Senate Fiscal Agency
P.O. Box 30036
Lansing, Michigan 48909-7536

BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986

Senate Bills 181 through 183 (as passed by the Senate)
Senate Bill 190 (Substitute S-1 as passed by the Senate)
Sponsor: Senator Curtis S. VanderWall (S.B. 181 & 190)
Senator Lana Theis (S.B. 182)
Senator Michael D. MacDonald (S.B. 183)
Committee: Health Policy and Human Services

Date Completed: 4-28-22

RATIONALE

In Michigan, health facilities must apply for and receive a Certificate of Need (CON) from the Department of Health and Human Services (DHHS) for certain acquisitions or modifications of covered clinical services, including any increase or relocation of licensed beds or before acquiring or modifying an air ambulance service (see **BACKGROUND)**. This requirement applies to an increase in licensed psychiatric beds which are located in psychiatric units or hospitals. Licensed psychiatric beds provide mental health services to Michigan residents suffering from a mental illness such as bipolar disorder, schizophrenia, or psychosis.

According to a final workgroup report discussing inpatient psychiatric admissions prepared by the Michigan Department of Health and Human Services (DHHS) in 2018, the number of licensed psychiatric beds in the State has decreased significantly over the past three decades. Some people have concerns that the reduction in licensed bed capacity and the increasing concern of mental illness's prevalence and acuity has brought about a licensed psychiatric bed shortage in the State. It has been suggested that the requirement to apply for and receive a CON for any increase in licensed psychiatric beds be removed.

An air-ambulance service is a helicopter or fixed-wing airplane that has the appropriate medical personnel and license to provide medical attention to sick or injured patients in transport to or between health facilities. Air ambulances commonly are used when mobile emergency medical services cannot reach a patient or arrive quickly. In Michigan, air-ambulance providers are regulated by multiple entities, and some contend that not all of these regulations are unnecessary. Accordingly, it also has been suggested that the requirement to obtain a CON for air-ambulance services be removed.

CONTENT

Senate Bill 181 would amend Part 222 (Certificates of Need) of the Public Health Code to modify the definitions of "change in bed capacity", "covered capital expenditure", and "covered clinical service".

Senate Bill 182 would amend Part 222 of the Code to do the following:

-- **Increase, from 11 to 13, the membership of the Certification of Need Commission, and require the Commission to include two individuals representing the general public, one of whom would have to be from a county with a population of less than 40,000.**
-- **Modify the requirements for members of the standard advisory committee appointed by the Commission.**

Senate Bill 183 would amend Part 222 of the Code to delete a provision prohibiting a hospital from transferring more than 35% of its licensed beds to another hospital or freestanding surgical outpatient facility more than once if it is located in a city that has a population of 750,000 or more.

Senate Bill 190 (S-1) would amend the Mental Health Code to do the following:

- **Require, as a condition of licensing, a psychiatric hospital or psychiatric unit to public patients and to maintain 50% of beds available to public patients.**
- **Beginning June 1, 2021, require a psychiatric hospital and psychiatric unit to submit an annual report to the Department of Health and Human Services (DHHS) as a part of the application for license renewal certain data related to total patient days of care provided and total beds available during the previous calendar year.**
- **Allow the DHHS to use the annual report data or a DHHS investigation to determine if a psychiatric hospital or psychiatric unit maintained 50% of beds available to public patients.**

Senate Bills 181 through 183 are tie-barred. Senate Bill 190 (S-1) is tie-barred to Senate Bill 181.

Senate Bill 181

Under Part 222 of the Public Health Code, "change in bed capacity" means one or more of the following:

- An increase in licensed hospital beds.
- An increase in licensed nursing home beds or hospital beds certified for long-term care.
- A change from one licensed use to a different licensed use.
- The physical relocation of beds from a licensed site to another geographic location.

In addition, "change in bed capacity" means an increase in licensed psychiatric beds. The bill would delete this provision.

Part 222 defines "covered capital expenditure" as a capital expenditure of $2.5 million or more, as adjusted annually by the DHHS 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 bill would increase the threshold of a capital expenditure from $2.5 million to $10.0 million, adjusted annually.

