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HEALTH POLICY BULLETIN

FOCUS: DISCIPLINING HEALTH PROFESSIONALS

The Special Ad Hoc Committee on Physician Licensure chaired by Rep. Gubow released its report last week. The report analyzes current licensure and discipline practices in the state and contains recommendations for legislative action. The committee broadened its inquiry beyond the original charge from the Speaker and studied licensing and discipline practices for all of the fifteen health professions that are regulated by the Bureau of Health Services, Department of Licensing and Regulation (L and D), through Article 15 of the Public Health Code (health occupations). The only group omitted is social workers, who are regulated by the Bureau of Commercial Services within the department.

The committee had its origins in the Speaker's interest in integrated licensure—a system whereby the Michigan State Medical Society would have assumed the responsibility for licensing and disciplining physicians. Such a system would be analogous to that used by the State Bar of Michigan to regulate attorney behavior. However, when Michael Franck, executive director, State Bar of Michigan, noted that this function is performed by the bar association under the direction of the Michigan Supreme Court, it quickly became apparent that no authority is able to make a similar delegation to the medical society. Instead, the committee recommended separating the licensing and discipline processes; the boards would retain their licensing and continuing education functions, but a new board and a new process would be created to handle discipline for all of the health professions. Approximately 200,000 licensees would be affected by the new program; the single largest group is nurses (135,000), followed by MDs and DOs (28,000).

The committee's recommendations fall into four broad areas: Separation of licensing and discipline functions, creation of a new board and a new process to handle discipline hearings and sanctions, public information and reporting of substandard practices, and other discipline and reporting recommendations (increased fees to pay for the new process, establishment of an impaired provider program within L and R, audits of physician practices, and review of the question of regulating resident hours).

The new board would be composed of seven members—five public members (who would be unclassified, full-time state employees) appointed by the governor with the advice and consent of the Senate and two members (on a rotating basis) from the same profession as the licensee who is up for discipline. The discipline board would have very broad powers: It could (1) order testing for competency, physical and mental condition, and chemical dependency; (2) take action against licensees who continue to practice without renewing their licenses and refer complaints against those persons to the attorney general for criminal prosecution; (3) issue cease-and-desist orders and subpoenas and obtain injunctions; (4) require licensees to pay restitution and to perform community service as part of a disciplinary action; and (5) require a licensee to complete satisfactorily an educational, training, and/or substance abuse or mental health treatment program or programs. Decisions of the board are by a majority of those present and voting—since a quorum of the board is four members, a licensee could face disciplinary action on the basis of three votes. The standard of proof to be used by the board is the preponderance of evidence used in civil actions rather than the more stringent standard used in criminal actions. Board decisions may be appealed only to the state court of appeals.

Under the new procedures, a complaint would move through four stages before reaching the discipline board: allegations/complaints, investigation, mandatory settlement conferences, and hearings before regional panels. The regional panels are composed of three members—an attorney and two licensees from the same profession as the person under investigation. All health professionals, as a condition of licensure, would be required to be available to serve on the panels. Although the panels do not recommend penalties, they do determine whether the Public Health Code has been violated; their conclusions are sent to the discipline board for final action. The panel process has real teeth: Appearance is compulsory and failure to appear subjects a licensee to penalties for civil contempt and a default judgment.

The new program would be financed by increasing and earmarking the licensing fees for health professionals. According to Julie Croll, director, administrative section, Bureau of Health Services, L and R, in FY 1989 approximately $6 million was collected from licensees, while the general fund appropriation for licensing and disciplining functions was $4.4 million. Legislative staff estimate that it would cost an additional $5 million to implement the program.

Reaction to the proposals is generally supportive. Kevin Kelly, assistant director, Michigan State Medical Society, said, "We see the separation of licensure and discipline, more investigatory staff, and regional review panels of physicians as positive developments. Physicians will be reviewing the actions of physicians, and physician review is important to

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us." Carol Franck, executive director, Michigan Nurses' Association, noted that the proposals address a very important issue: the timeliness of discipline. "The public is not well served if discipline is not handled in a timely fashion," she said. Franck likes the regional panels because "it is easier for people to participate, and the basic assessment comes from your peers."

