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HEALTH POLICY BULLETIN

FOCUS: A CON REVIEW CATCH 22

The new certificate of need law, effective October 1, 1988, provided that all items applied for or in appeals under Part 221 of the old law had to be treated as though the total existed and was on line before projects applied for under Part 222 of the new law could be awarded when there was competition for particular resources such as hospital or nursing home beds or other items subject to comparative review. According to Walter Wheeler III, chief, Bureau of Health Facilities, Michigan Department of Public Health (MDPH), this provision was necessary to ensure that (1) all parties with appeals pending under Part 221 had their rights protected and (2) the state did not end up with more facilities or equipment than was needed to provide adequate access to health care services (who can forget Huron Valley?). However, the provision effectively has held Part 222 projects hostage to Part 221 appeals and any subsequent litigation that may arise from the 221 appeals; that has attracted the attention of the legislature and of the Certificate of Need Commission.

A fine tension exists between the need to have a fair competition for limited resources (in this case, beds), and the state's determination to limit the duplication of health resources beyond those justified by a demonstrated need. The state's response to allowing for the vagaries of its own appeal process and for those of litigation was to persuade the legislature to put into the CON reform statute the caveat that the total number of, say, beds to be awarded had to include those that had been applied for but not yet ruled on under Part 221 and those that had been denied or awarded to another applicant under Part 221 and were being appealed either through the state's own process or through the courts. For example, if the bed need methodology indicated 1,000 beds were available, and the total number of beds applied for under pending Part 221 appeals met or exceeded the need, all Part 222 applications were denied because (1) the new CON statute requires the MDPH to rule on Part 222 applications within a certain period of time and (2) the treatment of available beds under Part 221 means there is no bed need left for Part 222 applicants.

It should be noted that the "Catch 22" could have arisen with any beds or equipment subject to comparative review, but the focal point of this attention is Wood Care, Inc., a long-term care company, that filed 11 applications for CONs for nursing home beds on April 1, 1988, under Part 221. The CONs totaled 1,020 beds and $64.5 million in new construction; the MDPH denied all 11 requests, and Wood Care, Inc., has appealed to the Certificate of Need Appeals Board. With the exception of Oakland County, the number of beds applied for exceeded the number of beds available (according to the department's bed need methodology) in each county.

Wood Care's appeal hearings have not gone smoothly for several reasons, most of them, according to department representatives, beyond the control of the MDPH. Ronald Styka, assistant attorney general, noted that Wood Care's attorney had asked for a delay due to injuries he had suffered in an accident, and, as a consequence, the hearings were moved down on the schedule. He also noted that Wood Care had declined the department's offer to consolidate the applications for hearings. Wheeler pointed out that the department's decision to hire its own hearing officers rather than continue to use contract hearing officers at the behest of the attorney general's office and the Department of Management and Budget also contributed to the delay. Wood Care's representative, attorney Jay Seifman, does not agree with the attorney general's assessment: he says he is prepared and is ready for hearings. Enter SB 909.

Senators Binsfeld, DeGrow, Posthumus, and others introduced a bill on April 3 that would prohibit the Certificate of Need Appeals Board from considering beds granted under Part 222 when deciding reviews or appeals under Part 221. This would allow Part 222 projects to be decided without reference to the Part 221 projects and would mean that the Part 222 beds would not be counted when determining bed availability under Part 221. However, the proposed legislation would not be in line with the state's current bed need determination. One possible avenue to avoid legislative tinkering with the CON law is a bureaucratic solution: create a special pool of beds to account for possible Part 221 beds and separate them from Part 222 beds. There is precedent for this kind of solution: At present a special pool of 700 beds exist outside the bed need methodology for Alzheimer's disease, AIDS, and rural patients. The Certificate of Need Commission also could resolve the problem through its long-term care standards by creating a pool of beds. At its April 23 meeting, the commission asked its staff to study the situation and report on it at the commission's July meeting.

Speaking for Wood Care, Seifman says, "My client and I have been waiting for two years for hearings. How can they approve beds under Part 222 when Part 221 isn't resolved? People already in the system should have preference. I think everybody should be on a level playing field; otherwise, it isn't fair."

