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SFA BILL ANALYSIS

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Senate Bill 1436 (as enrolled) **PUBLIC ACT 619 of 2002**
Sponsor: Senator John J. H. Schwarz, M.D.
Senate Committee: Health Policy
House Committee: Health Policy

Date Completed: 4-28-03

CONTENT

The bill amended Part 222 of the Public Health Code, which governs the certificate of need (CON) program, to do the following:

-- Increase from $2 million to $2.5 million the capital expenditure threshold at which a health facility must obtain a CON before improving, constructing, or replacing a clinical service area
-- Eliminate from the CON program projects involving a nonclinical service area, as well as certain psychiatric program services.
-- Allow a hospital to relocate licensed beds to another hospital or a freestanding surgical outpatient facility, or to provide services or use beds in a veterans health care facility, without a CON under certain circumstances.
-- Allow a nonprofit organization to obtain an acknowledgment from the Department of Community Health (DCH), instead of a CON, for a magnetic resonance imager (MRI) unit in a county with a population over 160,000 that has fewer than two MRI units.
-- Allow an applicant to file a single, consolidated CON application under certain conditions.
-- Increase the CON Commission from five to 11 members and specify the required membership.
-- Require the Commission to develop CON review standards and, at least every three years, review each set of standards.
-- Require the Commission, by January 1, 2004, to include in all CON review standards a requirement that each applicant participate in the Medicaid program.
-- Require the Commission to recommend the revision of CON application fees if the fees collected are not within 10% of three-fourths of the DCH's costs.
-- Create a joint legislative committee to review CON issues.

The bill took effect on March 31, 2003.

CON Thresholds/Definitions

Under Part 222, a person must obtain a certificate of need from the Department of Community Health in order to do any of the following:

-- Acquire an existing health facility or begin operating a health facility at a site that is not already licensed for that type of facility.
-- Change the bed capacity of a health facility.
-- Make a covered capital expenditure.

Under the bill, "covered capital expenditure" means a capital expenditure of $2.5 million or more by a person for a health facility for a single project, excluding the cost of nonfixed medical equipment, that includes or involves the acquisition, improvement, expansion, addition, conversion, modernization, new construction, or replacement of a clinical service area. (The previous dollar amount was $2 million.) The bill retains a requirement that the DCH adjust the threshold each year for inflation.

The previous definition of "covered clinical expenditure" also included a capital expenditure of $3 million or more for a single project that involved a nonclinical service area. The bill deleted that provision.

The bill requires the DCH, in consultation with the CON Commission, to define single project as it relates to capital expenditures.

Part 222 lists those services that are considered "covered clinical services". The bill removed from the list partial hospitalization psychiatric program services. The bill also removed a partial hospitalization psychiatric program from the definition of "health facility".

Hospital Exemptions

Under the bill, a CON is not required for the physical relocation of licensed beds, as described below, if the relocation does not result in an increase of licensed beds within a health service area. No licensed beds may be physically relocated, however, if seven or more members of the CON Commission (after the appointment of the six additional members under the bill, but before June 15, 2003) determine that relocation may cause great harm and detriment to the access and delivery of health care to the public and the relocation should not occur without a CON.

This exemption applies to the physical relocation of licensed beds from one licensed hospital site to another, if both sites are covered by the same license and the hospitals are located within a two-mile radius of each other.

The exemption also applies to the physical relocation of licensed beds from a licensed hospital to a licensed freestanding surgical outpatient facility, if that facility satisfied each of the following criteria on December 2, 2002:

-- It was owned by, was under common control of, or had as a common parent the hospital seeking to relocate beds.
-- It was licensed before January 1, 2002.
-- It provided 24-hour emergency care services at that site.
-- It provided at least four different covered clinical services at that site.

In addition, a CON is not required for the physical relocation of licensed beds from one licensed hospital to another within the same health service area, if the hospital receiving the beds is owned by, under common control of, or has as a common parent the hospital seeking to relocate its beds.

