House
Legislative
Analysis
Section

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HEALTH FIELD LICENSE/HOSPITAL QUALITY ASSURANCE FEES

House Bill 5103 as enrolled (vetoed)
Second Analysis (8-7-02)

Sponsor: Rep. Raymond Basham
Committee: Health Policy

THE APPARENT PROBLEM:

The state health code regulates health care professions through a system of licensure and registration. Under the code, "license" is defined as an authorization to *practice* where practice would otherwise be unlawful, whereas "registration" means the authorization to *use a designated title* where its use would otherwise be prohibited. A licensed health professional who has acquired a level of skill and knowledge beyond the minimum needed for licensure may apply for specialty certification in a "health profession specialty field," i.e., an area within the scope of practice of a licensed health profession that requires advanced education and training beyond that required for initial licensure. Although only licensed health professionals may obtain such specialty certification, the specialty certification itself is a form of registration. Thus, the lack of specialty certification in a health profession specialty field does not restrict a professional's scope of practice but does restrict his or her use of designated titles.

Dentists may currently apply for specialty certification in any one or more of the following specialty fields: prosthodontics, endodontics, oral and maxillofacial surgery, orthodontics, pediatric dentistry, periodontics, and oral pathology. To obtain specialty certification, a dentist must meet the additional education and training requirements mentioned above and demonstrate to the Board of Dentistry his or her competency through an examination or other credentialing process. Since specialty certification is a form of registration, both generalists and specialists may perform dental services in the seven specialty fields, but only a dentist who has received specialty certification may use a title indicating that he or she is a specialist in the areas in which he or she has received such certification. Some specialists believe that the term "speciality certification" makes it difficult for the public to distinguish between a true specialist and a generalist who has perhaps received some additional schooling and training in a specialty field, e.g., a weekend conference, but has not been gone through the examination or credentialing process required by the Board of Dentistry.

In a separate matter, a June 2002 Citizens Research Council "Memorandum" entitled "Michigan Hospital Finances" states that "fewer hospitals [in the state] realized surpluses in 2000 than in 1998" and that "the total amount of surpluses for all hospitals dropped while revenues increased" during the same period. What is more, the report indicates that hospitals are generally losing money on patient care and find themselves increasingly dependent on revenue from other sources, such as investments, cafeteria and gift shop sales, and fund raising. While acknowledging and reaffirming their commitment to their charitable mission, the state's hospitals argue that it is difficult to turn a surplus when taking care of uninsured and underinsured patients. Because many of these patients cannot afford to pay for the portion of their care that is not covered, hospitals are all the more dependent on receiving adequate reimbursement from insurers for those services that they do cover. Like nursing homes and health maintenance organizations (HMOs), hospitals have suggested that the state's Medicaid current reimbursement rates are too low. According to a representative of the Michigan Health and Hospital Association, Medicaid pays only about 75 percent of the costs of services provided to Medicaid participants. Still, a March 2000 issue paper by the Senate Fiscal Agency (SFA) entitled "Medicaid and Michigan Hospitals: A Look Behind the Numbers" disputes the claim that low Medicaid reimbursement rates contribute significantly to hospitals' financial difficulties. In the report the SFA suggests that the keys to explaining hospitals' financial troubles are hospitals' low occupancy rates and the Federal Balanced Budget Act of 1997's effect on *Medicare* reimbursement rates.

So then, are Medicaid reimbursement rates *significantly* responsible for hospitals financial troubles or not? In the end, the answer to the question probably depends on what counts as "significant", but rather than forging through that semantic quagmire, various parties might agree that if current Medicaid reimbursement rates do not cover the cost of the services provided, then the rates should be raised. Whether or not this would "significantly"

ameliorate hospitals' financial woes, everyone would at least be clear that the Medicaid program was not contributing to their problems. In May the state enacted legislation creating Medicaid "quality assurance assessment" fees for nursing homes and HMOs. Under the plan, the state collects fees from providers, combines the revenue with the state's current allocation to leverage additional matching funds from the federal government, and then sends the money back to the nursing homes and HMOs in the form of increased Medicaid reimbursement rates. Supporters of that legislation argue that it creates a win-win situation for both Medicaid providers, who receive higher Medicaid payments for covered services, and the state, which is able to raise its Medicaid reimbursement rates without actually having to increase its contribution of general fund revenues. Some people believe that creating a Medicaid quality assurance assessment fee for hospitals similar to the fee for nursing homes and HMOs would help alleviate hospitals' financial problems without having to reach consensus on the extent to which those troubles are the result of current Medicaid reimbursement rates.