But there are some problems: The first is constitutional. The state constitution (Article V, Section 5) requires a majority of a professional board to be members of the profession. A discipline board composed of five public members and two professional members may not meet the requirements of the constitution. Some observers feel that the removal of licensure cannot be delegated by a professional board to a discipline board; other observers note that the powers of professional boards are statutory (and not constitutional) and therefore capable of amendment by statute. A second problem is the definition of public member for the discipline board. The appointment by the governor with the advice and consent of the Senate of public members who are unclassified, full-time state employees does not fit the usual definition of public members accepted by political scientists and government specialists.

Legislation to implement the program currently is being drafted and could be introduced and passed before the November elections.

FOCUS: RURAL HEALTH LEGISLATION

Federal foot-dragging on rural access to health care has led to the bipartisan introduction of four bills in the Senate (SBs 889–892) and two companion bills (HBs 5629 and 5647) in the House to start to deal with the state's rural health problems and those of some smaller urban hospitals. Cathy Virskus, Senate Republican staff, said, "We need to provide some relief to our rural facilities now. We thought there would be some definite federal standards by now, but there aren't. Our problem is how to get relief and stay reimbursable by Medicaid and Medicare." To date no dollar figures have been attached to the bills, although the costs for some might be substantial, and no one is indicating where the money will come from.

Two bills apply exclusively to hospitals with fewer than 150 beds, a number that describes almost half of the state's acute care hospitals. SB 889 would allow hospitals to apply to the MDPH for designation as primary care hospitals. The legislation is modeled after a California law and would let these hospitals provide emergency care, stabilization, basic inpatient care, obstetrical care, primary inpatient surgery and outpatient surgical care, ambulatory care, and basic radiology and laboratory services. Primary care hospitals would be required to participate in the Medicaid program but would not be required to meet the current staffing requirements of acute care hospitals. SB 891 (identical to HB 5647) would remove some of the CON restrictions on the smaller hospitals—no CON would be needed to buy mobile covered medical equipment jointly with another small hospital. It would appear that the latter provision would allow small hospitals to band together to purchase mobile MRI equipment and CT scanners without going through the CON process, a provision that is apt to distress their larger competitors and the CON Commission.

The third bill, SB 890, would allow "bed-banking." Hospitals could delicense beds for a period of five years with one five-year extension allowed and could use the space for alternative purposes such as senior respite and day care or mental health services or lease the space to providers—no CON would be needed for these alternative uses. The beds would stay in the state's bed inventory and could be relicensed without going through the CON process.

The fourth bill, SB 892 (identical to HB 5629), abolishes the Medicaid program's differential reimbursement for hospitals and providers in rural and urban areas and would make the Medicaid program a payer for patients in swing beds (currently Medicare pays for such patients). This is the bill that is apt to be most costly for the Medicaid program and is the program that observers concede definitely will not be revenue neutral.

Nancy Fiedler, group vice-president, public affairs, Michigan Hospital Association, said that her group supports the concepts. While noting that getting Medicaid to pay its full share (defined as getting full costs for services provided by hospitals) remains a high priority for the MHA, she said, "It's absolutely a step in the right direction. The Medicaid differential is a major item for rural hospitals."

OF INTEREST

Both houses adjourn for the Easter break on April 5 and return on April 24. The House Committee on Public Health expects to hold a hearing on HB 5426 (adult day care licensure) and to take up HB 4176 (dental specialties). The top priority in the Senate Committee on Health Policy is HB 4952 (emergency medical services) and SBs 469–471 (DNA profiling). Rural health, according to Sen. Sederburg, is a major initiative.

—Frances L. Faverman, Editor

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