Before relocating beds to a freestanding surgical outpatient facility or to another hospital in the same health service area, the hospital seeking to relocate its beds must provide the information requested by the Department of Consumer and Industry Services that will allow it to verify the number of licensed beds that were staffed and available for patient care at that hospital as of December 2, 2002. A hospital may transfer up to 35% of its licensed beds to a freestanding surgical outpatient facility or to another hospital in the same health service area not more than once after the bill's effective date, if the hospital seeking to relocate its beds or another hospital owned by, under common control of, or having as a common parent that hospital, is located in a city with a population of at least 750,000.

The beds relocated to a freestanding surgical outpatient facility or to another hospital in the same health service area will not be included as new beds in a hospital or as a new hospital under the CON review standards for hospital beds. Half of the beds relocated, up to a maximum of 100, must be beds that were staffed and available for patient care as of December 2, 2002. For five years after a hospital relocates beds to a freestanding surgical outpatient facility, the hospital may not reactivate licensed beds within that hospital that were unstaffed or unavailable for patient care on December 2, 2002.

In addition, under the bill, a licensed hospital is not required to obtain a CON to provide one or more covered clinical services in a Federal veterans health care facility or to use long-term care unit beds or acute care beds that are owned and located in such a facility, if the hospital has each of the following:

-- An active affiliation or "sharing agreement" with the Federal veterans health care facility.
-- Physicians who have faculty appointments at the Federal facility, or an affiliation with a medical school that is affiliated with a Federal veterans health care facility and has physicians who have faculty appointments at that facility.
-- An active grant or agreement with the State or Federal government to provide at least one of the following functions relating to bioterrorism: education, patient care, research, or training.

As used in these provisions, "sharing agreement" means a written agreement between a Federal veterans health care facility

and a licensed hospital for the use of the facility's beds and/or equipment to provide covered clinical services. The hospital may not use procedures performed at the Federal facility to demonstrate need or to satisfy a CON review standard unless the covered clinical service provided at the Federal facility was provided under a certificate of need.

Also, under the bill, if a licensed hospital had fewer than 70 licensed beds on December 1, 2002, it is not required to satisfy the minimum volume requirements under the CON review standards for its existing operating rooms as long as those rooms continue to exist at that hospital site.

MRI Service

Under Part 222, fixed and mobile magnetic resonance imager services are included in the definition of "covered clinical service", and therefore subject to the CON requirements.

Under the bill, however, instead of obtaining a CON, a person may file a letter of intent with the DCH before initiating, expanding, replacing, relocating, or acquiring a fixed or mobile MRI unit within a county that has a population over 160,000 but does not have at least two MRI units. Within 30 days after receiving the letter of intent, if the DCH verifies that the county has a population over 160,000 and does not already have two MRI units, the Department must send the person a written acknowledgment approving the initiation, expansion, replacement, relocation, or acquisition of a fixed or mobile MRI unit.

The person filing a letter of intent must be a nonprofit organization, demonstrate that the service will be accessible to all patients regardless of their ability to pay, and participate in the Medicaid program.

Previously, the DCH was required to use an adjustment factor of 2.0 in applying a review standard that established the minimum number of MRI procedures necessary for a CON for an MRI service serving only hospitals in rural counties. The DCH had to use an adjustment factor of 1.4 in applying a review standard that established the minimum number of MRI procedures necessary for a CON for an MRI service serving hospitals located in both rural and nonrural counties. The bill deleted these requirements.

Single Applications

The bill specifies that an applicant seeking a CON for the relocation or replacement of an existing health facility may file a single, consolidated application if the project does not result in an increase of licensed beds, or the initiation, expansion, or replacement of a covered clinical service. A person relocating or replacing an existing health facility is subject to the applicable CON review standards in effect on the date of the relocation or replacement of the health facility.

Within six months after the bill's effective date, the DCH must create a consolidated application for a CON for the relocation or replacement of an existing health facility.

Medicaid Participation

The bill requires the CON Commission, by January 1, 2004, to include in all CON review standards (except for nursing home and long-term care bed unit review standards) a requirement that each applicant participate in Title 19 of the Social Security Act (Medicaid). The DCH must monitor the participation in Title 19 of each CON applicant approved under Part 222. The DCH must require each applicant to provide verification of participation in Title 19 with its application and annually thereafter.