Legislation has been introduced to replace dental specialty certification with dental specialty field licensure to provide dental specialists with some additional title protection. The legislation would also create a Medicaid quality assurance assessment fee for hospitals similar in concept to the fee for nursing homes and HMOs.

THE CONTENT OF THE BILL:

House Bill 5103 would amend the Public Health Code (MCL 333.16105 et al.) to phase out dental "specialty certification" and create a new credential for qualified dentists—the "health profession specialty field license". A "health profession specialty field license" (or "field license") would be defined as an authorization *to use a title* issued to a licensed dentist who had met certain qualifications established by the Michigan Board of Dentistry for *registration* in one or more of the seven (currently acknowledged) health profession specialty fields. Any individual who held a dental specialty certification on the bill's effective date would be considered to hold a field license in that specialty and could renew the field license on the specialty certification's expiration date. Just as specialty certification authorizes the use of a title and so is considered a form of registration under current law, a field license would really be a form of registration. The bill would also specify that a licensed dentist who had not been issued a field license in any of the dental specialty fields was not prohibited from performing services in those fields.

The bill would explicitly authorize the Board of Dentistry to issue a field license to a licensed dentist who had satisfied certain requirements that exceed those required for initial licensure and that currently apply to dentists seeking dental health profession specialty certification. The bill would change various other requirements in the code so that the same requirements held whether an individual held (or was applying for) specialty certification or a field license. Among other things, an individual who held a health profession specialty field license from another state could apply for a field license in this state, according to the reciprocal licensure and registration procedures set forth in the health code. The bill would amend the code to apply the current fee structure and requirements for holders of (and applicants for) a health profession specialty certification to holders of (and applicants for) a health profession specialty field license.

In a separate matter, House Bill 5103 would amend the code to charge each hospital a quality assurance assessment fee to maintain increased Medicaid reimbursement rates. The fee would be assessed at a rate that generated funds that could not exceed the maximum allowable funds under federal matching requirements, except that:

- in fiscal year 2002-2003, $18.9 million of the quality assurance assessment fee would be deposited into the general fund; and

- a portion of the funds collected from the fee could be used to offset any reduction to existing intergovernmental transfer programs with public hospitals that could result from implementation of the enhanced Medicaid payments financed by the fee. This portion of the funds would have to be used to finance hospital Medicaid appropriations.

The quality assurance assessment fee would be assessed on all net patient revenue, before deduction of expenses, less Medicare net revenue, and it would be payable on a quarterly basis, with the first payment due 90 days after the date the fee was assessed. (The fee would be calculated on the basis of the most recently available Medicare cost report, and "Medicare net revenue" would include Medicare payments and amounts collected for coinsurance and deductibles.) The fee would not be assessed or collected after September 30, 2004 (the end of the 2003-2004 fiscal year). Nor would it be assessed or collected if the fee was ineligible for federal

matching funds. Any portion of an assessment collected from a hospital that was ineligible for federal matching funds would be returned to the hospital.

Upon implementation of the fee, which would occur on the act's effective date, the Department of Community Health (DCH) would increase the hospital Medicaid reimbursement rates for the balance of that year. For each subsequent year in which the fee was assessed and collected, the DCH would maintain the hospital Medicaid reimbursement rate financed by the fees. The DCH would be directed to implement these provisions in a manner that complied with federal requirements necessary to assure that the fee qualified for federal matching funds.

If a hospital failed to pay the assessment, the DCH could assess the hospital a penalty of five percent of the assessment for each month that the assessment and penalty were not paid up to a maximum of 50 percent of the assessment. The bill would establish a "Hospital Quality Assurance Assessment Fund" within the state treasury, and DCH would deposit the revenue raised through the fee into the fund. In each fiscal year, the fee would only be collected and expended if Medicaid hospital inpatient DRG and outpatient reimbursement rates and disproportionate share hospital and graduate medical education payments were not below the level of rates and payments on April 1, 2002 as a direct result of the fee.

The bill would also appropriate approximately $779.3 million for hospital services and therapy to the Department of Community Health for the 2002-2003 fiscal year. Approximately $431.8 million would come from federal revenues, $66.5 million would come from the Medicaid Quality Assurance Assessment, and $281 million would come from the state's general fund.

FISCAL IMPLICATIONS:

Fiscal information is not available.

