as a hospice and in compliance with Federal standards for at least two years immediately preceding the date of application. A licensed hospice residence could provide both home care and inpatient care at the same location. A hospice residence providing inpatient care would have to comply with Federal standards.

The owner, operator, and governing body of a licensed hospice residence that provided care only at the home care level would have to do all of the following:

-- Provide 24-hour nursing services for each patient in accordance with his or her hospice care plan as required under the Federal regulation.
-- Have an approved plan for infection control that included provisions for isolating each patient with an infectious disease.
-- Obtain fire safety approval pursuant to the Code.
-- Equip each patient room with a Department-approved device for calling the staff member on duty.
-- Design and equip areas within the hospice residence for the comfort and privacy of each patient and his or her family members.
-- Permit patients to receive visitors, including young children, at any hour.
-- Provide individualized meal service plans in accordance with the Federal regulation.
-- Provide appropriate methods and procedures for the storage, dispensing, and administering of drugs and biologicals pursuant to the Federal regulation.

Under the Code, a hospice must provide a program of planned and continuous hospice care whose medical components are under the direction of a physician; and an individual may not be admitted to or retained for care by a hospice unless he or she is suffering from a disease or condition with a terminal prognosis. The bill would extend these provisions to a hospice residence. In addition, hospice care currently must consist of a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis. The bill would refer, instead, to a set of coordinated services rendered at home or in hospice residence or other institutional settings on a continuous basis.

The Department would have to make at least a biennial visit to each hospice residence for the purposes of survey, evaluation, and consultation. A hospice residence would be subject to a fee of $200 per license survey and $20 per licensed bed. Investigations or inspections, other than inspections of financial records, would have to be conducted without prior notice to a hospice

residence. The Department could not delegate survey, evaluation, or consultation functions to a local health department that owned or operated a licensed hospice or hospice residence.

The bill would remove a health facility or agency in a correctional institution from the definition of "health facility or agency"; and specify that the definition of "hospital" in Article 17 would not include a hospital operated by the Department of Corrections. (This means that those facilities in a correctional institution would not be regulated by the Department of Consumer and Industry Services.)

MCL 333.20109 (H.B. 5490)
333.20106 et al. (H.B. 5491)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

A hospice program is a managed system of care provided to persons with a terminal illness, and their families. Hospice patients usually have a life expectancy of six months or less. Unlike hospitals and nursing homes that offer acute, curative medical services, hospices provide palliative services--which have an emphasis on relieving the symptoms or effects of a disease, such as alleviating pain. Hospice care typically is rendered in a person's home with his or her family members as the primary caregivers, and focuses on encouraging patients to live fully and with dignity in the final weeks and months of life. Most hospice programs have contracts or arrangements with area hospitals and nursing homes for patients needing acute care or skilled nursing services. Hospice programs provide a wide array of support services through a multidisciplinary team consisting of physicians, nurses, social workers, chaplains, home health aides, and trained volunteers. Together, the hospice team, patient, and family develop a care plan tailored to the ill person's needs and wishes. Typical services include home visits by licensed nurses; physician services for medical management; medications; medical supplies; physical, occupational, and speech therapy; home health aide and homemaker services; short-term inpatient care, including respite care; counseling, pastoral care services, and emotional support; and bereavement services. Because the emphasis is on symptom management and not on curing the patient, hospice costs usually are significantly lower than those of an equivalent hospital or nursing home stay.

Many people, however, do not have access to in-home hospice care. These individuals might include, for example, an elderly person whose spouse is physically unable to provide the needed in-home care; someone who has no family nearby or whose family members must work and so cannot provide 24-hour supervision; an individual with AIDS whose family is unable or unwilling to care for him or her; a homeless person; and a child who, due to his or her age, needs a setting different than a nursing home. When a 24-hour caregiver is not available, an individual needing supervision who cannot afford a personal nurse or companion usually ends up in a high-cost and less personal inpatient facility such as a hospital or nursing home.

The establishment of hospice residences, where hospice programs could provide services to multiple patients in a single location, is a viable solution to the dilemma faced by those who desire hospice care in a home-like setting but are unable to retain the necessary caregivers. Providing a separate license for hospice residences would ensure the continuation of the same high quality of care already being provided patients in their homes by hospice programs. A hospice residence would save money for individuals, insurance companies, and public assistance programs alike.

Supporting Argument

Under present law, hospices may not provide inpatient services unless they are also licensed as a hospital, nursing home, home for the aged, or other health facility or have been awarded nursing home beds from a special pool created in 1993 under the certificate of need (CON) program. Unfortunately, once a hospice receives such licensure or CON beds, it is required to conform to all of the rules and regulations associated with the particular facility's licensure requirements, and, for those awarded beds under the CON program, the regulations governing nursing home beds. Many of the rules and regulations of such facilities are contradictory to the hospice approach of palliative care. For example, hospitals and nursing homes are required to conduct various tests and use certain procedures, such as forced feedings and ventilators, that hospice programs would find unnecessary for the dying patient and against their philosophy of neither prolonging nor shortening life. Unlike nursing homes where patients usually are residents for years, hospice patients are in the

final stages of a terminal illness, usually with a life expectancy of less than six months; therefore, the rules and regulations that nursing homes must obey do not always apply to the type of care provided in hospice. Further, nursing homes have stringent staff/patient ratios and requirements for medical and diagnostic equipment that are not applicable to hospice care. Certain required diagnostic tests and the use of certain types of antibiotic medications in nursing homes are not appropriate for the dying patient. This is not to say that hospice residences would be unregulated under the bills, however; compliance with stringent Federal criteria would be required for licensure.

Legislative Analyst: G. Towne

FISCAL IMPACT

The bills would have an indeterminate fiscal impact. Hospice services are intended to provide supportive (as opposed to curative) services to the terminally ill. In this State these services are provided in-home; when the individuals can no longer be maintained in their home, they are placed in a hospital or nursing home. These bills would allow the establishment of hospice "residences", which are assumed to be less costly than hospital or nursing home per diems, again because of the supportive nature of hospice care. To the extent that this assumption is true, total health care costs for treating the terminally ill should decrease. It should be noted that any additional cost or savings would 1) be marginal due to the cost/savings being the incremental difference between hospice residence and hospital/nursing home per diems, and 2) be limited due to the fact that hospice services are restricted to the terminally ill with less than six months to live. In other words, these "residences" cannot generate their own demand beyond this restricted clientele group.

Given these limitations on the demand for hospice services, the number of hospice residences that would be established would be small. As a result, the costs associated with licensing the hospice residences also would be small and could be absorbed within existing State health facility licensure program resources.

Fiscal Analyst: J. Walker
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