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MEMORANDUM

TO: House Health Policy Committee
FROM: Health Care Association of Michigan (HCAM)
RE: Nursing Facility Employment of Physicians – SB's 65, 66 and 67
Clinical Process Guidelines – SB 64
DATE: May 19, 2015

Representative Callton, committee members, my name is David LaLumia, I am the President/CEO of the Health Care Association of Michigan (HCAM). HCAM is a statewide trade association representing proprietary, non-proprietary, county medical and hospital long-term skilled nursing and rehabilitation facilities. Our profession consists of more than 400 facilities employing more than 40,000 dedicated workers throughout our state. Thank you for the opportunity to discuss Senate Bills 65, 66 and 67 addressing the issue of proprietary nursing facilities directly employing physicians.

HCAM is seeking clarification to the “learned professions” doctrine, also known as the “corporate practice of medicine” doctrine that prohibits proprietary nursing facilities from directly hiring physicians for resident care. The principle arose in the 19th century in common law that a corporation may not offer professional services to the public.

One of the philosophical underpinnings of the learned professions doctrine has been concern that profit motive will corrupt the purity of professionalism that society deserves, which has contributed to an exception to the Michigan doctrine.

Michigan’s doctrine is based on an Attorney General opinion that stated a nonprofit corporation, not being formed to make profit, might safely offer professional services through employment and a business corporation could not. Thus, in the extended care world, Michigan has an odd dichotomy: nonprofit institutions may hire their own physicians, while proprietary entities cannot.

Senate Bill 65 amends the Public Health Code to establish that a nursing facility’s license includes within its scope not only room, board and nursing care, but physician care. Senate Bills 66 and 67 amend the Business Corporation Act and Limited Liability Company Act to allow an exception to the “learned profession” doctrine for nursing facilities to hire physicians.

The Public Health Code, the Business Corporation Act 284 and Limited Liability Company Act 192 intersect unexpectedly when a for-profit nursing facility, seeks to truly integrate physician services through direct employment. Under the Public Health Code, the state routinely issues nursing facility licenses to Act 284 corporations, who offer professional nursing services.

That Code also requires that nursing facilities provide medical (physician) services. If an Act 284 nursing facility can't offer physician services directly to its patients, then the objectives of the Public Health Code are obstructed.

The language of Act 284 therefore may not require that institutional and professional services be separated, but offers a clear path to the efficient hiring of physicians by nursing facilities.

Accountable care organizations, managed care for "duals," complex medical treatment are all reason why we are seeking this change.

Initiatives in the Patient Protection and Affordable Care Act intensified the federal movement from compartmentalized health care, calling for the creation of Accountable Care Organizations (ACO) and managed care for the "dual" eligibles. At root, ACOs serve the same goal in integrating institutional and professional services, with interdisciplinary sharing of case management. For nursing facilities, it means careful management of hospital readmissions, working with their ACO "partners" to minimize returns to hospital inpatient settings.

Similarly to the ACOs, the impetus behind integrated care for "dual" eligibles is the integration and coordination of patient care transitions through the different health care settings. Managed care organizations will be looking for step down alternatives to hospital stays and competent providers capable of caring for complex physical conditions out of the hospital setting. Nursing facilities will have to develop clinical specialties and improve existing clinical skills.

The residents in nursing facilities today have come to resemble those in general hospitals two decades ago, requiring more specialized therapy and complex medical treatments.

Nursing facilities are reaching the limits of the traditional model of independent physician services in their facilities. An obvious step is to follow the lead of many hospital systems, and add physicians known as "hospitalists" to the employed staff, where, free of the competing obligations of private practice, physicians concentrate on developing coordinated care.

Nursing facilities across the country are starting to explore this option as well. Hiring what is affectionately called a "SNFist." This will allow for meaningful care as physicians in facilities on a daily basis will get to know residents and families very well. They will identify immediately a decline in a resident's health and start treatment before it becomes acute and potentially avoid a hospitalization. Preventing hospitalizations is key, as it not only provides better care, but saves Medicare and Medicaid dollars.

The healthcare landscape is significantly changing. Nursing facility providers need tools in the tool box...ultimately, this option will lead to the facility physicians, the primary-care doctors and hospitals working together as a unified team to ensure the best care.

Senate Bill 64

I would also like to briefly speak to Senate Bill 64. In 2012, Public Act 322 sponsored by Senator Geoff Hansen, provided a comprehensive update to the survey and enforcement process of Michigan's nursing facilities. The legislation, in part, required the biennial update of all Michigan specific Clinical Process Guidelines (CPG.)

The CPGs were put in place a decade earlier as a tool for nursing facilities to establish a commonly held standard of practice in certain clinical process areas and to promote common understanding and consistent decision making in the state oversight process of nursing facilities. They served their purpose well, resulting in improved resident outcomes. Some of the CPG clinical areas include; prevention of pressure ulcers, nutrition, hydration, dementia and falls, etcetera.

Public Act 322 also established a Clinical Advisory Committee comprised of individuals from the Department of Licensing and Regulatory Affairs, provider associations, the Long-Term Care Ombudsman's Office, the Michigan Chapter of the American Medical Directors Association and the Michigan Peer Review Organization. The committee was asked to review and update the current set of Michigan Clinical Process Guidelines, as appropriate.

Following a thorough review, the committee determined in the intervening years since Michigan specific CPGs were established that many other nationally-recognized evidence-based clinical process guidelines and best practice resources have become available and are being widely used by providers for the purpose of improving and maintaining the quality of care for residents. For example, the American Medical Directors Association currently publishes and regularly updates clinical process guidelines specific to nursing facility practice on twenty-two clinical topics (a menu far greater than the clinical topics included in the Michigan CPGs.) More are being developed. These resources, and others, are developed by and vetted through national experts in geriatric medicine. Based upon the availability of superior nationally-recognized, evidenced-based guidance, the committee recommended the outdated Michigan CPGs be eliminated. The committee took its recommendation and the support data for its position to the LARA Stakeholders Workgroup, where it was thoroughly considered and unanimously supported. These recommendations were brought to the sponsor of PA 322 of 2012 for reconsideration and were determined to be appropriate, hence introduction of SB 64.

What is most important is that facilities use an evidence-based nationally-recognized clinical process guideline or best practice resource for development and implementation of operational policies and evaluation of performance in all critical areas of clinical practice. SB 64 establishes that standard and reinforces an expectation for superior clinical performance confirmed by the state oversight process for all nursing facilities.

Thank you for your time.