The bill requires the DCH to revoke a CON if its approval was based on a stipulation that the project would participate in Title 19 and the project has not participated for at least 12 consecutive months within the first two years of operation. (Previously, under these conditions, a CON ceased to be effective.) The bill also requires revocation if a project has not continued to participate annually after its first two years of operation, if CON approval was based on a stipulation that the project would participate.

The DCH, however, may not revoke or deny a CON for a licensed nursing home if did not participate in Title 19 on the bill's effective date but agrees to participate if beds become available. The bill states that these provisions do not prohibit a person from applying for and obtaining a CON to acquire or begin operating a nursing home that does not participate in Title 19.

CON Commission

Part 222 provides for the creation, powers, and duties of a CON Commission, appointed by the Governor with the advice and consent of the Senate. The bill increases the size of the Commission from five to 11 members, and requires the Governor to appoint the six additional members within 30 days after the bill's effective date.

The additional members must include the following:

-- Two individuals representing hospitals.
-- One individual representing physicians licensed to practice medicine.
-- One individual representing physicians licensed to practice osteopathic medicine and surgery.
-- One licensed physician representing a school of medicine or osteopathic medicine.
-- One individual representing nursing homes.

The members constituting the Commission on the day before the bill's effective date must serve on the Commission for the remainder of their terms. When the term of one of these members expires, the Governor must appoint as a successor an individual representing one of the following, in the order listed below:

-- Nurses.
-- A company that is self-insured for health coverage.
-- A company that is not self-insured for health coverage.
-- Blue Cross and Blue Shield of Michigan.
-- Organized labor unions in this State.

The bill retains a requirement that Commission members serve for a term of three years or until a successor is appointed. Of the six members appointed within 30 days of the bill's effective date, two must be appointed for a one-year term, two for a two-year term, and two for a three-year term.

The bill deleted a requirement that three appointees be members of a major political party and two be members of another major political party. Under the bill, the Governor must not appoint more than six members from the same major political party, and must appoint five members from another major political party.

Under Part 222, in making appointments, the Governor must, to the extent feasible, assure that the membership is broadly representative of the interests of all the people of this State. Under the bill, the membership also should be broadly representative of the various geographic regions.

Part 222 requires the DCH to furnish administrative services to the Commission and provide secretarial and other staff necessary to allow the proper exercise of the powers and duties of the Commission. The bill specifies that, in addition, the DCH must provide at least two full-time administrative employees to the Commission. The bill also requires the DCH to make available a brief summary of the actions taken by the Commission.

CON Review Standards

Under Part 222, the CON Commission must approve, disapprove, or revise CON review standards that establish (for purposes of the CON review process) the need, if any, for the initiation, replacement, or expansion of covered clinical services, the acquisition or new operation of a health facility, a change in bed capacity, or covered capital expenditures. The Commission also must approve, disapprove, or revise CON review standards governing the acquisition of new technology. Under the bill, the CON Commission must develop, as well as approve, disapprove, or revise, these review standards.

The bill also requires the Commission to review and, if necessary, revise each set of CON review standards at least every three years.

Previously, Part 222 required the Commission to appoint ad hoc advisory committees in order to assist in the development of proposed review standards. An ad hoc committee had to complete its duties and submit its recommendations to the Commission within the time limit specified by the Commission. The bill instead requires the Commission, if it determines the appointment necessary, to appoint standard advisory committees to assist in the development of proposed review standards. A standard advisory committee must complete its duties and submit its recommendations within six months unless the Commission specifies a shorter period of time. A standard advisory committee must include the same individuals who currently must be on an ad hoc committee, but may not include a registered lobbyist. An individual may not serve on more than two standard advisory committees in any two-year period.

If a standard advisory committee is not appointed and the Commission determines it necessary, the Commission must submit a request to the DCH to engage the services of private consultants or request the Department to contract with any private organization for professional and technical assistance and advice or other services to assist the Commission in carrying out its duties and functions under Part 222.

Within six months after the appointment and confirmation of the six additional Commission members under the bill, the Commission must develop, approve, or revise CON review standards governing the increase of licensed beds in a licensed hospital, the physical relocation of hospital beds from one licensed site to another geographic location, and the replacement of beds in a licensed hospital. As already required for proposed Commission action on other CON review standards, the Commission must hold a public hearing at least 30 days before taking final action.