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FOCUS: "ASK NOT FOR WHOM THE BELL TOLLS"

State leaders are considering the fallout from Judge Robert Holmes Bell's opinion last week. The Michigan Hospital Association (MHA) sued the state for inadequate Medicaid payments in July 1989. In his ruling Judge Bell found that the state had not made any attempt to determine whether its payments met the standard set in the federal law, specifically in the Boren Amendment, which requires that payments to hospitals be at the level of 95 percent of the costs of efficiently and economically operated facilities. Judge Bell threw out the present reimbursement system and reinstated the previous system, ordering the state to present a plan to him within 180 days. Some published estimates indicate that another $100 million will be needed to fund the Medicaid budget for FY 1990, and another $112 million will have to be added to the FY 1991 budget that the legislature currently is working on. Sen. Geake, chairperson, Senate Appropriations Subcommittee on Social Services, said, "I have no idea where we will find another $100 million in this year's budget."

Kevin Seitz, director, Medical Services Administration, Michigan Department of Social Services, says that the agency and the department are "busy sorting out the implications of the ruling and attempting to decide if the state will appeal." He noted that the agency had submitted a plan amendment to HCFA at the beginning of April and that the amendment had not been considered in Judge Bell's ruling. The proposed amendment would define efficient and economically operated hospitals as those operating at 80 percent of licensed bed capacity and whose costs were at or below the median costs for all Michigan hospitals—a definition that would leave out close to half of the hospitals in the state. When asked how much he thought the ruling would cost the state, Seitz remarked, "Right now, I don't know—in fact, we are in the modeling stages of trying to work out the costs for interim relief [the reinstatement of the Medicaid payment formula used in 1986 with market basket inflation updates to 1990] and the costs of a permanent plan."

Fred Baker, an attorney with Honigman, Miller, Schwartz, and Cohn, the law firm representing the MHA, observed that "the state has to follow federal law when it has a plan. The last plan that met the requirements of the law is reinstated, and that plan provides interim relief. Judge Bell's ruling adhered very closely to the requirements of the federal law. It does not interfere with the state but merely makes the state follow the law. This ruling is very narrow and does not make social policy." Baker interprets the ruling to mean that hospitals will have to be paid the 1986 rates plus a cumulative 22 percent update for market basket inflation, a significant contrast to the total 4 percent update granted by the state over the past four years.

PSC asked legislators and others about the implications of the ruling for a possible Oregon-style rationing system for Medicaid services and for the competitive bidding amendment attached to HB 5484, the House-passed budget bill for social services. The Oregon plan would create a commission to set priorities and limits for health services; for example, Oregon would fund family planning, prenatal care, treatment for acute illnesses but not alcohol and drug abuse education, eye and hearing examinations for nonelderly adults, or organ transplants and cosmetic surgery. Seitz pointed out that the Oregon plan has yet to receive a waiver from HCFA, that the waiver is being blocked by several congressmen. "The fear," according to Seitz, "is the creation of a two-tier system where public insurance will be characterized by explicit rationing and will differ significantly from private insurance. Competitive bidding (selective contracting) has proved to be a fairly viable way of complying with the Boren Amendment." Major states using selective contracting are California, Illinois, and Washington; however, they are also under attack for inadequate reimbursement.

Rep. Munsell, one of the sponsors of the competitive bidding amendment, said the process would be a cost containment measure: "It would have the most relevance in urban areas where there is competition. Reimbursement for full costs would give hospitals incentives to bid on the procedures they are best at. It is harder to convince people to bid competitively if they are losing money." She also observed that one of the problems in measuring costs is that there is no industrywide consensus on what should be counted as costs.

Sen. Geake thought "if the hospital occupancy rates are low enough, it might work."

Competitive bidding raises questions about access—by definition, there are always winners and losers in such a process. Currently, all hospitals in the state participate in Medicaid. What happens if suddenly half the hospitals in the state do not? What about communities where the local hospital is the sole provider?

OF INTEREST

In the next thirty days, look for the

- House Committee on Public Health to report out HB 5004 (social worker licensing), HB 5688 (residency requirements for board members), and HB 5531 (exemption from licensing for organizations providing only information about substance abuse services) and
- Senate Committee on Health Policy to report out SBs 889–892 (the Senate's rural health package), SB 661 (tanning facilities), SB 664 (do-not-resuscitate orders), and SB 910 (immunity from suit for health care providers and facilities).

—Frances L. Faverman, Editor