Under Part 222, "covered clinical service", except as modified by the Certificate of Need Commission, means one or more of the following:

- The initiation or expansion of neonatal intensive care services or special newborn nursing services; open heart surgery; or extrarenal organ transplantation.
- Initiation, replacement, or expansion of a service not listed in the definition but designated by the Commission as a covered clinical service.
- Initiation, replacement, or expansion of extracorporeal shock wave lithotripsy; megavoltage radiation therapy; positron emission tomography; certain surgical services; a fixed and mobile magnetic resonance imager service; a fixed and mobile computerized tomography scanner service; or an air ambulance service.

Under the bill, "covered clinical service" would include initiation, replacement, or expansion of air ambulance services until June 1, 2021.

"Covered clinical service" also means the initiation or expansion of a specialized psychiatric program for children and adolescent patients utilizing licensed psychiatric beds. The bill would delete this provision.

Senate Bill 182

The Public Health Code creates the CON Commission in the Department of Licensing and Regulatory Affairs and requires the Governor to appoint 11 members to the Commission with the advice and consent of the Senate. Under the bill, the Commission would consist of 13 members.

Currently, the Commission consists of the following members:

-- Two individuals representing hospitals.
-- One individual representing physicians licensed under Part 170 (Medicine) of the Code.
-- One individual representing physicians licensed under Part 175 (Osteopathic Medicine and Surgery) of the Code.
-- One individual who is a physician licensed under Part 170 or Part 175 representing a school of medicine or osteopathic medicine.
-- One individual representing nursing homes.
-- One individual representing nurses.
-- One individual representing a company that is self-insured for health coverage.
-- One individual representing a company that is not self-insured for health coverage.
-- One individual representing a nonprofit healthcare corporation operating under the Nonprofit Health Care Corporation Reform Act or a nonprofit mutual disability insurer into which a nonprofit health care corporation has merged as provided in the Insurance Code.
-- One individual representing organized labor unions in the State.

Under the bill, the Commission also would have to consist of two individuals representing the general public, one of whom would have to be from a county with a population of less than 40,000.

Generally, the Commission must develop, approve, disapprove, or revise certificate of need review standards that establish for purpose of the Code the need for the initiation, replacement, or expansion of covered clinical services, the acquisition or beginning of a health facility, making changes in bed capacity, or making covered capital expenditures, among other things.

If the Commission determines it necessary, it may appoint a standard advisory committee to assist in the development of proposed certificate of need review standards. The Code requires the committee to include all of the following:

-- Experts with professional competence in the subject matter of the proposed standard, who must constitute a two-thirds majority of the committee.
-- Representatives of health care provider organizations concerned with licensed health facilities or licensed health professions.
-- Representatives of organizations concerned with health care consumers and the purchasers and payers of health care services.

Under the bill, the standard advisory committee would have to include all of the following:

-- Experts with professional competence in the subject matter of the proposed standard, who must constitute at least two-thirds majority of the committee.
-- At least one representative of health care provider organizations concerned with licensed health facilities or licensed health professions.
-- At least one representative of organizations concerned with health care consumers or the purchasers or payers of health care services.

Senate Bill 183

Under the Public Health Code, subject to exceptions and if the relocation does not result in an

increase of licensed beds within that health service area, a certificate of need is not required for any of the following:

-- The physical relocation of licensed beds from a hospital site licensed under Part 215 (Hospitals) to another hospital site licensed under the same license as the hospital seeking to transfer the beds if both hospitals are located within a two-mile radius of each other.
-- The physical relocation of licensed beds from a hospital site licensed under Part 215 to a freestanding surgical outpatient facility licensed under Part 215 if that freestanding surgical outpatient facility satisfies certain criteria on December 2, 2002.
-- The physical relocation of licensed beds from a hospital licensed under Part 215 to another hospital licensed under Part 215 within the same health services area if the hospital receiving the licensed beds is owned by, is under the control of, or has a common parent the hospital seeking to relocate its licensed beds.

