Gerald Faverman, Ph.D. • *Chairman of the Board*
Craig Ruff • *President*
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Public Sector Reports

HEALTH POLICY BULLETIN

FOCUS: NEW MEDICAID RATES

On April 1, Medicaid rates of reimbursement for hospitals underwent major changes. Last year, the legislature directed the Medical Services Administration (MSA) to rebase (recalculate) the rates to assure that no hospital's reimbursement is less than 95 percent of its costs. MSA Director Kevin Seitz says the reason is that the old DRG rates, when combined with adjustments for inflation and indigent patient volume, resulted in some hospitals--particularly those that serve a disproportionately high number of indigent patients--being paid more than their billed charges. As of last month, the new payment rates rearranged the list of winners and losers among state hospitals.

Medicaid payments went up for hospitals that had been receiving payments equal to less than 95 percent of their reported costs. Some hospitals, however, are receiving significantly reduced Medicaid reimbursement. These "losers" include major teaching hospitals such as the University of Michigan and Henry Ford and large inner-city hospitals such as Detroit Receiving and Michigan Osteopathic Medical Center that treat large numbers of indigent patients. Seitz defends the new rates, saying, "What we've done is to even out the playing field and correct errors." About 40 percent of hospitals won higher rates of reimbursement; 60 percent fared worse. Those suffering lower rates, however, consume 80 percent of Medicaid hospital funds.

The governor's budget calls for an additional $18.7 million in cost savings through DRG rebasing and new cost containment initiatives during the 1987-88 fiscal year. Hospitals feel these savings are excessive; but with the prospect of the economy cooling off and the state budget tightening up, state legislators appear unsympathetic.

FOCUS: CARDIAC CARE CERTIFICATES OF NEED

While the legislature deliberates on proposed changes to loosen the certificate of need law, the Department of Public Health is preparing to settle a major CON case in southeast Michigan. The case involves eight hospitals that sought new or expanded cardiac care services, including cardiac catheterization. After a complicated and complex appeal of CON decisions, it appears that the MDPH will offer to settle the dispute by permitting all eight hospitals to expand cardiac services. This action seems to run counter to the State Health Plan, which states, "No additional cardiac catheterization laboratories should be developed unless each existing unit in the health services area is operating and continuing to operate at greater than 500 adult cardiac catheterizations per year . . .." At least three of the eight hospitals involved fail to meet this criterion. Also at issue is a criterion limiting labs to no more than one for each 300,000 area residents; this may also be set aside in this case.

One reason for loosening cardiac care regulation is the growing sophistication of and need for interventional cardiology, through which patients suffering heart attacks can be quickly stabilized. New drugs--such as TPA, which, when injected directly into the heart muscle, stops a heart attack immediately--and new technology--such as lasers that destroy blockages during heart attacks--can be administered or installed in almost any hospital, not just in regional cardiac care centers, as was envisioned when the State Health Plan and earlier Public Health regulatory guidelines were written.

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OF INTEREST

The Grand Valley Health Plan recently declined to pay for a heart transplant on two grounds: (1) the procedure is experimental, not therapeutic, and (2) since they are not a federally qualified HMO, they need not follow Medicare certification rules. Richard Yerian, D.O., Chief Medical Consultant, MDPH Bureau of Health Facilities, subsequently directed the plan to pay for the transplant on the grounds that a heart transplant is an accepted medical practice, a position also held by the Insurance Bureau.

Bill Sederburg, chair of the Senate Health Policy Committee, will be watching closely as the Department of Social Services awards the contract for Medicaid utilization and peer review functions. The present Medicare reviewer, Michigan Peer Review Organization (MPRO), is a likely bidder, but has been accused by some professionals as well as patients and their families of endangering quality health care. The Senate Health Policy Committee, reacting to criticisms of MPRO, included language in a resolution (House Concurrent Resolution 33) that called MPRO "a medical hazard to the senior citizens of Michigan" and stated that MPRO "lacks compassion for senior citizens and has denied admission to dying patients because [it] believes the patient would have died anyway."

Michael Bennane, chair of the House Public Health Committee, has appointed four subcommittees on major health issues:

Nursing Homes
Gubow (Huntington Woods), chair
Barns (Westland)
Palamara (Wyandotte)
Bandstra (Grand Rapids)
Pridnia (Harrisville)
Rocca (Sterling Heights)

Infant Mortality
Stallworth (Detroit), chair
Gire (Mount Clemens)
Docherty (Port Huron)
Stabenow (Lansing)
Krause (Rockford)
Trim (Waterford)

Certificate of Need*
Bennane (Detroit), chair
Gubow (Huntington Woods)
Porreca (Trenton)
Palamara (Wyandotte)
Stabenow (Lansing)
Brotherton (Farmington)
Dunaskiss (Lake Orion)
Law (Plymouth)
Rocca (Sterling Heights)

AIDS
Hunter (Detroit), chair
Barns (Westland)
Bennane (Detroit)
O'Connor (Ann Arbor)
Pridnia (Harrisville)

*The CON subcommittee will not consider pending legislation until the MDPH/OHMA work group report on health planning and CON revision comes out in early July. This means there likely will be no House action on CON issues until after the summer recess.

--Frances L. Faverman
Editor