Part 222 also required the Commission, at least 30 days before taking final action on review standards, to submit the proposed action for comment to the standing committees in the Senate and the House of Representatives with jurisdiction over public health matters. The bill, instead, requires the Commission chairperson to submit the proposed action and a concise summary of its expected impact for comment to the joint legislative committee (described below). The Commission must inform the joint committee of the date, time, and location of the next meeting regarding the proposed action. The bill requires the joint committee promptly to review the proposed action and submit its recommendations and concerns to the Commission.

Previously, the Commission also had to submit proposed final action to the Governor and the Senate and House standing committees with jurisdiction over public health matters. Under the bill, the Commission chairperson must submit proposed final action, including a concise summary of its expected impact, to the Governor and each member of the joint committee. As Part 222 provides, the Governor or the Legislature may disapprove the final proposed action.

The bill prohibits the Commission from developing, approving, or revising a CON review standard that requires the payment of money or goods or the provision of services unrelated to the proposed project as a condition that must be satisfied by a person seeking a CON to initiate, replace, or expand covered clinical services, acquire or begin operation of a health facility, change bed capacity, or make covered capital expenditures. The bill specifies that this provision does not preclude a requirement that each applicant participate in the Medicaid program or provide covered clinical services to all patients regardless of their ability to pay.

Joint Legislative Committee

The bill creates a six-member joint legislative committee to focus on proposed actions of the Commission regarding the CON program and CON standards, and to review other CON issues. The joint committee consists of the chairperson, the vice-chairperson, and the minority vice-chairperson of the Senate Committee on Health Policy, and the chairperson, the vice-chairperson, and the minority vice-chairperson of the House Committee on Health Policy.

The joint committee must be co-chaired by the chairpersons of the Senate and House Health Policy Committees. The joint committee may administer oaths, subpoena witnesses, and examine the application, documentation, or other reports and papers of an applicant or any other person involved in a matter properly before the committee.

The joint committee may develop a plan for the revision of the CON program. If it does so, the committee must recommend to the Legislature the appropriate statutory changes to implement the plan.

Application Fees

Under Part 222, the DCH must report annually to the CON Commission regarding the Department's implementation costs and the CON application fees collected in the preceding fiscal year. If the reports indicate that application fees collected have not been within 10% of one-half of the DCH's costs, the Commission must make recommendations for revising the fees. Previously, the recommended fees had to be capable of collecting approximately one-half of the costs. Under the bill, the Commission must make recommendations so that application fees collected equal approximately three-quarters of the Department's costs to implement Part 222.

The bill requires the joint committee to review the CON Commission's recommendation for application fees and submit a written report to the Legislature outlining the costs to the DCH to implement the program, the amount of fees collected, and its recommendations regarding the revision of those fees.

DCH Responsibilities

Part 222 requires the DCH to promulgate rules to implement its powers and duties under this part. Under the bill, these rules are subject to approval by the CON Commission.

The bill requires the DCH annually to review the application process, including all forms, reports, and other materials that must be submitted with an application. If needed to promote administrative efficiency, the Department must revise the forms, reports, and other required materials.

Part 222 had allowed the DCH to monitor compliance with issued CONs. The bill instead *requires* the DCH to monitor compliance with all CONs issued. Further, Part 222 contains a list of actions for the DCH to take if it determines that a CON recipient is not in compliance with the terms of the CON or is in violation of Part 222 or rules promulgated under Part 222. The actions may include revoking or suspending the CON, imposing fines, and taking any enforcement action authorized by the Code. The bill requires the DCH to take one or more of the listed actions or to take any other action determined appropriate.

Previously, the DCH was required to prepare and publish annual reports of reviews conducted under Part 222. The bill requires the DCH to prepare and publish the reports monthly.

The bill also requires the DCH, upon request, to provide copies of an application or part of an application, and allows the DCH to charge a reasonable fee for the copies.

Regional Agencies

Previously, the DCH was required to develop standards for the designation by the Department of a regional CON review agency for each review area to develop advisory recommendations for proposed projects. The standards had to be approved by the Commission before they were implemented. The DCH could terminate the designation of a regional CON review agency for noncompliance with the standards. The bill requires the Commission, instead of the DCH, to develop these standards, and requires Commission concurrence in the termination of an agency's designation. (A review area is a geographic area established for a health systems agency or established by the Commission for a regional CON review agency.)