Before relocating beds to a hospital site licensed to a freestanding surgical outpatient facility, the hospital seeking to relocate its beds must provide the information requested by the Department of Licensing and Regulatory Affairs (LARA) to allow LARA to verify the number of licensed beds that were staffed an available for patient care at that hospital as of December 2, 2002.

A hospital may transfer not more than 35% of its licensed beds to another hospital or freestanding surgical outpatient facility not more than one time if the hospital seeking to relocate its licensed beds or another hospital owned by, under common control of, or having as a common parent the hospital seeking to relocate its licensed beds is located in a city that has a population of 750,000 or more. The bill would delete this provision.

Senate Bill 190 (S-1)

Under the Mental Health Code, a person may not construct, establish, or maintain a psychiatric hospital or psychiatric unit or use those terms without first obtaining a license. The Director of the DHHS must require an applicant or licensee to disclose certain information. If approved, a license generally may not be granted for longer than one year after the date of issuance.

Under the bill, as a condition of licensing, a psychiatric hospital or psychiatric unit would have to accept public patients and would have to maintain 50% of beds available to public patients.

(Under Public Act 285 of 2020, which will take effect on March 24, 2021, "public patient" means an individual approved for mental health services by a community mental health services program. The term includes an individual who is admitted as a patient under Sections 423, 429, or 438 of the Code. Section 423 specifies that a hospital designated by the DHHS or by a community health services program must hospitalize an individual presented to the hospital pending receipt of a clinical certificate by a psychiatrist stating that the individual requires treatment. Section 429 provides that certain hospitals contracted with community health services as required by the Code must receive and detain an individual presented for examination, for not more than 24 hours, under certain circumstances related to a peace officer's detaining and delivering a person to a hospital under a petition, a physician's clinical certificate, or a court order. Section 438 specifies that if a court determines that an individual requires immediate assessment because the individual presents a substantial risk of significant physical or mental harm to himself or herself in the near future, or substantial harm to others, the court can order a peace officer to take the individual into protective custody and deliver the individual to a contracted hospital for screening.)

Beginning June 1, 2021, a psychiatric hospital and psychiatric unit would have to submit an annual report to the DHHS as a part of the application for license renewal. The DHHS could develop the annual report format. The annual report would have to include data on all of the following:

-- Total patient days of care provided to public patients during the previous calendar year.
-- Total beds available during the previous calendar year.
-- Total patient days of care during the previous calendar year.

The DHHS could use the annual report data or a DHHS investigation to determine if a psychiatric hospital or psychiatric unit maintained 50% of beds available to public patients.

MCL 333.22203

BACKGROUND

A CON is a state-authorized document that must be acquired before the construction or renovation of certain health facilities and is intended to ensure that only needed services are developed in a state. For the purposes of Michigan's CON program, a health facility means a hospital, a psychiatric hospital or unit, a nursing home or a hospital long-term care unit, a freestanding surgical outpatient facility, or a health maintenance organization (i.e., an HMO). Michigan's CON Program requires an entity to apply and receive approval for a CON from the Department of Health and Human Services (DHHS) to undertake any of the following: the increase in or relocation of licensed beds; the acquisition of an existing health facility, or establishment of a health facility; the modification of a covered clinical service; or the payment of a covered capital expenditure. The list of covered clinical services for which a CON is necessary includes air ambulance services, cardiac catherization services, computed tomography scanner services, hospital beds, magnetic resonance imaging services, megavoltage radiation therapy services, neonatal intensive care units, nursing home/hospital long-term care unit beds, open heart surgery services, positron emission tomography scanner services, psychiatric beds and services, surgical services, transplantation services, and urinary lithotripter services.

The DHHS uses review standards approved by the CON Commission, an 11-member body appointed by the Governor, to evaluate CON applications. The CON Commission revises the review standards for covered health facilities and each covered clinical service every three years, on a rotating schedule. When the DHHS receives a CON application and considers it complete, a proposed decision is issued by certain deadlines depending on the review type; the shortest deadline is 45 days and the longest is 150 days. If an application is denied, an applicant can request a hearing after which the Director of the DHHS makes a final determination.