ARGUMENTS:

For:

Since a specialty field license, like specialty certification, would be a form of registration, the bill proposes nothing more than a name change. The bill would not affect dentists' scope of practice. At the same time, the bill proposes nothing less than a name change, and as the distinction between licensure and registration makes clear, the use of a title is very important for a dentist who has received professional recognition for a particular expertise that he or she has acquired. The health code currently prohibits a dentist from advertising himself or herself as "limiting his or her practice to, being specially qualified in, or as giving particular attention to a health profession specialty field for which a board issues a specialty certification without first having obtained a specialty certification." Still, dental specialists report frustration that some generalists who attend a weekend conference in a specialty area and receive a certificate in that specialty area use that certificate as a justification for describing themselves as certified in the specialty. The distinction between a weekend *certificate* and state *certification* is clear enough when one looks at the different processes involved in obtaining the two credentials, but it remains ambiguous terminologically. The bill would eliminate this ambiguity by allowing a specialist who had met the Board of Dentistry requirements for a specialty in orthodontics, for instance, to advertise herself as a licensed orthodontist. A generalist could still perform orthodontic services and could indicate that he had received "certification" in orthodontics after having attended a weekend orthodontic conference and having satisfied whatever requirements were set for the certificate, but the generalist could say that he was a *licensed dentist*—not a licensed orthodontist. Prospective patients would be in a much better position to determine whether an individual dentist had truly achieved expertise in a specialty area or was a generalist who had received some—perhaps even significant—training in a specialty area but had not actually satisfied board requirements.

For:

Whether or not Medicaid reimbursement rates are significant factors in hospitals' inability to turn a surplus, the rates are currently too low to cover the cost of the services that hospitals are providing to patients covered by Medicaid. Since hospitals are, by and large, losing money on patient care, largely due to the cost of providing care to patients who are either uninsured or underinsured, it is absolutely essential that Medicaid and other insurance programs reimburse at rates that cover the costs of those services that they do cover. Fortunately, the state can do this at no additional cost to itself in the manner that the bill proposes—i.e., by "taxing" hospitals, calling the revenues from the tax a "state contribution", using this state contribution to leverage additional federal matching funds, and then sending the federal money together with the money that

originally came from the hospitals back to the hospitals in the form of higher Medicaid reimbursement rates. Aside from some additional administrative work, the state does not really have to contribute anything to the mix. Although such a plan may seem to rest on a dubious interpretation of the type of "state contribution" required to qualify for the federal matching funds, the federal government has more or less approved similar plans in 26 other states. Similar legislation for increasing Medicaid reimbursement rates to nursing homes and HMOs was enacted by Michigan legislators earlier this year.

Against:

In his letter explaining his veto of the bill, Governor Engler linked the quality assurance assessment program with the tobacco settlement revenue ballot proposal. The ballot proposal gives voters the choice of approving or rejecting a plan to distribute 90 percent of the revenue to hospitals, nursing homes, and other health organizations throughout the state and the remaining 10 percent to the state's general fund. Speaking of the quality assurance assessment program and the tobacco ballot proposal, the governor wrote "[t]he state can afford one, but not both. The choice is straightforward. One program offers $143 [million] in additional Medicaid dollars into the system. The other, the promise of a bitter electoral battle for the hope of more funding in the future. I have been very clear throughout the entire legislative process that I would not support a hospital assessment if the ballot proposal moved forward."

Response:

Setting aside the issue of the tobacco settlement ballot proposal, the quality assurance assessment program proposed by the bill would cost the state nothing. The *hospitals* would be paying the assessment fee, which the state would then call a *state* "contribution", in order to obtain more federal matching funds. In fact, the bill would actually include an $18.9 million deposit into the general fund. Like the quality assurance assessment for nursing homes and HMOs, the hospital assessment is a way that the state can increase Medicaid reimbursement rates, without spending a dime of its own funds. The bill would create some losers. For instance, federal regulations for such schemes, which are supposed to assure the quality of the state's Medicaid program, require that at least ten percent of the state's hospitals lose out. Moreover, to a certain extent all hospitals are taking a risk insofar as they have essentially assented to a tax, albeit one whose revenue would, for the most part, cycle its way back to them. One might even be tempted to say that the federal government loses out in such matching schemes, except that the federal government has already assented to similar schemes in 26 other states. Still, one thing is clear: the state would not lose under the plan. The state can afford the quality assurance assessment program since the program would not really cost the state anything. House Bill 5103 should be approved or rejected on the basis of its merits rather than on the basis of its "association" with the tobacco settlement revenue ballot proposal.

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