Under Part 222, before developing a recommendation on a CON application, a regional CON review agency must hold a public hearing on the proposed project. If a regional agency has not been designated for the review area in which the proposed project will be located, the DCH must hold a public hearing on the project, if the Department determines that local interest merits a hearing. (Previously, holding a public hearing under these circumstances was permissive.)

Other Provisions

Part 222 provides that the decision to grant or deny a CON application must be made by the DCH Director. The applicant may appeal the final decision to the circuit court for the county where the applicant has its principal place of business, or to the Ingham County Circuit Court. Under the bill, an applicant will have 30 days after the Director's final decision to appeal.

Part 222 requires the Commission to appoint a medical technology advisory committee to assist in the identification of new medical technology or new medical services that may be appropriate for inclusion as a covered clinical service. A majority of the committee members must represent health care provider organizations concerned with licensed health facilities or licensed health professions and other persons knowledgeable in medical technology. In addition, the Commission must appoint to the committee representatives of health care consumer, purchaser, and third party payer organizations. The bill requires the Commission also to appoint faculty members from schools of medicine, osteopathy, and nursing in the State.

Part 222 allows the DCH to issue emergency CONs after necessary and appropriate review. The bill specifies that an emergency CON is a final decision and the applicant is not required to submit a formal application for a second review.

Part 222 had required the Center for Rural Health to designate a CON ombudsman to provide technical assistance and consultation to hospitals and communities located in rural counties regarding CON proposals and applications. The ombudsman also was required to act as an advocate for health concerns of rural counties in the development of CON review standards. (The responsibilities of the Center for Rural Health were transferred to the DCH by Executive Order 1997-4.) The bill deleted these requirements.

The bill repealed Section 22217, which provided for the use of interim CON review standards and approval procedures after Part 222 was enacted.

Legislative Analyst: Suzanne Lowe

FISCAL IMPACT

The fiscal impact is indeterminate. For FY 2002-03, the CON program was originally appropriated at $944,800 Gross ($222,900 GF/GP). Executive Order 2003-3 eliminated the GF/GP funding for this program, leaving the FY 2002-03 year-to-date appropriation at $721,900 Gross. Although the bill requires the DCH to perform some additional duties relating to the administration of this program, it appears that those duties can be covered with existing resources.

Quantifying the impact of the changes to the CON program, as provided by this bill, is difficult. Arguments have been made in support of both sides of the issue (continuation of the CON process or removal/restructure of the CON process), all in the name of providing access to quality health care.

The CON program is a mechanism to control costs and improve the quality of health care by regulating the supply of health care services. The premise of the CON program is based on an extrapolation of Roemer's Law (a hospital bed built is a hospital bed filled--and billed), which suggests that an increase in the supply of health care services will lead to an increase in the use of health care, independent of need.

It has been well established that the presence of third party insurance coverage has expanded the demand for health care services and made consumers insensitive to price. As a result, health care providers compete for patients on the basis of the types of services and amenities they offer, rather than their ability to provide the consumer with bargain health care. One concern raised about the removal of CON requirements is that it will lead to excess capacity of expensive, high-technology services or facilities. An increase in capacity of these types of services or facilities, without a corresponding increase in need, may lead to a number of situations, all detrimental to health care costs and quality, such as: higher total and per-unit costs; an increase in the receipt of unnecessary health care services; decreased volume per facility/provider; and underused facilities.

On the other hand, in situations in which there are currently shortages in service capacity, removing CON requirements might result in improved access to care for some. However, this is not likely to be a very efficient or effective mechanism for improving access to care. Without CON requirements, health care providers might offer services based on whether they believe a service will be profitable, not based on whether a community is in need of the particular service. Areas with a high concentration of insured individuals, such as suburban areas, may see an increase in the availability of high-technology services, potentially to the point of excess capacity. For other areas that have lower total population and/or a high proportion of publicly insured or uninsured individuals, such as rural and urban areas, access to care is not likely to be improved.

Fiscal Analyst: Dana Patterson

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