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

According to a 2018 DHHS report on psychiatric admissions, community hospitals in the State have reduced their capacity from 3,041 beds in 1993 to 2,197 beds in 2017, a decrease of approximately 28%.[1] The Treatment Advocacy Center, a national nonprofit that studies barriers to treatment for severe mental illness, estimates that the reduction has left Michigan with 7.3 State hospital psychiatric beds per 100,000 people in 2016. This is approximately 4.4 beds below the national average, which is far below the average in other countries of comparable development.

With fewer State-run psychiatric hospital beds, the DHHS report specifies that there is a 200-person waitlist for admission to a State psychiatric hospital on most days. Waitlists of this size force patients suffering from mental illness to resort to hospital emergency rooms while awaiting admission. Hospital emergency rooms are not equipped to treat these patients properly and must offer stabilization to patients suffering from mental illness instead of inpatient treatment that is sometimes necessary. As a result, hospital emergency rooms become overburdened by the influx of patients suffering from mental illness and perpetuate the cycle of inadequate care for these patients.

[1] "Michigan Inpatient Psychiatric Admissions Discussion - Final Workgroup Report", Michigan Department of Health and Human Services. Retrieved on 4-27-2022.

The current lack of State psychiatric hospital beds is worsened by the stringent and time-consuming CON requirements imposed on these psychiatric beds. According to testimony before the Senate Committee on Health Policy and Human Services, current CON determinations for an increase in State psychiatric hospital beds take between three to six months. This delay further inhibits patients suffering from mental illness from receiving inpatient psychiatric care and the DHHS ultimately could determine the increase in psychiatric beds is not necessary if the application did not meet review standards. These outcomes perpetuate the inadequate State psychiatric bed capacity as 200 patients occupy space in improperly equipped emergency rooms while remaining on a waitlist. The requirement to obtain a CON for the increase of licensed psychiatric beds should be eliminated to improve the health outcomes of patients suffering from mental illness in the State.

Response: According to testimony presented before the Senate Committee on Health Policy and Human Services, Michigan's licensed psychiatric bed occupancy rate in previous years has been at 70%, which leaves a sizeable portion of psychiatric beds empty. These beds could provide inpatient care to patients suffering from mental illness but remain unfilled because of staffing shortages. Staffing shortages occur for many reasons, including the physical demands of providing psychiatric care, an increase in acuity of mental illness, and the inability to recruit and retain physicians in psychiatric medicine. A higher acuity of mental illness cases can require staff-to-patient ratios of one-to-one or two-to-one, which limits the attention and treatment provided to other patients. In addition, a small portion of medical students choose to pursue psychiatry and recruiting these few students to work in Michigan psychiatric units is challenging. Given that occupancy rates are below 100% and the levels of staffing cannot meet the demands of mental illness's prevalence and acuity, policy looking to improve mental health services in the State should focus on recruitment of personnel.

Supporting Argument

Air ambulance services in Michigan are regulated by the Federal Aviation Administration (FAA), the Department of Health and Human Services' DHHS administrative rules for life support agencies and emergency medical services (EMS), and the DHHS's CON program. The FAA regulates the operations, pilot certifications, flight safety, and equipment involved with an air-ambulance service. The Department's administrative rules for life support agencies and EMS regulate the licensure of the air-ambulance operation as an ambulatory service in the State and the sanitation and medical standards for providing care. Generally, the FAA regulates the standards concerning aviation and the Department's rules regulate the standards concerning the provision of medical services.

The FAA's regulations and the DHHS's administrative rules are comprehensive and ensure the safety of pilots, medical personnel, and patients on board. However, the DHHS's CON program also regulates air-ambulance services in Michigan through its review standards. The review standards provide requirements only for the initiation, acquisition, and expansion of air-ambulance services. Given the comprehensiveness of the FAA regulations and DHHS's administrative rules, the CON requirements are not necessary to ensure that appropriate aviation and medical standards are met. The CON requirements for air-ambulatory services should be removed because they are unnecessary regulations.

