Legislative Analysis

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TRANSFER OR DELICENSURE OF BEDS BY CERTAIN HEALTH FACILITIES

Senate Bill 183 as enacted
Public Act 265 of 2022
Sponsor: Sen. Michael D. MacDonald
House Committee: Health Policy [Discharged]
Senate Committee: Health Policy and Human Services
Complete to 7-13-23

SUMMARY:

Senate Bill 183 amends the Public Health Code to require notification to the Department of Health and Human Services (DHHS) if a hospital applies for designation as a rural emergency hospital, to allow certain rural emergency hospitals to apply to temporarily delicense beds, and to eliminate a provision prohibiting the use of temporarily delicensed beds to comply with a bed reduction plan. The bill also removes a limit that formerly applied to certain types of transfers between hospitals located in Detroit and freestanding surgical outpatient facilities.

Rural emergency hospitals

The bill requires a hospital to notify DHHS if the owner, operator, or governing body of the hospital applies for designation as a ***rural emergency hospital***.

> ***Rural emergency hospital*** means a hospital designated by the federal Centers for Medicare and Medicaid Services to offer *rural emergency hospital services* as that term is defined under federal law.[1]

The bill allows a rural emergency hospital that is licensed under Article 17 (Facilities and Agencies) of the code and is not located in a ***urbanized area*** to apply to the Department of Licensing and Regulatory Affairs (LARA) to temporarily delicense 100% of its licensed beds for up to five years. Delicensed beds are unavailable for patient use. (In general under the code, a hospital that is not located in an urbanized area can apply to LARA to delicense up to 50% of its licensed beds for up to five years.)

> ***Urbanized area*** means:[2] "An area defined by the Bureau of the Census according to specific criteria, designed to include the entire densely settled area around each large city. An urbanized area must have a total population of at least 50,000. The urbanized

[1] https://www.law.cornell.edu/uscode/text/42/1395x (See subsection (kkk).)

[2] This definition is that given to the term *urbanized area* by the Office of Federal Statistical Policy and Standards of the U.S. Department of Commerce in an appendix to its final standards for establishing metropolitan statistical areas following the 1980 census, as published in the Federal Register on January 3, 1980, with notice of a comment period open until March 3 of that year, as that document is incorporated by reference in the Public Health Code. https://www.govinfo.gov/content/pkg/FR-1980-01-03/pdf/FR-1980-01-03.pdf (see page 182 of the pdf)
The Census Bureau now defines *urbanized area* as "A retired statistical geographic entity type consisting of a densely settled core created from census tracts or blocks and adjacent densely settled territory that together have a minimum population of 50,000 people," adding that "Urbanized areas were not identified for the 2020 census." https://www.govinfo.gov/content/pkg/FR-2022-03-24/pdf/2022-06180.pdf

area criteria define an boundary based primarily on a population density of at least 1,000 persons per square mile, but also include some less densely settled areas within corporate limits, and such areas as industrial parks, railroad yards, golf courses, and so forth, if they are adjacent to dense urban development."

The bill also removes a provision prohibiting a hospital that has beds subject to a hospital bed reduction plan or to a LARA action to enforce Article 17 from using temporarily delicensed beds to comply with the bed reduction plan.

Hospitals and freestanding outpatient facilities

Under the code, a hospital does not have to obtain a certificate of need, but must provide certain information to LARA, before relocating beds from a hospital to a freestanding surgical outpatient facility under certain specific conditions.

The code also previously provided that if a hospital (or another hospital under common control with the hospital) was located in a city with a population of 750,000 or more, the hospital could not transfer more than 35% of its licensed beds to another hospital or freestanding surgical outpatient facility more than one time. This provision referred to Detroit, which was once the only Michigan city with a population of 750,000 or more, but because its population in the 2020 census was 672,351, there are no longer any Michigan cities that meet the threshold, so the provision no longer applies to any hospitals.

The bill removes this provision (i.e., rather than reducing the population threshold so that it would apply again to Detroit).

MCL 333.20145 et seq.

The bill took effect December 22, 2022.

BRIEF DISCUSSION:

The provisions of Senate Bill 183 relating to rural emergency hospitals are nearly identical to those of House Bill 6380 of the 2021-22 legislative session.[3] The bill allows certain rural hospitals to convert from either a critical access hospital or a rural prospective payment system hospital to a rural emergency hospital model under recently enacted federal legislation. According to written testimony on House Bill 6380 from the Michigan Health and Hospital Association,[4] a hospital that is a rural emergency hospital can receive enhanced federal reimbursements and can operate a distinct part skilled nursing facility or off-campus provider-based departments. Allowing a hospital that converts to a rural emergency hospital to temporarily delicense beds allows further savings if the hospital generally is not at full capacity. Such flexibility and increased reimbursements for patient services can help struggling rural hospitals to stay in operation and continue to provide much needed medical services to nearby residents. Hospitals could convert back to their previous hospital model at a future time if needed.

[3] House Bill 6380 would have differently revised the criteria of a *distressed area* for purposes of a provision that appears to have been last effective in 1993.

[4] https://www.house.mi.gov/Document/?Path=2021_2022_session/committee/house/standing/health_policy/meetings/2022-09-22-1/documents/testimony/092222%20HB%206380%20Lauren%20LaPine%20and%20Elizabeth%20Kutter.pdf

FISCAL IMPACT:

Senate Bill 183 would have an indeterminate, though likely modest, fiscal impact on the Department of Licensing and Regulatory Affairs. The potential exists for LARA to experience decreased fee revenue under the bill. If rural emergency hospitals choose to delicense beds, they would no longer be liable for the $10 fee per bed that is assessed in addition to the $500 base fee for hospital licensure. LARA believes that a limited number of hospitals may delicense their beds and that it would be a fairly low number of beds delicensed at each facility (estimated at no more than 50 beds each). The department's current projected revenue decrease is $1,500 or less.

The bill would likely have no impact on the state Medicaid and Healthy Michigan Plan programs. Critical access hospitals and hospitals in eligible rural areas that transition to the rural emergency hospital provider type would still provide emergency and outpatient services, and there would be no change in the Medicaid reimbursement rates for such services. Rural emergency hospitals would benefit from the 5% increase in federal Medicare reimbursement rates for emergency and outpatient services, as well as the monthly distribution from the Centers for Medicare and Medicaid Services.

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