Opposing Argument

Air-ambulance services provide transportation for patients that need medical attention during life-threatening situations that mobile ambulatory services cannot physically access or arrive quickly. While the rapid response is valuable, air-ambulance services also assume more serious safety risk when compared to mobile ambulatory services. According to testimony presented before the Senate Committee on Health Policy and Human Services, there are eight air-ambulance programs in Michigan, and the industry serves approximately 3,000 patients annually. The finite number of patients can create a competitive market for the existing providers, and in addition to challenges with reimbursement for provided services, can result in some air-ambulance programs operating at a loss. These financial factors can exacerbate the risks associated with air-ambulance services. For example, in January 2019, an Ohio air-ambulatory service provider accepted an emergency response request after two air-ambulatory service providers had declined the request because of inclement weather conditions. The air-ambulatory service provider that accepted the emergency

response request crashed soon after departure, and the pilot and medical responders died. A report on the crash by the National Transportation Safety Board revealed that the provider that responded to the request was operating at the minimal FAA weather standards, which were below the standards by which the other two providers operated. Ohio has a significantly larger and more competitive air-ambulatory services market and it is believed that competition between providers motivated the air-ambulatory service providers to act on the request.

While the FAA regulates weather standards for flight, crashes still occur, and state policies can assist in mitigating the factors that can lead to crashes, such as competitive markets. Among other mitigation policies, Michigan's requirement that an air-ambulance service must obtain a CON before operating in the State reduces the proliferation of air-ambulance services. Fewer air-ambulance service providers reduces competition and can contribute to the safety and quality of air-ambulance transportation. While FAA and State regulations bolster the benefits of air-ambulatory services in the State, Michigan's CON requirement for air-ambulance services protects patients, pilots, and medical first responders through risk mitigation, and all three forms of regulation should remain in place.

Legislative Analyst: Stephen P. Jackson

FISCAL IMPACT

Senate Bills 181 & 190 (S-1)

Senate Bill 181 would raise the CON cap for clinical service projects from $2.5 million to $10.0 million. The bill also would exempt air ambulance services and specialized psychiatric programs for children and adolescents from the CON process. As such, it would have a minimal fiscal impact.

The increase in the cap would appear to have minimal fiscal impact as the CON process is focused on larger scale expansions and the cap would still exist for those expansions.

There is evidence from other states (such as an Iowa Attorney General's opinion) that the Federal Aviation Act regulates air ambulance services and bars states from implementing statutes overriding Federal law and regulation on aviation services. It appears that the intent of the air ambulance exemption is to bring State CON law in line with Federal law. Accordingly, the air ambulance change would not have a fiscal impact except for a small reduction in CON fee revenue.

Under Senate Bills 181 and 190 (S-1), the exemption for specialized psychiatric programs for children and adolescents and the requirement that a psychiatric hospital or psychiatric unit maintain 50% of available beds for public patients would clearly lead to an increase in the number of licensed psychiatric beds and thus make more beds available for Community Mental Health Services Program (CMHSP) clients. The costs of placing an individual in a private psychiatric hospital bed are paid by the CMHSP; however, the cost of that placement must be compared to the cost of providing services in the community. Shifting a person from community services to a private psychiatric bed likely would lead to a marginal increase in costs in the short term, but more intensive treatment would lead to lower long-term costs for services to many clients. Furthermore, the greater availability of private psychiatric beds for CMHSP clients could lead to the shifting of individuals from lengthy stays in more expensive State psychiatric facilities to shorter term placements in private beds, leading to a net savings. The research on those questions has not led to a definitive answer as to whether greater availability of private psychiatric beds increases or decreases net costs. As such, the fiscal impact of this provision is indeterminate but likely would not be significant.

The Department also would incur minor administrative costs to develop a form for the submission of data required under Senate Bill 190 (S-1).

Senate Bills 182 & 183

The bills would have no fiscal impact on State or local government.

Fiscal Analyst: Ellyn Ackerman

SAS\A2122\s181a

This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.